General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Delmergate Ltd., Sittingbourne Memorial Hosp., Bell Road, SITTINGBOURNE, Kent, ME10 4XX

Pharmacy reference: 1032959

Type of pharmacy: Community

Date of inspection: 28/10/2019

Pharmacy context

The pharmacy is part of a small chain of pharmacies and it is located next to a GP surgery and a hospital with a minor injuries unit. It is surrounded by residential premises and it receives around 85% of its prescriptions electronically. The people who use the pharmacy are mainly older people and those who have been seen by a clinician at the hospital. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations, smoking cessation, weight management and INR testing. And it supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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
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 not all met	4.3	Standard not met	The pharmacy does not store medicines which need cold storage properly. This makes it more difficult for the pharmacy to show that the medicines are safe to use. The pharmacy does not always keep medicines in containers which are properly labelled. This may increase the risk that date checks or product recalls are not effective.
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. It records and regularly reviews any mistakes that happen during the dispensing process. And uses this information to help make its services safer and reduce any future risk. It protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. It mostly 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 adequate 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 and review processes. Team members had signed the SOPs to indicate that they had read and understood them.

Near misses were highlighted with the team member involved at the time of the incident. The dispenser said that the pharmacist usually pointed out the error and team members rectified their own mistakes. Near misses were recorded and 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. Posters displaying medicines that 'looked alike or sounded alike' were displayed in the dispensary. Team members highlighted to each other when medicines were received that were in similar packaging. This helped to ensure that everyone was made aware to take care when unpacking boxes or selecting these medicines. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong strength of medicine had been supplied to a person. The pharmacist said that the person had not taken any of the medicine and the error was likely due to the fact that the pharmacy did not stock the strength of medicine the person needed, so the other strength was supplied in error.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The pharmacy had three computer terminals; this helped with the workflow and the team member working on the medicines counter could use the computer in the consultation room to check medication records. The 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. The dispenser said that the pharmacy would open if the pharmacist had not turned up in the morning. She confirmed that she would not sell any medicines or hand out any dispensed items until the pharmacist had arrived. But she thought that she could carry out dispensing tasks. 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. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed medicine was made. And the emergency supply records were completed correctly. There were signed in-date Patient Group

Directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The responsible pharmacist (RP) log was completed correctly and the right RP notice was clearly displayed. The private prescription records were mostly completed correctly, but there were several private prescriptions that did not have the required information on them when the supply was made. This could make it harder for the pharmacy to find these details if there was a future query.

Confidential waste was shredded, 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. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the recent survey were displayed in the shop area and were available on the NHS website. Results showed that 100% of respondents were satisfied with the pharmacy overall. The complaints procedure was available for team members to follow if needed. The pharmacist said that she was not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had received some safeguarding training provided by the pharmacy's head office. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The dispenser could give examples of action the pharmacy had taken in response to safeguarding concerns. 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. They are provided with some training to support their learning needs and help maintain their knowledge and skills. And the team discusses adverse incidents and uses these to learn and improve. Team members 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. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist and three trained dispensers working during the inspection. Team members wore smart uniforms with name badges displaying their role. And they had completed accredited courses for their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The dispensers appeared confident when speaking with people. One of them when asked 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.

The pharmacist was aware of the Continuing Professional Development requirement for the professional revalidation process. She had completed declarations of competence and consultation skills for the services offered, as well as associated training. And she explained that she had recently completed face-to-face travel vaccination training, including CPR and anaphylaxis. The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. They also had regular reviews of any dispensing mistakes and discussed these openly in the team. The dispenser explained about some refresher training she was due to attend about the weight management and smoking cessation services.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacist said most information was discussed in regular informal meetings, but more formal meetings were held around once a month to discuss any ongoing issues. The dispenser explained that team members had yearly appraisals and performance reviews with the pharmacist.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that the pharmacy regularly met the targets and she did not feel under pressure to achieve them. She confirmed that she carried out these services for the benefit of the people who used the pharmacy and would not let the targets affect her professional judgement.

