General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pender Pharmacy, 49 High Street, Gravesend, Kent, DA11 0AY

Pharmacy reference: 9012195

Type of pharmacy: Community

Date of inspection: 01/10/2024

Pharmacy context

The pharmacy is on a busy high street in a town centre in a largely residential area. It provides NHS dispensing services, the New Medicine Service, flu vaccinations (seasonal) and COVID vaccinations. It 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 substance misuse medications to a small number of people. The pharmacy had relocated around five months prior to the inspection, and this was the first inspection of the new premises.

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	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. Team members understand their role in protecting vulnerable people. And people can provide feedback about the pharmacy's services. The pharmacy largely protects people's personal information. And it largely keeps the records it needs to keep by law. But it doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) and team members' roles and responsibilities were specified in them. Team members had signed to show that they had read, understood, and agreed to follow the SOPs. They knew which tasks should only be undertaken if there was a responsible pharmacist (RP) signed in. And they knew what tasks they should not undertake if the pharmacist had not turned up in the morning. Team members knew that they should not sell pharmacy-only medicines or hand out dispensed medicines if the pharmacist was not in the pharmacy.

Team members explained how near misses, where a dispensing mistake was identified before the medicine had reached a person, were dealt with. The near misses 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 not recorded which meant that the pharmacy could be missing out on opportunities to learn. This was discussed with the team during the inspection. 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 clearly highlighted where medicines that looked alike and sounded alike were kept. Team members were not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. The pharmacist said that dispensing errors would be recorded on a designated form and a root cause analysis would be undertaken. 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.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And there was ample workspace in the dispensary which was free from clutter. Baskets were used to help minimise the risk of medicines being transferred to a different prescription. Team members initialled dispensing labels when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity insurance. The right RP notice was clearly displayed, and the RP record was completed correctly. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. And any liquid overage was recorded in the register. 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 nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The importance of maintaining complete records about private prescriptions

and emergency supplies was discussed with the team.

Bagged items waiting collection could not be viewed by people using the pharmacy. Confidential waste was shredded, computers were password protected and people using the pharmacy could not see information on the computer screens. The pharmacist did not have her own smartcard to access the NHS spine and was using someone else's. And some other team members did not have their own smart cards. Team members said that they were in the process of applying for them.

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

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained 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. Team members can take professional decisions to ensure people taking medicines are safe. And they can raise any concerns or make suggestions.

Inspector's evidence

There was one pharmacist, two trained dispensers (one was a locum dispenser) and one trained medicines counter assistant (MCA) working during the inspection. The MCA 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. Team members communicated effectively during the inspection to ensure that tasks were prioritised, and the workload was well managed.

The MCA appeared confident when speaking with people. She said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care. And she was aware of the restrictions on sales of medicines containing pseudoephedrine. Team members asked people relevant questions to establish whether the medicines were suitable for the person they were intended for.

Team members said that they were not provided with ongoing training on a regular basis, but they did receive some on an ad hoc basis. The pharmacist explained that she had recently shared information with the team about vitamins for breast feeding mothers and sodium valproate. The pharmacist was aware of the continuing professional development requirement for professional revalidation. And she had recently undertaken training for the Pharmacy First service.

Team members explained that they had informal huddles at the start of the day in which they discussed any issues and allocated tasks. They also used a messaging chat group to share important information. Targets were not set for team members. And the pharmacist said that she felt able to make professional decisions. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they said that they had informal ongoing performance reviews.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. And 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 was in the shop area. 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. And people with a range of needs can access the pharmacy's services. 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. The pharmacy highlights prescriptions for higher-risk medicines so there is an opportunity to speak with people when they collect these medicines.

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 some health information leaflets were available in the shop area. The induction hearing loop appeared to be in good working order and the pharmacy could produce large-print labels for people who needed them.

There were signed in-date patient group directions available for the relevant services offered. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not routinely kept. 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 which helped to minimise the chance of these medicines being handed out when the prescription was no longer valid. Team members said that they checked CDs and fridge items with people when handing them out. 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 pharmacist said that she would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacy usually dispensed these medicines in their original packaging, but there were some people who had them dispensed into their multi-compartment compliance packs. Team members explained that the pharmacy had undertaken risk assessments for these people. And team members ensured that the additional warnings were added to each pack.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist 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. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and items due to expire within the next six months were highlighted. There were no date-expired items found in with dispensing stock during a random spot check and medicines were kept in their original packaging.

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. 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.

Uncollected prescriptions were checked regularly. Team members said that items were only returned to dispensing stock where possible once the prescription had expired. This was discussed with the team, and they said that they would review this system. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. Part-dispensed prescriptions were checked frequently. '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.

One of the dispensers said that people had assessments by their GP to show that they needed their medicines in multi-compartment compliance packs. The pharmacy ordered prescriptions for people receiving their medicines in these packs in advance so that any issues could be addressed before people needed their medicines. One of the dispensers explained that prescriptions were sometimes received two days before the packs were due to be supplied. She said that these packs were assembled in advance of the prescription being received so that there were no delays in people receiving their medicines. Team members used the last backing sheet for reference when dispensing the packs and the original packaging from the medicines remained with the packs until the prescription was received. The pharmacist confirmed that the packs would not be supplied until the prescription was received. And the prescription would be checked against the backing sheet and medicines to ensure that there had not been any changes. 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. The pharmacist said that she would speak with the surgeries and request that prescriptions be sent to the pharmacy more than two days in advance.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible, and these were recorded in a way so that another person's information was protected. 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

Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only which 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. Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines only. Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was new, and it appeared to be in good working order. Team members said that it would be replaced in line with the manufacturer’s guidance. The phone in the dispensary was portable so it could be taken to a more private area where needed. And the shredder was in good working order.

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.