

# Registered pharmacy inspection report

**Pharmacy Name:** Maidstone & Tunbridge Wells NHS Trust, Pharmacy Department, Maidstone Hospital, Hermitage Lane, MAIDSTONE, Kent, ME16 9QQ

**Pharmacy reference:** 1032831

**Type of pharmacy:** Hospital

**Date of inspection:** 31/05/2019

## Pharmacy context

The pharmacy is in Maidstone Hospital. The hospital is surrounded by residential premises. The people who use the pharmacy are mainly those who have been seen by a clinician at the hospital. The pharmacy uses its registration to sell pharmacy only medicines. And to supply medicines against private prescriptions and to other hospitals. The pharmacy is open seven days a week.

## 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>                                    | Good practice     | 2.2                          | Good practice    | The pharmacy encourages its team members to undertake ongoing training. And it gives them time set aside to do it.   |
|  |                   | 2.4                          | Good practice    | The pharmacy has a good culture of learning. It promotes learning, continuous improvement and the personal development of its team members.                          |
| <b>3. Premises</b>                                 | Standards met     | N/A                          | N/A              | N/A  |
| <b>4. Services, including medicines management</b> | Standards met     | 4.1                          | Good practice    | The pharmacy tailors its services to help meet the needs of the people in the local community. This means that people with a range of needs can access the services. |
| <b>5. Equipment and facilities</b>                 | Standards met     | N/A                          | N/A              | N/A  |

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy generally identifies the risks associated with its services. The pharmacy keeps the records required by law, but they are not always complete. So, they may not be reliable in the event of a future query. It generally protects people's information. And it actively seeks feedback from the public. Team members understand their role in protecting vulnerable people.

### Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. All the standard operating procedures (SOP) required by law were not available on the day of the inspection. The missing SOPs may make it harder for the pharmacy team to know what the right procedures are. The procedures not found included: 'the circumstances in which a member of pharmacy staff who is not a pharmacist may give advice about medicinal products' and 'the arrangements which are to apply during the absence of the responsible pharmacist from the premises'. The pharmacist said that she would ensure that these were made available.

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 trends and patterns. Due to the use of the dispensing robot there were few errors where the incorrect medicine had been selected. The pharmacist said that most errors happened during the labelling process. Reflective accounts were written by inexperienced team members if they made several similar mistakes. Medicines which looked alike or sounded alike were separated where possible. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the dispensing labels had been placed on the wrong boxes of injections. The mistake was noticed by a member of the ward team and highlighted to the pharmacy. The person was given the correct dose by the hospital. The pharmacist said that if medicines in similar packaging were received into the hospital, the team working in the stores would routinely make the pharmacy team aware. The regional newsletter was used to share learnings following mistakes.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Trays 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 pharmacy technician (accuracy checking technician (ACT)) knew which prescriptions she could accuracy check. The pharmacists initialled prescriptions which had been clinically checked. She said that she would not check any prescriptions if she had been involved in the dispensing process.

The dispenser said that the pharmacy would remain closed if the pharmacist had not turned up. This would be very unlikely to happen as there was always a minimum of three pharmacists on shift at the weekend. And there were more on shift on weekdays.

The pharmacy had current professional indemnity and public liability insurance in place. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. The address of the prescriber was not recorded in the private prescription register. The pharmacy did not make emergency supplies; the pharmacist said that people were referred to the

accident and emergency department.

Controlled drug (CD) running balances were checked around once every two weeks and at the time of dispensing. The recorded quantity of one item checked at random was the same as the physical amount of stock available. There were several occasions where the responsible pharmacist (RP) had not completed the log when they ceased to be RP. And there were alterations and obliterations which were not initialled. Some entries were not legible. The correct RP notice was clearly displayed.

Confidential waste was removed by a specialist waste contractor. And the people using the pharmacy could not see information on the computer screens. Computers were password protected. 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 not be viewed by people using the pharmacy. The pharmacy team members had completed General Data Protection Regulation training. There were some prescriptions left on the counter during the inspection. These were accessible to the public. The pharmacist said that she would remind team members to keep the counter clear.

