General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Delmergate Ltd., 163 Wayfield Road, CHATHAM, Kent, ME5 0HD

Pharmacy reference: 1032680

Type of pharmacy: Community

Date of inspection: 24/05/2021

Pharmacy context

The pharmacy is on a parade of shops in a largely residential area and the people who use the pharmacy are mainly older people. The pharmacy receives most of its prescriptions electronically. It provides a range of services, including the New Medicine Service, emergency hormonal contraception, chlamydia treatment, a stop smoking service and a needle exchange service. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people. The inspection was carried out during the Covid-19 pandemic.

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

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. And it uses this information to help make its services safer. It regularly seeks feedback from people who use the pharmacy. It generally keeps the records it needs to keep by law. Team members understand their role in protecting vulnerable people. And the pharmacy largely protects people's personal information well.

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), and reporting and reviewing of dispensing mistakes. And the pharmacy had carried out workplace risk assessments in relation to Covid-19. 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. Team members identified and rectified their own mistakes and near misses were recorded. The pharmacist said that he regularly reviewed the near miss record for any patterns, but this review was not recorded. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. There had been several near misses where the wrong strength of a medicine had been selected. The shelf where these were kept was highlighted to remind staff to double-check the strength they have selected before continuing with the dispensing process. Team members had undertaken some training to help them identify medicines which looked alike or sounded alike. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The pharmacist recalled an error where the wrong type of medicine had been supplied to a person. The two medicines involved had similar names and were in the same coloured packet. These were now kept separated on the shelves to help minimise a similar incident.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Team members worked in separate areas to help maintain a suitable distance. Baskets were used to minimise the risk of medicines being transferred to a different prescription. Team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs and the team worked to these during the inspection. The dispenser and medicines counter assistant (MCA) described the tasks they could and could not do if the responsible pharmacist (RP) had not turned up. The MCA knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. But she was not aware that she should not sell medicines on the general sales list if there was no RP signed in. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was clearly displayed and the RP record was completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. Controlled drug (CD) registers examined were

filled in correctly and the CD running balances were checked at regular intervals. The pharmacy's electronic CD register gave prompts for the checks to be carried out. 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 pharmacist was not able to access the private prescription record or the emergency supply record during the inspection. This was due to the slow running of the computer system when he attempted to access them. The pharmacist explained that he would record the nature of the emergency if he made a supply of a prescription-only medicine without a prescription. The inspector discussed the requirements of the private prescription records with the pharmacist.

Confidential waste was sent to the pharmacy's head office for appropriate disposal. Computers were password protected and the 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. Bags of dispensed medicines were kept in boxes on shelves behind the medicines counter. Some people's personal details were visible on them and could potentially be seen from the shop area. The MCA said that she would change the storage system to ensure that all people's details were protected from view.

The pharmacy carried out yearly patient satisfaction surveys. Results from the April to November 2020 survey available on the NHS website. And 93% of people who had completed the survey had rated the overall performance of the pharmacy as very good or excellent. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The dispenser would refer any complaints to the pharmacist and he would then report them to the pharmacy's head office. The pharmacist explained that the pharmacy had received a complaint and this had been managed by the pharmacy's head office.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (level 2) training about protecting vulnerable people. Other team members had completed safeguarding training, but the dispenser could not locate her certificate to show which training provider this had been done with. She could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The dispenser explained how she had referred a concern to the pharmacist and this had been passed to the person's GP. 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 trained team members to provide its services safely and the team are provided with some ongoing training to help maintain their knowledge and skills. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. 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 and these are not affected by the pharmacy's targets.

Inspector's evidence

There was one regular full-time pharmacist, two trained dispensers and one trained MCA working during the inspection. Another dispenser was on leave, but the team were managing the workload well. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The MCA appeared confident when speaking with people. She was not aware of the restrictions on sales of pseudoephedrine-containing products. But said that she would check with the pharmacist before selling more than one box of any over-the-counter medicine. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She used effective questioning techniques to establish whether the medicines were suitable for the person.

The team kept certificates in their individual folders to show what training had been undertaken and when this had happened. The pharmacist said that team members were not currently provided with ongoing training on a regular basis and this was due to the increased workload during the pandemic. He said that the training would recommence once the level of workload allowed time for this. The pharmacist explained that he read pharmacy-related magazines and passed on relevant information informally to team members. The team also had regular reviews of any dispensing mistakes and discussed these openly.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process and he felt able to take professional decisions. He had completed declarations of competence and consultation skills for the services offered, as well as associated training. The pharmacist kept a record of interventions and was in the process of recording one during the inspection. He had queried a high dose of a medicine for a child and the prescription had been changed to an alternative form so that a lower dose could be given.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The dispenser said that she would bring any issues to the attention of the pharmacist as they arose. Team members had all received two doses of the Covid-19 vaccination and they carried out twice weekly lateral flow tests.

