

# Registered pharmacy inspection report

**Pharmacy Name:** Daysol Pharmacy, 3 Parkside Parade, Northend Road, ERITH, Kent, DA1 4RA

**Pharmacy reference:** 1032739

**Type of pharmacy:** Community

**Date of inspection:** 03/02/2020

## Pharmacy context

The pharmacy is located on a small parade of shops in a residential area near to a large town, and close to the M25 motorway. This is one of two independent pharmacies owned by the same family. The pharmacy offers a variety of services. And provides multi-compartment compliance packs to around ten people who live in their own homes and substance misuse medications to around ten people.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

Overall, the pharmacy identifies and manages the risks associated with its services. It protects people's personal information well and people can feedback about the pharmacy's services. The pharmacy keeps the records it needs to keep by law, to show that its medicines are supplied safely. And team members understand their role in protecting vulnerable people.

### Inspector's evidence

The pharmacy adopted some 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 processes. The superintendent (SI) pharmacist kept a record of near misses, but he confirmed that there had not been any that had occurred recently. The SI said that he would encourage team members to record their own mistakes and he would review the log for patterns. Medicines in similar packaging were separated where possible. Designated forms were available for recording dispensing incidents. The SI said that he would report the incident on the National Reporting and Learning System. He said that he was not aware of any dispensing incidents at the pharmacy.

Baskets were sometimes used to minimise the risk of medicines being transferred to a different prescription. But they were not consistently used. There were several dispensed medicines on top of prescriptions and this could increase the chance of errors. The SI placed these items in baskets during the inspection and said that he would use baskets in the future. The SI signed the dispensing label to show that he had checked each item.

Team members roles and responsibilities were specified in the SOPs. The SI said that the pharmacy would remain closed if he had not arrived in the morning. He confirmed that other team members did not have access to the pharmacy in his absence.

The pharmacy had current professional indemnity and public liability insurance in place. The private prescription records and emergency supply records were completed correctly. The responsible pharmacist (RP) log had been completed correctly and the right RP notice was displayed. Controlled drug (CD) registers complied with requirements. CD running balances were checked at regular intervals and any liquid overage was recorded in the register. A CD medicine was checked and the balance in the register matched the quantity in stock.

Confidential waste was shredded and computers were password protected. People using the pharmacy could not see information on the computer screens. The SI used his own smartcard to access the NHS spine during the inspection. He said that he removed the card from the docking station at the end of his shift and secured it in the pharmacy.

The SI said that the pharmacy carried out yearly patient satisfaction surveys. The most recent results available on the NHS website were from the 2017 to 2018 survey. But results from the 2019 survey were not available. The SI said that there had not been any recent complaints. And the pharmacy had a complaints procedure available for team members to refer to where needed.

The SI had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. He could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the relevant authorities. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The SI 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. And they undertake training for their role. Team members discuss any mistakes openly so that they can learn from them. But the pharmacy could do more to ensure that team members are enrolled on accredited pharmacy courses in a timely manner.

### Inspector's evidence

The SI was working during the inspection. The SI said that the trainee dispenser had worked at the pharmacy for around three months, but she had not yet been enrolled on an accredited course. Following the inspection, the SI confirmed that the trainee dispenser had been enrolled on a suitable course for the tasks she was undertaking.

The SI communicated effectively with people who were using the pharmacy. He discussed their medicines with them and he used effective questioning techniques to ensure that the medicines were suitable for the person. He prioritised tasks and managed the workload well throughout the inspection. The SI took a break between dispensing and checking medicines and sometimes checked them with people when handing out.

The SI explained that he was in the process of undertaking some training on sepsis and 'look alike and sound alike' medicines. He said that he planned to attend a workshop about managing gastrointestinal conditions. And he confirmed that he would ask the trainee dispenser if they would like to attend also.

The SI said that he carried out ongoing informal appraisals and performance reviews with the trainee dispenser. He said that this would be more formal and documented once the dispenser had worked at the pharmacy for a longer period. He said that he discussed her mistakes with her at the time to help minimise the chance of a similar mistake. And he said that he passed on any information to her during the day. He confirmed that he asked for feedback from her about the pharmacy and its processes and how these might be improved.

Targets were not set for the services. The pharmacist said that he carried out Medicines Use Reviews for the benefit of the people using the pharmacy.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The premises generally provide a safe and secure environment for the pharmacy's services. But the pharmacy could do more to keep the dispensary free from unnecessary clutter.