The hospital carried out patient satisfaction surveys; results were available on the internet. The pharmacist said that a national in-patient survey was carried out yearly. The pharmacy had a complaints available procedure for team members to follow if needed. She was not aware of any recent complaints.

All team members had completed training about protecting vulnerable people and dementia training provided by the Trust. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. There were matrons within the hospital who specialised in safeguarding vulnerable people and people with learning difficulties. The pharmacist said that she was not aware of any safeguarding incidents at the pharmacy.

## Principle 2 - Staffing ✓ Good practice

### Summary findings

The pharmacy has enough trained 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 members are provided with protected training time. This means that they can complete this training at work. 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. The team discusses adverse incidents and uses these to learn and improve.

### Inspector's evidence

There were two pharmacists, two ACTs, two pharmacy technicians, one pre-registration pharmacy student, one dispenser and one trainee dispenser working in the dispensary during the inspection. The pharmacist said that other team members were working in the hospital carrying out other duties. The team 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 dispenser appeared confident when speaking with people. She said that only NVQ level 3 qualified team members or pharmacists were allowed to sell over-the-counter medicines. The pharmacy technician was aware of the restrictions on sales of pseudoephedrine containing products. She said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

Team members completed mandatory training every two years, including; safeguarding, data protection, fire safety, manual handling. The trainee said that she had nearly completed the NVQ level 2 pharmacy course. A team member was enrolled on the NVQ level 3 course. The pre-registration student was allowed protected training time and was given a training package by a course provider. All pharmacists had either completed or were enrolled on the clinical pharmacy foundation programme. Pharmacy technicians were either enrolled on or due to start the medicines optimisation programme or ACT training. Some team members completed educational supervisor training. This was for those team members who were supporting people doing courses. The pharmacist was currently carrying out a Masters in pharmacy practice. She said that there were a few team members enrolled on The Edward Jenner programme with the NHS leadership academy. This led onto a leadership scholarship with the Florence Nightingale Foundation.

The chief pharmacy technician said that she had completed continued professional development entries and was due to have her peer to peer review with the pharmacist. External organisations carried out training for the pharmacy team. The pharmacist said that the Mental Health Trust was due to carry out a presentation on mental health medicines. Webinars were available on the intranet. Team members were encouraged to attend lunchtime training events. These were regular training sessions held by various people within the pharmacy team or from external training providers. The chief pharmacy technician said that the next one was on the revalidation process. She said that some team members had expressed concerns about the new revalidation processes.

The pharmacist said that there were daily team meetings to ensure that tasks were delegated and any issues from the previous day could be discussed. There were monthly clinical governance meetings. These were cross-site with teleconference facilities available. Departmental meetings were regularly held to discuss staff changes, changes in working practice, new procedures and any issues. A communication board was used to ensure that important information was available to all team members. Team members were reminded to initial and date any notes they left, so that any queries could be directed back to the person who wrote it. The pharmacist felt confident to discuss any issues with the pharmacy manager. Targets were not applicable in relation to GPhC registered activities.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services.

### Inspector's evidence

The pharmacy was secured from unauthorised access. Pharmacy-only medicines were kept behind the counter. It was bright, clean and tidy throughout; this presented a professional image. Air-conditioning was available; the room temperature was suitable for storing medicines.

There were ten chairs in the waiting area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The window at the counter was primarily used by hospital staff when the pharmacy was closed.

The consultation room was accessible from the waiting area and the dispensary. Low-level conversations in the consultation room could not be heard from the shop area. There was a table and four chairs available. The room was accessible to wheelchair users. The door to the waiting area could not be opened from the outside. There were see-through windows in the door to the dispensary. But the pharmacist said that the room was only used to discuss people's medicines in private and not for any other services. 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. And it generally manages its services well. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe to use.

### Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. The pharmacy team had a clear view of the medicines counter and waiting area from the dispensary. A variety of patient information leaflets were available. Services and opening times were clearly advertised. The induction hearing loop appeared to be in good working order. The pharmacist said that this was checked every six months. A bell was used to attract the attention of the pharmacy team. The pharmacy had implemented a 'Medicines; A Patient Profile Summary' system including easy-read leaflets. These were to help with compliance and to ensure that people understood what their medicine was for and how to take it. The leaflets included the medication helpline number. The pharmacy was subscribed to the 'Translabel' service. This enabled the pharmacy to print information leaflets in 40 different languages to help address the needs of the local community. The pharmacist said that the pharmacy was involved in a project with community pharmacy and with Kent County Council. The hospital would produce medication charts for carers when a person was discharged. These would be sent to the person's pharmacy and the pharmacy would provide a copy to the carer to ensure that the patient received a continuity of care.

The pharmacist said that she would check monitoring record books for people taking high-risk medicines such as methotrexate and warfarin. She said that she would contact the prescriber where needed. And that all private prescriptions had to be approved by the pharmacy manager or chief pharmacist before medicines were supplied. She said that she was not aware of any private prescriptions for these types of medicines. The pharmacist said that all medicines when handed out were shown to the person and team members discussed their medicines with them. Fridge items were labelled with 'keep in the refrigerator' and a highlighted 'use before date' was recorded on liquid antibiotics. The pharmacist said that all patients taking valproate medicines who may become pregnant were provided with warning cards and patient information leaflets. There were currently no patients who needed to be on the Pregnancy Prevention Programme. There was an audit trail to ensure that all patients who needed to be supplied with a warning card were supplied with it. The computer prompted team members to supply the warning card while they were dispensing these medicines.

Stock was stored in an organised manner in the dispensary. Expiry dates were for items not in the dispensing robot were checked every month and this activity was recorded. Stock due to expire within the next four months was marked. Short-dated stock lists were kept. There were no date-expired items found in with dispensing stock. Items with fewer than 12 months shelf life had their expiry date manually entered when put into the robot. Other items were given a 12 month expiry date from the date they were placed in the robot. Each month, items with an expiry date within the next four months were removed from the robot and placed on a short dated stock shelf. Items with less than one-month shelf life were disposed of appropriately. The pharmacy technician said that there was only one 'picking head' in the robot. When this was not working, team members were able to manually pick medicines from inside the machine.



Part-dispensed prescriptions were checked twice a day. The pharmacist said that people were kept informed about any supply issues and contacted when their medicine was ready for collection. Prescriptions for alternative medicines were requested from prescribers where needed. Where an unlicensed alternative medicine had to be used, a risk assessment was carried out and agreed with the prescriber and the chief pharmacist before being supplied. Uncollected prescriptions were checked monthly. Items uncollected after two months were returned to dispensing stock where possible. The pharmacist said that people were contacted to ask if they required their medicines. Some prescribers were informed if their patient had not collected their medicines depending on the drug or person it was for.

Denaturing kits were available for the safe destruction of CDs. CDs people had returned, and expired CDs were clearly segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded. The CDs were kept securely.

Only licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and recalls were received from the NHS via the cascade system. Any action taken was recorded, checked by the pharmacy manager and kept for future reference.

The pharmacy manager said that a business case had been put forward for the implementation of the EU Falsified Medicines Directive. The pharmacy did not yet have the equipment needed.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

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

### Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring medicines was available and clean. A separate measure was marked for CD use only. Triangle tablet counters and tweezers were available and clean; separate counters and tweezers were marked for cytotoxic use only. This helped avoid any cross-contamination. The phone in the dispensary was portable so could be taken to a more private area where needed.

Records indicated that the fridge temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. Temperatures were monitored every 15 minutes using a remote electronic sensor. If the temperature went below 2.5 degrees Celsius or above 7.5 degrees Celsius an alarm would sound with a flashing light. The on-call pharmacist and pharmacy manager would be informed. The pharmacist could view the temperature records and knew how long the medicines had been out of range for. She said that manufacturers would be contacted to find out if the medicines were safe to use.

### 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.  |