

Registered pharmacy inspection report

Pharmacy Name: Pharmacy 1st Ltd, 186-188 Canterbury Street,
Gillingham, Kent, ME7 5XG

Pharmacy reference: 9011572

Type of pharmacy: Community

Date of inspection: 08/10/2024

Pharmacy context

The pharmacy is in a largely residential area near Gillingham town centre. It provides NHS dispensing services, the New Medicine Service and the Pharmacy First service. The pharmacy supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. And it provides medicines to a small number of care homes.

Overall inspection outcome

✓ **Standards met**

Required Action: None

Follow this link to [find out what the inspections possible outcomes mean](#)

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	N/A	N/A	N/A
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 learns from mistakes that happen during the dispensing process to help make its services safer. The pharmacy protects people's personal information well. And people can provide feedback about the pharmacy's services. The pharmacy largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which were kept electronically. Team members used their individual log ins to access the SOPs on the pharmacy's tablet. The team knew which tasks could only be undertaken when there was a responsible pharmacist (RP) signed in. They said that the pharmacy would open if the pharmacist had not turned up in the morning. And they would signpost people to other local pharmacies if needed. Team members knew that they should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. 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. Following a recent review, pregabalin was now kept in a different area so that the different strengths could be kept separated. Team members said that they were not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person.

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. And workspace in the dispensary was largely free from clutter. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. The pharmacist marked prescriptions as 'checked' so that the accuracy checking technician knew which prescriptions had been clinically checked.

The pharmacy had current professional indemnity insurance. The dispenser said the people were referred to NHS 111 if they needed a supply of a prescription-only medicine in an emergency without a prescription. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were largely completed correctly, but the correct prescriber details were not always recorded. The right RP notice was clearly displayed, and the RP record was largely completed correctly. But there were several occasions recently where the RP had not completed the record when they had finished their shift and there was a different pharmacist working the following day. The importance of maintaining complete RP and private prescription records was discussed with the team during the inspection.

Confidential waste was removed by a specialist waste contractor, computers were password protected

and people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed and details about it were available in the shop area. Team members said that there had not been any recent complaints. And they said that they would refer any complaints to the SI.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about protecting vulnerable people. One of the dispensers described potential signs that might indicate a safeguarding concern and said that he would refer any concerns to the pharmacist. Team members said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. But the pharmacy could do more to ensure that team members are enrolled on accredited pharmacy courses in a timely manner. Team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist, two trained dispensers, one trainee dispenser and a college student on work experience, working during the inspection. One of the trainee dispensers had worked at the pharmacy for over three months and had not been enrolled on an accredited course for his role. Later, on the same day as the inspection, the SI confirmed that the trainee dispenser was now enrolled on a suitable course. Team members explained that holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. The pharmacy was up to date with its dispensing. And team members worked well together and communicated effectively during the inspection to ensure that tasks were prioritised, and the workload was well managed.

Team members appeared confident when speaking with people. One of the dispensers when asked knew about the restrictions on sales of pseudoephedrine-containing products. And she said that she would refer to the pharmacist if a person regularly requested to purchase medicines which may require additional care or could be misused. Team members knew which questions ask to establish whether the medicines were suitable for the person they were intended for.

Team members said that they were provided with ongoing training on a regular basis. And they said that their training was monitored by one of the pharmacists. They said that they could complete the training at work during quieter periods. The pharmacist was aware of the continuing professional development requirement for professional revalidation. And she felt able to make professional decisions.

Team members said that they had informal huddles each morning to discuss any issues and allocate tasks for the day. The pharmacy used a messaging chat group to share important information. And meetings were held on an ad hoc basis. Targets were not set for team members. Team members said that the services were provided for the benefit of the people using the pharmacy. Team members explained that they had performance reviews every six months, and they said that the trainees had monthly reviews. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions.

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 against unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter. 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 was seating in the shop area for people waiting for services. The consultation room was accessible to wheelchair users, and it could be accessed from the shop area and the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume 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. The pharmacy 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. And people who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

There was step-free access into the pharmacy through a wide entrance. 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 pharmacy could produce large-print labels for people who needed them.

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 (PPP). The pharmacy dispensed these medicines in their original packaging. The pharmacist said that she would refer people to their GP if they needed to be on the PPP and weren't on one. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The dispensers said that the regular pharmacist asked people about their recent blood test results, but these were not recorded on their patient's medication record. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being handed out when the prescription was no longer valid.

Stock was stored in a generally organised manner in the dispensary. But some different medicines or different strengths were not kept separated. Expiry dates were checked regularly, and this activity was recorded. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. And short-dated items were highlighted. The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. One of the dispensers explained the action the pharmacy took in response to any alerts or recalls. 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.

Fridge temperatures were checked daily, and 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. CDs were stored in accordance with legal requirements and denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Part-dispensed prescriptions were checked daily, and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. A dispenser

said that uncollected prescriptions were checked regularly, and people were usually contacted if they had not collected their items after around six weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The dispenser said that people had assessments by their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. But prescriptions for 'when required' medicines were not routinely requested by the pharmacy. The dispenser said that people requested these from their GP 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 it 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 that were placed in these packs. The care homes were responsible for requesting prescriptions for their residents. The pharmacy cross-referenced the prescriptions against a list of medicines ordered and any discrepancies were queried with the care home.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible, and these were recorded on a handheld electronic device and recorded in a way so that another person's information was protected. The pharmacy could track the driver and let people know when they could expect their delivery if they asked. 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.

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. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was in good working order, otoscope, and thermometer. Use disposable tips. An automated unit dose packaging machine was used for dispensing some medicines for care homes. It was in good working order and regularly cleaned.

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.