

Registered pharmacy inspection report

Pharmacy Name: Medication Delivery Services Ltd, Unit C6, Meridian Industrial Estate, Hoyle Road, PEACEHAVEN, East Sussex, BN10 8LW

Pharmacy reference: 1103465

Type of pharmacy: Community

Date of inspection: 17/06/2021

Pharmacy context

This pharmacy provides its services 'behind closed doors' from a warehouse unit on an industrial estate on the outskirts of Peacehaven near Brighton. It is not open for people to visit the pharmacy in person as it mainly dispenses prescriptions for people in care homes. The medicines its supplies are almost all supplied in multi-compartment compliance packs to help people and their carers manage their medicines. It also delivers some medicines in multi-compartment compliance packs to people who live in their own homes.

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	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 has up-to-date and well organised written instructions which tell its team members how to complete their tasks safely. It also has separate, suitably adjusted, sets of instructions to help its team members protect themselves and those around them during the pandemic. It has adequate insurance in place to help protect people if things do go wrong. Members of its team are clear about their roles and responsibilities. They work to professional standards, identifying and generally managing risks effectively. They keep satisfactory records of the mistakes they make so that the team as a whole can learn from them and help prevent them happening again. The pharmacy manages and protects people's private information well. Team members also understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

There were up-to-date Standard Operating Procedures (SOPs) in place to support all professional standards which had last been updated in February 2021. Each SOP had a signature sheet signed by all staff to show that they had read and understood it. There were also separate SOPs to reflect the changes made to various procedures during the pandemic. These had been created in April 2020 and updated in December 2020.

A workplace risk assessment had been carried out, involving all members of the team. Although the various elements of this were evident in different places, there was no single document recording that risk assessment. Upon reflection both the superintendent pharmacist (SI) and the managing director (MD) agreed to document this. Individual risk assessments had been completed for each member of staff. The majority of team members had received at least one dose of COVID-19 vaccine and all were self-testing twice weekly. The results of those tests were all recorded. The team had collectively identified the biggest risks as being the deliveries, both in and out, and individual team member's activities outside of work. They had focussed their attentions on the delivery drivers, the delivery process and the delivery van itself (see principle 4 for more detail). Everyone's temperature was measured and recorded as soon as they arrived for work, and anyone displaying a high temperature would return home. Although they were not wearing masks, the workplace was a large warehouse with a high ceiling, and everyone could easily maintain their distance from each other.

Every member of the team ensured that their partners and other members of their households were testing themselves twice weekly and minimising the risks of transmitting the virus within the household and ultimately to the team itself. There was a business continuity plan in which the pharmacy planned to have separate smaller teams on separate shifts over 24 hours a day, seven days a week. To date, the pharmacy had not yet needed to implement the plan. The MD was aware of his obligation to report any cases of COVID-19 suspected of having been contracted in the workplace to the appropriate authorities.

Errors and near misses were recorded on separate sheets, one for each care home. The MD collated those sheets and analysed them. The RP then discussed them within the team, highlighting any trends or patterns identified, so that everyone learned from them. Those record sheets also noted everyone who was on duty at the time of the error, to help identify any patterns relating to staffing levels at the time.

Staff were able to describe what action they would take in the absence of the responsible pharmacist (RP), and they explained what they could and could not do. They outlined their roles within the pharmacy and where responsibility lay for different activities. All dispensing labels were signed by two people to indicate who had dispensed the item and who had checked it. The RP notice was correct and clearly displayed for people to see, but the electronic RP record could not be accessed at the time of the inspection as the RP's NHS Smartcard had expired. The MD had been trying to rectify this and in the meantime the pharmacy had reverted to a paper record. The entries for the day of the inspection and the day before hadn't been completed, but when this was pointed out to the SI, who was also the RP, she completed the necessary entries. The SI was reminded of her obligation to maintain the record and the MD was continuing his efforts to reinstate the smartcard with the NHS.

The pharmacy hadn't needed to complete a Community Pharmacy Patient Questionnaire (CPPQ) this year owing to the pandemic. The MD described how they sent each care home a feedback form every year which they analysed. They also ensured that the care homes were happy with their service on an ongoing basis. A current certificate of professional indemnity and public liability insurance was available.

Private prescription records were kept in a bound book, but they only dispensed one or two private prescriptions a year. Those entries seen were in order. Those sections of the Controlled Drug (CD) registers examined were in order. Alterations were annotated with an asterisk and an explanation at the foot of the page. The footnotes were dated and initialled. There was a folder for keeping records of unlicensed 'specials' which were in order.

All staff were able to demonstrate an understanding of data protection and they had undertaken General Data Protection Regulation (GDPR) training. They were able to provide examples of how they protect people's confidentiality, for example not disclosing personal information over the phone. The MD explained that if people had to self-isolate and were working from home, they could undertake basic admin tasks or order items, but they would not have access to any patient-sensitive information outside of the pharmacy. Confidential waste was kept in large bins separate from general waste and taken offsite for shredding by an appropriately registered contractor.