Targets were set for the New Medicine Service. The pharmacist said that the pharmacy usually managed to reach the target for this service and he carried them out for the benefit of the people using

it. He did not feel under pressure to achieve the targets.

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, which presented a professional image. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. This meant that the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available and the room temperature on the day of the inspection was suitable for storing medicines.

There was a screen at one of the medicines counters to help minimise the spread of infection. The other counter did not have a screen, but the counter was such that it ensured that people maintained a suitable distance. The pharmacy was limiting the number of people in the shop area.

There was a small padded seating bench in the shop area for people to use. It was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. One seat on the bench was badly torn and this detracted somewhat from the overall appearance of the pharmacy.

The pharmacy's consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened. 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

People with a range of needs can access the pharmacy's services. The pharmacy provides its services safely and manages them well. And it dispenses medicines into multi-compartment compliance packs safely. 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 that there is an opportunity to speak with people when they collect these medicines.

Inspector's evidence

There was a small step up to the pharmacy, and there was a wide 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 MCA explained how the needle exchange service worked and how people were asked to place used sharps containers in a bag so that she did not have to handle them. She then transferred the container to a large yellow sharps bin.

The MCA and one of the dispensers managed the stop smoking service and they had both completed the necessary training. The MCA explained that she would not hand out any nicotine replacement therapy items during the initial consultation. She would discuss the six-week course with the person and make an appointment for them to return to the pharmacy to start the course. The MCA talked about the chlamydia packs and what details the pharmacist needed to check before supplying them. Treatment was provided by the pharmacist against a patient group direction and recorded on PharmaOutcomes. There were signed in-date patient group directions available for the relevant services offered.

The pharmacist checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was kept on the person's medication record. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 CDs were highlighted and the MCA knew how long these were valid for. The inspector did not find any prescriptions for Schedule 4 CDs during the inspection so could not check that these were also highlighted. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said that team members checked CDs and fridge items with people when handing them out. He 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). He said that he would make a note on the person's medication record if they were on the PPP. The pharmacy had the relevant patient information leaflets and warning cards available.

Stock was stored in a well-organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months was marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. The pharmacy kept lists of short-dated items which made it easier for team members to identify these for removal before they were due to expire.

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, but not always kept until the medicines were collected. This could make it harder for team members to refer to the original prescription when the medicines were handed out. The pharmacist said that he would ensure that a copy of the prescription was kept with the items until they were collected. Uncollected prescriptions were checked monthly. The pharmacist said that people were contacted if they had not collected their medicines after around two months to check if they needed them, before the items were returned to dispensing stock. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber.

The pharmacist said that there had been an increased number of people asking for their medicines to be dispensing into multi-compartment compliance packs. He had carried out assessments for these people to show that they needed the packs. The dispenser said that 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. And people contacted the pharmacy to request their 'when required' medicines when they needed them with their packs. 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 and medicine expiry dates were put on the packs to help people and their carers identify the medicines. Patient information leaflets were routinely supplied with the packs so that people had up-to-date information about how to take their medicines safely. Team members wore gloves when handling medicines that were placed in these packs. Team members involved with preparing and assembling the packs shared the workload and could provide cover where needed.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. Expired CDs were clearly marked and segregated. CDs that people had returned were recorded in a register. Two signatures were recorded to show that the destruction had been witnessed.

Deliveries were made by a delivery driver. The driver also delivered medicines for other pharmacies within the company. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. The driver explained that he asked people to confirm their details while maintaining a suitable distance, before leaving the items with them. 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, MHRA and the pharmacy's head office. 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.

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 and separate measures were used for certain liquids. Triangle tablet counters were available and clean. And separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitors were replaced yearly. The carbon monoxide testing machine had been calibrated by an outside agency before the pandemic, but it was not currently being used. The phone in the dispensary was portable so it could be taken to a more private area where needed.

The pharmacy had personal protective equipment, including masks, gloves and visors. Team members chose to wear either a mask of a visor where needed. And they used hand sanitiser frequently to help minimise the spread of infection. Hand sanitiser was also available in the shop area for people to use.

Fridge temperatures were checked daily and the maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The pharmacist said that the temperature settings had to be altered frequently to ensure that the temperature remained within the recommended range. He explained that the fridge was due to be replaced and the pharmacy was expecting a new one to be delivered on the day of the inspection.

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.