### Inspector's evidence

The pharmacy was secure to restrict unauthorised access and pharmacy-only medicines were kept behind the counter. The SI had a clear view of the shop area from the dispensary, so he could talk with people when they entered the pharmacy.

Air-conditioning was available; the room temperature was suitable for storing medicines. There were three chairs available in the shop area. Workspace in the dispensary was cluttered with little space for dispensing. But there was a small cleared space where the pharmacist was working.

The consultation room was accessible from the shop area and it was well screened. Low level conversations in the consultation room could not be heard from the shop area. And the sharps container was kept out of reach of children. Toilet facilities were not used for storing pharmacy items. There were separate hand washing facilities available. These were also not used for storing pharmacy items.

## 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 largely stores them properly. And 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.

### Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. The pharmacy team had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. A variety of patient information leaflets were available. Services and opening times were clearly advertised.

The SI said that he checked monitoring record books for people taking high-risk medicines such as methotrexate and warfarin. And he confirmed that a record of the person's blood test results was kept on their medication record. This made it easier for the pharmacy to show that people were having their blood tests at regular intervals. The pharmacist said that the local surgeries would not usually issue a prescription if the person needed a blood test. He said that he handed out prescriptions to people and discussed their medicines with them at the time. The SI said that prescriptions for Schedule 3 and 4 CDs were highlighted. None of these prescriptions were found during the inspection, so this could not be checked. The SI said that medicines requiring refrigeration were dispensed when the person came in to collect. He said that these were shown to people when handing out. He said that the pharmacy supplied valproate medicines to one person in the at-risk group. He confirmed that he had spoken with the person about the risks. And the pharmacy had the relevant patient information leaflets and warning cards available.

Stock was stored in an organised manner in the dispensary. The pharmacist said that expiry dates were checked regularly but records were not kept and short-dated items were not marked. And there were a few date-expired medicines found with dispensing stock. This could increase the chance that people received a medicine which was past its 'use-by' date. A few boxes of medicines contained mixed batches. Any this could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts promptly. The SI said that he would remind team members to ensure that medicines were kept in their original packaging. He said that he would implement a more reliable date-checking procedure to help minimise the chance of out-of-date medicines being supplied to people.

The SI showed the inspector some part-dispensed prescriptions on the pharmacy's computer system. But he was not able to locate the original prescriptions for these. He explained that he would use the dispensing labels for reference when dispensing the medicines. This could potentially increase the chance of mistakes when dispensing the remaining medicine. The SI said that he would keep the prescriptions at the pharmacy until the items were dispensed. The SI said that 'owings' notes were provided and people were kept informed about supply issues. And prescriptions for alternative medicines were requested from prescribers where needed. He said that uncollected prescriptions were checked weekly. And any items uncollected after around two months were returned to dispensing stock where possible, and the prescriptions were returned to the NHS electronic system or to the prescriber.

The SI said that assessments were carried out by people's GPs 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. Prescriptions for 'when required' medicines were not routinely requested; the SI said that people contacted the pharmacy if they needed them when their packs were due. The pharmacy kept a record for each patient which included any changes to their medication. Packs were suitably labelled, but there was no audit trail to show who had dispensed and checked each tray. And the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. The pharmacist said that he would ensure that these were attached in the future. Medication descriptions were put on the packs and patient information leaflets were routinely supplied.

CDs were stored in accordance with legal requirements. Denaturing kits were available for the safe destruction of CDs. CDs 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.

The SI said that he only provided a delivery service to those people who could not physically access the pharmacy themselves. He explained that he made the deliveries to people after the pharmacy had closed. And the pharmacy obtained people's signatures for deliveries.

Only licensed wholesalers were used for the supply of medicines and medical devices. The pharmacy received drug alerts and recalls from the NHS and the MHRA. A record of any action taken was kept so that the pharmacy could show what had been done in response.

The pharmacy had the equipment and authorisation code ready for the implementation of the EU Falsified Medicines Directive. But these were not yet in use and the SI said that he was not sure when these would be used.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy generally has the equipment it needs to provide its services safely.

### Inspector's evidence

Suitable equipment for measuring medicines was available. A separate measure was for methadone use only. There was methadone residue in the measure. Triangle tablet counters were available, and a separate counter was marked for cytotoxic use only. The pharmacist said that he would ensure that the equipment was cleaned before each use.

Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so could be taken to a more private area where needed. The shredder was in good working order.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range.

### 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.