General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chopras Pharmacy Limited, Darent Valley Hospital, Darenth Wood Road, DARTFORD, Kent, DA2 8DA

Pharmacy reference: 1099289

Type of pharmacy: Hospital

Date of inspection: 07/02/2020

Pharmacy context

The people who use the pharmacy are mainly those who have been seen by a clinician at the hospital. It receives around 20% of its prescriptions electronically and the rest are mostly handwritten by prescribers at the hospital. It provides a range of services, including Medicines Use Reviews and the New Medicine Service. It also provides medicines as part of the Community Pharmacist Consultation Service. And it supplies medications in multi-compartment compliance packs to people in care homes.

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

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 any future risk. It largely protects people's personal information and team members understand their role in protecting vulnerable people. It regularly seeks feedback from people who use the pharmacy. And it largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

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 to indicate that they had read and understood the SOPs. 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. Dispensing incidents where the product had been supplied to a person were recorded on a designated form and a root cause analysis was undertaken. The responsible pharmacist (RP) said that any incidents were also recorded on the National Reporting and Learning System. She said that she was not aware of any recent dispensing incidents at the pharmacy.

Workspace in the dispensary was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription. And an organised workflow helped staff to prioritise tasks and manage the workload. 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. Team members knew where the SOPs were kept and had signed to show that they had understood them. The dispenser said that she would not carry out any dispensing tasks before the pharmacist had turned up in the morning. She said that the pharmacy would not open if there was only one member of staff. The trainee medicines counter assistant (MCA) knew that she should not sell any pharmacy-only medicines or hand out dispensed medicines if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The second pharmacist explained that the pharmacy had a service level agreement with the hospital which covered the dispensing of prescriptions written by prescribers in the hospital. 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 was a signed in-date patient group direction available for the influenza vaccination service. 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 private prescription records were mostly completed correctly, but the prescriber's details and the date the medicines were supplied was not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. There were several private prescriptions that did not

have the required information on them when the supply was made. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The RP said that she would ensure that the private prescription record and emergency supply record were completed correctly in the future.

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. The pharmacy team members had completed training about the General Data Protection Regulation. Confidential waste was usually shredded, but team members had been manually cutting up people's personal information. And there were a few pieces of paper with people's confidential information on found in with the general waste. The second pharmacist said that the superintendent pharmacist had ordered a shredder but the pharmacy had not yet received it. The RP contacted the pharmacy's stationary supplier during the inspection to order one. Following the inspection, the pharmacy confirmed that the shredder had been received and was being used.

The pharmacy carried out an ongoing patient satisfaction survey using an electronic device at the medicines counter. Results from the 2017 to 2018 Community Pharmacy Patient Questionnaire were available on the NHS website. Results were positive and 100% of respondents were satisfied with the service received from the pharmacist. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The second pharmacist said that he was not aware of any recent complaints.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had received some safeguarding training provided by the pharmacy. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The second 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely and they do the right training for their roles. The team discusses adverse incidents and uses these to learn and improve. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There were two pharmacists, one dispenser and one trainee MCA working at the start of the inspection. The second pharmacist said that there was usually only one pharmacist working at the pharmacy, but a second pharmacist was employed to work on busier days. One of the dispensers was on unplanned sick leave on the day of the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. The pharmacist said that the trainee MCA would be enrolled on an accredited course at the end of her three-month probationary period. The team worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee MCA appeared confident when speaking with people. She used effective questioning techniques were used to establish whether the medicines were suitable for the person. And she sought advice from the pharmacists throughout the inspection to ensure that people received the right advice about their medicines. 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.

The dispenser said that team members were not provided with ongoing training on a regular basis, but they did receive some. She said that the pharmacist passed on any new information to team members 'as and when'. The second pharmacist said that team members undertook any training which was required to be completed as part of the NHS Quality Payments Scheme. The pharmacists were aware of the continuing professional development requirement for the professional revalidation process. The second pharmacist had recently completed the CPPE training about risk management and was due to undertake some training about sepsis. He explained that he had recently attended a training event about Eliquis which was provided by the manufacturer. Team members also had regular reviews of any dispensing mistakes and discussed these openly in the team.

The pharmacists said that they felt able to take professional decisions. The second pharmacist said that he and the pharmacy team had a good working relationship with the superintendent pharmacist. He said that he had completed declarations of competence and consultation skills for the influenza vaccination service, as well as associated training.

The second pharmacist said that the team members received informal ongoing appraisals and performance reviews. And these were not usually documented. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. Targets were not set for team members.

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. It was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and it was located in the shop area. It was suitably equipped, well-screened, 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 clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. And people with a range of needs can access its services. The pharmacy systems allow the pharmacist the opportunity to speak with people when they collect their medicines. The pharmacy dispenses medicines into multi-compartment compliance packs safely. And it 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.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy's website provided contact details and detailed information about the pharmacy's services.

The RP said that the pharmacy rarely dispensed prescriptions for higher-risk medicines such as warfarin and lithium. She said that the pharmacy did dispense a few prescriptions for methotrexate as there was a rheumatology department in the hospital. She said that she would check record books for people taking these medicines and record any results on their medication record. The RP said that prescriptions for higher-risk medicines were highlighted. All dispensed items were shown to a pharmacist before being handed out so that they had the opportunity to speak with people about their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to 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 in the care homes. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. 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 at regular intervals and this activity was recorded. Short-dated items were marked and lists of short-dated items had been previously kept, but this had not been carried on since January 2020. The RP said that she would remind team members to record the short-dated items so that these could be easily identified and removed from dispensing stock before they had expired. There were no out-of-date medicines found with dispensing stock and medicines were kept in their original packaging.

Part-dispensed prescriptions were checked frequently. The RP said that when prescriptions could not be dispensed in full, the pharmacy made a record of the person's contact number and kept them informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The RP said that uncollected prescriptions were checked regularly. And any uncollected items were returned to dispensing stock if they had not been collected after around three months. The second pharmacist said that uncollected prescriptions were returned to the NHS electronic system or the prescribers were contacted before the prescriptions were disposed of appropriately at the pharmacy.

The second pharmacist said that people in the care homes had their medicines dispensed into multi-compartment compliance packs. And the pharmacy did not order prescriptions on behalf of people who

received their medicines in the packs. The second pharmacist said that prescriptions were managed by the care home staff and they ordered these in advance so that any issues could be addressed before people needed their medicines. The pharmacy received a list of any changes to people's medicines so that these could be checked against the prescriptions when they were received. 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. Pictures of the medications were recorded on the patient information chart which was provided with each pack. This helped the 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 and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for some deliveries and each care home had separate sheets to ensure that another care homes information was protected. The second pharmacist said that he would ensure that signatures were recorded for all deliveries in the future to show that the medicines were safely delivered.

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. The pharmacist said that team members had undertaken some training on how the system worked and there were written procedures available. And the pharmacy would be using the equipment fully in the near future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely 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 not for volumes less than five millilitres. The RP said that team members used plastic syringes when they needed to measure smaller amounts. She confirmed that she would order a suitable measure and this was confirmed following the inspection. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. The electronic tablet counter was not clean. The dispenser cleaned it during the inspection and the RP said that she would ensure that this was routinely cleaned to help avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The shredder was not in good working order on the day of the inspection, but a new one was received at the pharmacy shortly after the inspection. 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 fridges were suitable for storing medicines and were 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.