General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Delmergate Limited, 10 Tubs Hill Parade, London Road, SEVENOAKS, Kent, TN13 1DH

Pharmacy reference: 1032930

Type of pharmacy: Community

Date of inspection: 04/09/2024

Pharmacy context

The pharmacy is on a parade of shops in a largely residential area near Sevenoaks train station. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service and blood pressure checks. And it uses patient group directions to provide the travel vaccination and contraception services. The pharmacy also provides nicotine replacement therapy medicines and medicines to treat chlamydia under locally commissioned NHS services. And it supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support.

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. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce future risk. The pharmacy protects people's personal information well. And people can provide feedback about the pharmacy's services. Team members understand their role in protecting vulnerable people. And the pharmacy largely keeps its records up to date and accurate.

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. The medicines counter assistant (MCA) explained that the pharmacy would remain closed and the pharmacy's head office would be informed if the pharmacist had not turned up in the morning. And the pharmacy could return prescriptions to the NHS electronic system and people signposted to another local pharmacy if needed. The MCA said that she would attempt to contact the pharmacist and would inform the pharmacy's head office if needed. She was clear on which tasks should only be undertaken if there was a responsible pharmacist (RP) signed in. And she knew that she should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The dispenser explained that the pharmacist would inform him if he had made a dispensing mistake and it was identified before the medicine had reached a person (also known as a near miss). He said that he would be responsible for identifying and rectifying the mistake. And he recorded his mistakes on the near miss record. The pharmacist said that the near miss record was 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. The pharmacist said that following a recent review of the near miss record, the pharmacy now stored zopiclone and zolpidem separate to help minimise the chance of a similar mistake. The pharmacist said that the pharmacy made an electronic record of any dispensing errors, where a dispensing mistake had reached a person. He explained that a root cause analysis would be undertaken, and the pharmacy's head office would be informed. The pharmacist was not aware of any recent dispensing mistakes.

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

The pharmacy had current professional indemnity insurance. 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 right RP notice was clearly displayed, and the RP record was largely completed correctly. But there were several occasions recently when the RP had not completed the record when they had finished their shift and a different pharmacist was working the following day. The private prescription records were largely completed correctly, but the correct

prescriber details were not routinely recorded. And the nature of the emergency was not always 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, emergency supplies and the RP record was discussed with the team during the inspection.

Computers were password protected and people using the pharmacy could not see information on the computer screens. And confidential waste was shredded or removed by a specialist waste contractor. 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. And team members said that they had completed training about protecting people's personal information.

The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. Team members said that there had not been any recent complaints. The dispenser said that he would refer any complaints to the pharmacist and the pharmacy's head office would be informed.

The dispenser was aware of people who might be considered vulnerable, and he would refer any safeguarding concerns to the pharmacist. And he said that there was a safeguarding team in the pharmacy's head office. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about protecting vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely and they do the right training for their roles. They are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. And they get time set aside in work to complete it. They can raise any concerns or make suggestions and have regular meetings. And team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, one trained dispenser and one trained MCA working during the inspection. The pharmacist said that there were contingency arrangements for pharmacist cover if needed. And holidays were staggered to ensure that there were enough staff to provide cover. The pharmacy was up to date with its dispensing. And team members worked well together and communicated effectively with each other during the inspection to ensure that tasks were prioritised, and the workload was well managed.

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

The dispenser said that team members were provided with some ongoing training from the pharmacy's head office on an ad hoc basis. He said that this could be completed during quieter times at work or at home if they preferred. The pharmacist was aware of the continuing professional development requirement for professional revalidation. And he felt able to make professional decisions. He said that he had recently completed the CPPE training for the Pharmacy first service and had attended a workshop. He had also recently undertaken the face-to-face training for the flu vaccination service. And he had completed declarations of competence and consultation skills for the services offered and had done the associated training.

Team members said that they had informal huddles in the morning to allocate tasks and discuss any issues. The pharmacist said that the area manager regularly visited the pharmacy to undertake internal audits and discuss any issues. He said that the area manager could remotely access the pharmacy's computer to check the pharmacy's progress with tasks such as CD balance checks. Team members felt comfortable about discussing any issues with the pharmacist or the area manager. The MCA said that performance reviews were ongoing and informal.

Targets were set for the New Medicine Service and the Pharmacy First service. The pharmacist said that he did not feel under pressure to meet the targets. He explained that the pharmacy provided the services for the benefit of the people using the pharmacy. And he would not let the targets affect his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

People can have a conversation with a team member in a private area. And the premises provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was secured against unauthorised access and 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. It was bright, clean, and tidy throughout which presented a professional image. Air conditioning was not available on the day of the inspection. The pharmacist explained that the air-conditioning unit had broken around one week ago and it had been reported to the pharmacy’s head office. The pharmacy was waiting for the unit to be repaired. The room temperature on the day of the inspection was suitable for storing medicines.

There was seating in the shop area for people waiting for services. The consultation room was to the side of the medicines counter, and it was accessible to wheelchair users. It was suitably equipped and well-screened. And 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 and 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 overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls.

Inspector's evidence

There was a small step into the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and the MCA said that team members could help people into the premises if needed. Services and opening times were clearly advertised, and a variety of health information leaflets was available. 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. 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 he would refer people to their GP if they needed to be on the PPP and weren't on one. And he explained that the pharmacy dispensed these medicines in their original packaging and team members ensured that the information on the packaging was not covered with the dispensing label. Prescriptions for higher-risk medicines were routinely highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that he asked people about their blood test results, but the pharmacy did not keep a record of the checks made. 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 2 and 3 CDs were highlighted. But this was not done for Schedule 4 CDs, and this could increase the chance of these medicines being supplied when the prescription was no longer valid. There was a prescription in the retrieval system for a Schedule 4 CD which had had expired around one month ago. The MCA knew that prescriptions for CDs were only valid for 28 days, but she was not clear on which medicines were classified as Schedule 4. This was discussed with the team during the inspection.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. And 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 this activity was recorded. Stock due to expire within the next six months were highlighted. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

The fridge was suitable for storing medicines and it was not overstocked. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. 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.

Uncollected prescriptions were checked regularly. Items remaining uncollected after around three months were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. The dispenser said that part-dispensed prescriptions were checked frequently and prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

The dispenser said that people had assessments by their GP to before they received their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in the packs were ordered in advance by the pharmacy so that any issues could be addressed before people needed their medicines. And prescriptions for 'when required' medicines were not routinely requested. The dispenser said that people had to contact the pharmacy or their GP if they needed these medicines 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. There were no completed packs to check on the day of the inspection. The dispenser explained how the packs were labelled and he said that the backing sheets were attached to the packs. He said that there was an audit trail to show who had dispensed and checked each pack. And patient information leaflets were routinely supplied. Medication descriptions were printed of the backing sheets to help people and their carers identify the medicines. The dispenser said that he wore gloves when handling medicines that were placed in these packs.

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. Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor had been in use for around six months, and this would be replaced in line with the manufacturer's guidance. The weighing scales and the shredder appeared to be in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

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.