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; this 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; the room temperature was suitable for storing medicines.

There were two chairs in the shop area and near to the medicines counter. The pharmacist said that team members offered the use of the consultation room if a person wished to discuss something in a more private setting. The consultation room was accessible from the shop area and from behind the medicines counter, and it was accessible to wheelchair users. The room was suitably equipped, well-screened from people using the pharmacy, and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area.

Toilet facilities were available in the adjacent hospital. There were separate hand washing facilities available.

Principle 4 - Services **Standards not all met**

Summary findings

Overall, the pharmacy manages its services adequately. People with a range of needs can access the pharmacy's services. But the pharmacy does not store medicines which need cold storage properly. This makes it more difficult for the pharmacy to show that the medicines are safe to use. And it does not always keep medicines in containers which are properly labelled. This may increase the risk that date checks or product recalls are not effective. The pharmacy gets its medicines from reputable suppliers and it responds appropriately to drug alerts and product recalls. The pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to 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 a variety of health information leaflets was available.

The pharmacist explained that the pharmacy was in the process of carrying out audits for people taking methotrexate, lithium and sodium valproate medicines. This was to ensure that people were taking them properly and that they were aware about which over-the-counter medicines they should avoid. And to explain the signs and symptoms of toxicity. The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. A record of people's INR test results (for warfarin) was kept, but not for other higher-risk medicines. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that she would ensure that these were highlighted in future. Prescriptions for Schedule 3 and 4 CDs were highlighted to help minimise the chance of these medicines being supplied when the prescription is no longer valid. The pharmacist said that the pharmacy supplied valproate medicines to a few people. Some were on the Pregnancy Prevention Programme and this was annotated on their medication record. The pharmacy had the relevant patient information leaflets and warning cards available.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked around every three months and this activity was recorded. Stock due to expire within the next three months was marked and lists were kept for most of these items. This was so they could be removed from dispensing stock before they were due to expire. But, there were some expired items found with dispensing stock. The pharmacist said that she would ensure that more accurate records were kept for stock nearing its expiry date. Several medicines were found which were not kept in their original packaging. And the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. The dispenser said that she would ensure that these were disposed of appropriately, and she would keep medicines in their original packaging in future.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were not usually within the recommended range. And, the maximum temperatures recorded since December 2018 were all above the recommended maximum

temperature and had reached up to 14 degrees Celsius. The pharmacist said that this had been reported to the pharmacy's head office. There was a period of around three weeks in September 2019 where the temperatures had been between 1 and 2 degrees Celsius. And on a few occasions, it had been minus 4.3 degrees Celsius.

Part-dispensed prescriptions were checked. '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. If the medicine owing was a CD, an owing note was given to the person with the date they had to collect their medicines by. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacist said that uncollected prescriptions were checked monthly and people were contacted if they had not collected their items after two months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The dispenser said that assessments were carried out by people's GP before they had their medicines dispensed into multi-compartment compliance packs to show that they needed them. Prescriptions for people receiving their medicines in multi-compartment compliance 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 dispenser said that people usually contacted the pharmacy 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 but the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. The dispenser said that she would attach these in future. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register at the time of destruction. These were destroyed with a witness and two signatures were recorded.

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.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. 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.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being used. The pharmacist said that she had undertaken some training on how the system worked, but the team were due to undertake training before using the equipment. She said that the pharmacy was likely to start using it before the end of the year.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally 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 but these were covered in thick lime scale. The pharmacist said that she would order replacements or clean them. An electronic tablet counter was available but there was a thick layer of powder residue throughout the machine. The pharmacist said that she would order a triangle tablet counter and remove the electronic counter from the dispensary. A triangle tablet 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 carbon monoxide testing machine was calibrated by an outside agency. The weighing scales and the shredder were in good working order. But some information could still be read after it had been shredded. The pharmacist said that she would request a cross-cut shredder from the pharmacy's head office. 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.