General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Paydens Pharmacy, 7 Boughton Parade, Loose Road, MAIDSTONE, Kent, ME15 9QD

Pharmacy reference: 1123426

Type of pharmacy: Community

Date of inspection: 31/10/2019

Pharmacy context

The pharmacy is part of a large chain of pharmacies. It is located on a parade of shops in a residential area. It receives around 80% of its prescriptions electronically. And it provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations, a stop smoking service and emergency hormonal contraception. It also provides medicines as part of the Community Pharmacist Consultation Service. It supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. And it also supplies packs of this type to two nursing homes and one residential home.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	2.5	Good practice	Team members are comfortable about raising concerns about the pharmacy or other issues affecting people's safety. And they actively make suggestions about how to improve the pharmacy's procedures.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. It generally keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Team members had signed to show that they had read and understood the SOPs. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And shelf edges were highlighted with some of the similar drug names. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong type of medicine had been supplied to a person. An incident report had been completed and photocopy of the medicine box and label was kept at the pharmacy for future reference. The medicines were now kept on separate shelves to help minimise the chance of a similar mistake. The pharmacy received a monthly patient safety report from the pharmacy's head office and this was discussed during the monthly pharmacy meeting.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. The dispenser accuracy checker knew which prescriptions she could check and knew that she should not check items which she had dispensed. The pharmacist initialled prescriptions which he had clinically checked.

Team members' roles and responsibilities were specified in the SOPs. The admin manager explained that she would contact the pharmacy's head office if the pharmacist had not turned up in the morning. She knew that team members should not sell any medicines or hand out any dispensed items until the pharmacist had arrived. The dispenser accuracy checker said that she would not carry out any dispensing tasks or any check any dispensed prescriptions if there was no responsible pharmacist signed in.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. There were signed in-date Patient Group Directions available for the relevant services offered. And all necessary information was recorded when a supply of an unlicensed medicine was made. The private prescription records were mostly completed correctly, but the prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The nature of the emergency was not routinely recorded when a supply of a

prescription only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. Controlled drug (CD) registers examined were largely filled in correctly. But the address of the supplier was not usually recorded. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed and the RP log was largely completed correctly. But, the pharmacist had not completed the log since he signed out on 28 October 2019. The inspector explained about the importance of ensuring that the log was completed contemporaneously. The pharmacist completed the missing entries during the inspection. He said that he would ensure that all records were completed correctly and fully in the future.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens in the dispensary. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could be viewed by people using the pharmacy, but people's information could not be read from the medicines counter. Some of the pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website. Results were generally positive and over 75% of the respondents were satisfied with the staff overall. The complaints procedure was available for team members to follow if needed. The pharmacist said that he was not aware of any recent complaint.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had received some safeguarding training provided by the pharmacy's head office. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The team members gave an example of action they had taken in response to safeguarding concerns. The pharmacist said that he sought guidance from the pharmacy's head office before taking any action. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. The team discusses adverse incidents and uses these to learn and improve. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, three trained dispensers (one was an accuracy checker), two trainee dispensers and two trainee medicines counter assistants (MCAs) working during the inspection. Team members had completed an accredited course for their role or they were undertaking training. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The dispenser said that there had been some recent staffing issues, but head office had been supportive and provided some cover when needed.

The trainee MCAs appeared confident when speaking with people. One, when asked, was aware of the restrictions on sales of pseudoephedrine containing products. And she explained that she would refer to the pharmacist if a person regularly requested to purchase any of the pharmacy-only medicines. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. The pharmacist had completed declarations of competence and consultation skills for the services offered, as well as associated training. Team members completed regular ongoing training on the pharmacy's online system. The admin manager monitored training and kept records to show what training had been done. Team members were given the opportunity to attend training provided by external agencies. They were paid for the training time and travel if they attended these events. The pharmacy had regular reviews of any dispensing mistakes and discussed these openly in the team.

The pharmacist said that he had visited the local surgery to speak with the independent pharmacist prescribers. He explained that he had arranged for the pharmacy to have direct contact details for the prescribers. And this helped the pharmacy to deal with any queries about prescriptions promptly.

Team members had yearly appraisals and performance reviews. The newer team members had reviews six weeks and twelve weeks after starting work at the pharmacy. Team members felt comfortable about making any suggestions or discussing any issues with the pharmacist or admin manager. The admin manager said that one of the team members had suggested that they have a separate designated area for when they were assembling the packs for the homes. This was marked and kept clear on the days when they were working at the pharmacy. And this helped to reduce any distractions when preparing packs.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that he did not feel under pressure to achieve the targets and carried out these services for the benefit of the

people who used the pharmacy. He explained that the pharmacy's head office would help if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter. But, there was no barrier to restrict people's access behind the medicines counter. The pharmacist said that there were plans to install a wider counter in the pharmacy and this would restrict unauthorised access. And he would remind team members not to allow people access to this area in the meantime. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available and the room temperature was suitable for storing medicines.

There were four chairs in the shop area for people to use while they waited in the pharmacy. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

There were two consultation rooms in the pharmacy. Both rooms were accessible to wheelchair users and were located in the shop area. They were suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with a power-assisted door. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available.

The pharmacist said that the local surgery sometimes recorded people's blood test results on their prescriptions if they were taking higher-risk medicines such as warfarin. The pharmacy did not keep a record of the blood tests. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said that he would keep a record of blood test results in the future. Prescriptions for higher-risk medicines were not highlighted. So, the opportunity to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The pharmacy had received some stickers recently from the pharmacy's head office and team members were planning to use these in the future to highlight prescriptions for higher-risk medicines and CDs. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant patient information leaflets and warning cards available. But these were not always given when needed. The pharmacist said that he would ensure that these were routinely provided in the future.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. The dispenser said that items due to expire within the next few months were marked. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked regularly. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The dispenser said that a team member was in the process of checking the uncollected prescriptions. She said that the uncollected prescriptions were returned to the NHS electronic system or shredded in the pharmacy. There were several expired prescriptions in the retrieval system and two had not been dated by the prescriber. The dispenser said that she would return these to the surgery and remove expired prescriptions to help minimise the chance of these being handed out in error.

The pharmacist said that he was in the process of carrying out assessments for people who had their medicines in multi-compartment compliance packs, to show that these were needed. Prescriptions for

people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that people requested prescriptions for these if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines to help minimise the chance of cross-contamination. The care homes were responsible for ordering prescriptions for their residents. The pharmacist said that he had a good relationship with the staff in the care homes. He explained that that a member of the head office team visited each care home to carry out medicines audits.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not obtain people's signatures for deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. The pharmacist said that he would ensure signature were recorded in the future. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The pharmacist said that some team members had undertaken training on how the system worked, but the newer members had not done the training yet. He said that the pharmacy should be using the equipment fully by the end of the year.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was replaced at regular intervals. The carbon monoxide testing machine was calibrated by an outside agency and the shredder was in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.