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: 13/08/2020

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 and the New Medicine Service. 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.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	1.2	Good practice	The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk.
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 identifies and manages the risks associated with its services well. 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 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 up-to-date standard operating procedures (SOPs), and reporting and review processes for dispensing mistakes. Team members had signed the SOPs to indicate that they had read and understood them. Workplace risk assessments had been recently carried out as part of the response to the Covid-19 pandemic.

Dispensing mistakes which were identified before the medicine was supplied to a person (near misses) were highlighted with the team member involved at the time of the incident. Team members identified and 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 mistakes where the medicine had reached a person (dispensing errors) were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong type of medicine had been supplied to a person. The dispenser said that the person had not used any of the medicine and the error was due to the medicines having similar names.

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, and this helped with the workflow. The team member working on the medicines counter could use the computer in the consultation room to check medication records. 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. And she knew that she should not carry out any dispensing tasks until there was a responsible pharmacist (RP) signed in.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. The emergency supply records and

private prescription records were completed correctly. 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 RP record complied with requirements and the right RP notice was clearly displayed.

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 people who responded to the survey were satisfied with the pharmacy overall. The complaints procedure was available for team members to follow if needed and details were displayed in the shop area. The dispenser 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 pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. Team members were not aware of any recent safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. And they do the right accredited training for their roles. They are provided with some ongoing training to support their learning needs and help maintain their knowledge and skills. And the team discuss adverse incidents and use 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 locum pharmacist, four trained dispensers and one trainee medicines counter assistant (MCA) 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 dispenser said that the pharmacy's head office would be informed if a team member tested positive for the coronavirus, and cover would be arranged for the whole team.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And 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. The 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 had completed about the weight management and smoking cessation services.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The dispenser said that most information was passed on informally during the working day and in informal meetings, but more formal meetings were held regularly 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 dispenser said that the regular pharmacist usually met the targets. The locum pharmacist working on the day of the inspection confirmed that she carried out these services for the benefit of the people who used the pharmacy. And she 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 and the room temperature was suitable for storing medicines.

A screen had been installed at the medicines counter to help minimise the risk of spreading the coronavirus. Notices were displayed at the main entrance asking people to wear face coverings where possible. Only three people were allowed in the shop area at a time and there was enough space to allow for social distancing.

There were two chairs in the shop area. The consultation room was accessible from the shop area and from behind the medicines counter. 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 met

Summary findings

Overall, the pharmacy manages its services well and provides them safely. People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and it responds appropriately to drug alerts and product recalls. It stores its medicines appropriately to ensure that they are fit for their intended purpose.

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 dispenser said that the regular pharmacist checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. The dispenser was not sure whether a record of people's test results was kept. If a record of the results was not kept, then it might be harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The dispenser said that prescriptions for higher-risk medicines were highlighted. So, there was the opportunity for the pharmacist to speak with these people when they collected their medicines. The inspector was not able to find any prescriptions for these medicines to confirm this during the inspection. 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. And the trainee MCA knew that prescriptions for these medicines were only valid for 28 days. The dispenser said that the pharmacy supplied valproate medicines to a few people. Those people who needed to be on the Pregnancy Prevention Programme had this 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. There were no expired items found with dispensing stock.

Fridge temperatures were checked daily and maximum and minimum temperatures were recorded. Records indicated that the temperatures were sometimes above the recommended range. The dispenser said that she had reported these to the regular pharmacist and the higher temperatures were likely due to the warm air hitting the thermometer probe when the fridge door was opened. When the door was closed, the temperature returned to within the recommended range.

Part-dispensed prescriptions were checked daily. '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 dispenser 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 GPs before they had their medicines dispensed into multi-compartment compliance packs to show that they needed them. 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. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that people usually contacted the pharmacy when they needed them supplied 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 been attaching them, but had ran out of the double-sided stickers. She had placed these on order and said that the backing sheets would be attached 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 kept separate from regular stock. 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 was not asking people to sign for deliveries due to the coronavirus. The delivery driver said that she knocked on the person's door and placed the bag on the doorstep. She confirmed that she checked their details at a distance. 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 dispenser said that team members had undertaken some training on how the system worked, but they may need refresher training before using the equipment.

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 this was clean. An electronic tablet counter was available but there was some powder residue throughout the machine. The dispenser said that she would ensure that this was kept clean in the future. 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 weighing scales and the shredder were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

There was alcohol gel, gloves and face masks available for team members to use. Most team members wore protective equipment and other were able to maintain a suitable distance while moving around the dispensary.

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.