General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Delmergate Pharmacy, 269 Reculver Road, Beltinge & Reculver, HERNE BAY, Kent, CT6 6SR

Pharmacy reference: 1092202

Type of pharmacy: Community

Date of inspection: 18/12/2019

Pharmacy context

The pharmacy is located next to a large surgery in a largely residential area. The people who use the pharmacy are mainly older people or those with families. It receives around 90% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations, weight management and a stop smoking service. It also provides medicines as part of the Community Pharmacist Consultation Service. It supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines.

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
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

Overall, the pharmacy 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. It 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 its records up to date and accurate, 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. 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 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 pharmacy had recently moved metoprolol to a separate shelf to metoclopramide as there had been several mistakes made when 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 had completed an investigation and informed the pharmacy's head office. He had also reported the incident to the NPSA and discussed it with the team.

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 team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. And they had signed the SOPs to indicate that these had been read and understood.

Team members' roles and responsibilities were specified in the SOPs. The dispensers said that the pharmacy would open if the pharmacist had not turned up in the morning. They knew that they should not sell any medicines, hand out dispensed items or carry out dispensing tasks if there was no responsible pharmacist (RP) signed in. And team members were clear on tasks that should not be carried out if the RP was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available. The responsible pharmacist (RP) log was completed correctly and the right RP notice was clearly displayed. All necessary information was recorded when a supply of an unlicensed medicine was made and there were signed in-date Patient Group Directions available for the relevant services offered. The private prescription records and emergency supply 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. There were a few private prescriptions for Schedule 2 CDs at the pharmacy which had been dispensed over a month ago. The dispenser contacted the Controlled Drugs Accountable Officer during the inspection and

arranged for these to be sent to the appropriate authority.

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. Bagged items waiting collection could not be viewed by people using the pharmacy. Team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2019 survey were displayed in the shop area and were available on the NHS website. Results were positive overall and showed that 100% of respondents were satisfied with the pharmacy and staff. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The dispenser said that there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed 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. She 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing training to support their learning needs and maintain their knowledge and skills. 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. These are not affected by the pharmacy's targets.

Inspector's evidence

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

The MCAs appeared confident when speaking with people. One, when asked, 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 MCA referred a person to the pharmacist who had requested to purchase an over-the-counter medicine because they were taking some other medicines.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He said that he felt able to take professional decisions. And he had completed declarations of competence and consultation skills for the services offered, as well as associated training. The dispenser said that team members were not provided with ongoing training on a regular basis, but they did receive some. She explained that they completed some training modules during quieter periods. They also had regular reviews of any dispensing mistakes and discussed these openly in the team.

Team members had yearly appraisals and performance reviews. Team members said that they felt comfortable about discussing any issues with the pharmacist or making any suggestions. The dispenser said that the pharmacist had been working at the pharmacy for around one year and she explained that when he had started, he had watched how team members worked and provided constructive feedback gradually. She said that the pharmacist welcomed feedback and was willing to try new ways of working. The dispenser said that information was usually passed on informally. But there were more formal meetings held on a regular basis to ensure that any issues or information from head office was passed on to all team members.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist explained that he carried out these services for the benefit of the people using the pharmacy and would not let the targets affect his professional judgement. He said that the pharmacy regularly met the targets.

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 was a padded bench in the shop area for people to use. This was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The pharmacy had two consultation rooms. Both were accessible to wheelchair users and were located in the shop area. They were suitably equipped and kept secure when not in use. One of the consultation rooms was not well-screened and there was a clear view into the room from the dispensary. But the second consultation room was well screened. The pharmacist said that he would use this room if additional privacy was needed. Low-level conversations 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

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. 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. But 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 induction hearing loop appeared to be in good working order.

The stop smoking clinic managed by one of the dispensers and one of the MCAs. They used an appointment system to ensure that one of them was available. They explained that there had been some people who had used the service had been successful and had stopped smoking. The weight management clinic was managed by two of the dispensers. The dispenser said that some people had been successful and lost some weight. Team members involved with the stop smoking and weight management service had completed all required training to provide the services.

The pharmacist said that he was in the process of carrying out an audit for people taking methotrexate, and these prescriptions were highlighted. But prescriptions for other higher-risk medicines such as warfarin were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. This could also make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The dispenser explained that prescriptions for Schedule 3 and 4 CDs were highlighted to help minimise the chance of these medicines being supplied when the prescription was no longer valid. 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. The pharmacy did not have the relevant patient information leaflets or spare warning cards available. Most of the packaging had the warning cards attached, but the pharmacist said that he would order replacements from the manufacturer.

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 was removed from dispensing stock and returned to the pharmacy's head office. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Part-dispensed prescriptions were checked frequently. '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. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked frequently. The pharmacist said that uncollected prescriptions were checked regularly and people were sent a text message reminder 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 pharmacist explained that assessments were carried out by the medicines optimisation team for people who had their medicines in multi-compartment compliance packs to show that they needed the packs. 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 the pharmacy people ordered these if they needed them when their packs were due. 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 and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs.

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 and destroyed with a witness; 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 kept a list of items which were 'out for delivery' so that the person could be informed if they contacted the pharmacy.

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 fully used. Team members had undertaken some training on how the system worked, but the dispenser had not yet done the training. The pharmacist said that the pharmacy was likely to start using the system in the near future.

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 carbon monoxide testing machine was calibrated by an outside agency. The weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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

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.