There were safeguarding procedures in place for both adults and children. And contact details of both East Sussex and West Sussex adult and child safeguarding teams were easily available on the wall. All registrants had been trained to level 2 in safeguarding, and the other staff had been trained to the equivalent of level 1.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are appropriately trained, keep themselves up to date and they appear to work very well together. They have a clear understanding of their roles and how they can help those looking after other people's medicines.

Inspector's evidence

There were two dispensing assistants, one Accuracy Checking Technician (ACT), the managing director and the superintendent pharmacist (who was also the RP) on duty at the time of the inspection. This appeared to be sufficient for the workload at the time. The team had identified a critical time each day between 4.30pm and 5.30pm when the care homes, or their GP surgeries, all tended to send their prescriptions after their home visits. As a result, the RP and MD ensured that there were plenty of staff on duty at that time in particular. They had also pushed back the delivery driver's starting time by 30 minutes to 6.00pm in order to reduce the time pressure on the dispensing team.

One of the dispensing assistants was training to be a technician and had nearly completed the necessary accredited training course. All team members made helpful contributions or answers during the inspection, clearly demonstrating a good understanding of the operation.

The ACT described how she kept up to date by reading articles in the various pharmacy magazine available. The MD did not undertake any registered activities and was mainly involved in management and administrative tasks. He was aware of the GPhC guidance on providing pharmacy services at a distance and ensured that all staff, including the drivers, complied with it. Staff were heard asking appropriate questions when responding to phone calls.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are well suited for the type of work the pharmacy does. They provide a safe and secure environment for the pharmacy's team to provide its services with few distractions. The pharmacy has made suitable adjustments to parts of its premises to help minimise the spread of COVID-19, helping to protect both its team members and people visiting the pharmacy.

Inspector's evidence

The pharmacy's premises were a large warehouse with an open plan office area and staff rest area. There were four large island workstations which allowed plenty of space for individual tasks to be kept separate. It also allowed team members to easily maintain social distancing. All of the workstations contained work in progress, but they were well organised in a logical fashion and appeared to be flowing smoothly.

There was a cleaning rota in place with a reminder alarm every three hours. This prompted everyone to clean their workstation, wiping down keyboard, mouse and all other touchpoints. The MD explained how he had adapted the guidance from government and from the National Pharmacy Association (NPA) to produce a cleaning routine that suited their environment. The sink was reasonably clean and equipped with hot and cold running water. The temperature in the pharmacy was maintained at a comfortable level and was suitable for the storage of medicines.

The pharmacy had put some other measures in place to help minimise the risks associated with the virus. There were forehead thermometers on a table at the entrance so that visitor's temperature could be taken and recorded. There was also a hand sanitiser point. Just behind the table was a quarantine area for items returned to the pharmacy from the care homes. They were left for 72 hours before the contents were removed for disposal or other attention. The plastic crates themselves were then sprayed with a sanitiser solution using a garden sprayer and left to dry before being reused.

There was no consultation room, but the open plan office area was sufficiently distant from the dispensing workstations for someone to have a confidential phone conversation if necessary.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides a specialised service which it delivers in a safe and effective manner. It stores and manages its medicines safely. And it has made sensible changes to the way it delivers peoples' medicines during the pandemic. Those changes help to reduce the chances of spreading the coronavirus. But its team members don't do enough to identify people supplied with high-risk medicines so that they can give them extra information about taking their medicines safely.

Inspector's evidence

The pharmacy specialised in dispensing prescriptions for people living in care homes, or who needed their medicines in multi-compartment compliance aids. It relied upon word of mouth or referral from other healthcare professionals for people to access its services.

Controls were seen to be in place to reduce the risk of errors, such as using baskets to keep individual prescriptions separate. All of the prescriptions for an individual care home were kept separate from those for other care homes. The labels used on people's medicines had spaces for two signatures to show who had dispensed the prescription and who had checked it.

The pharmacy had a number of computer systems in place to help it carry out the various tasks involved in meeting the different needs of all their care homes. The main patient medication record system (PMR) was used to download all the NHS electronic prescription service (EPS) prescription tokens. The pharmacist on duty then undertook a clinical check of each prescription token before it was scanned into another system used for producing an electronic medicines administration record (eMAR) chart for the care home.

Care homes using these eMAR charts had a hand-held terminal linked to the system in the pharmacy so that they could see the scanned prescription token as well as the eMAR chart relating to it. This helped to minimise any queries the care home might have relating to the prescription. The system also allowed the pharmacy to see when the care home had signed the medicine in upon delivery from the pharmacy, as well as when it was administered by the care home staff. The MD related a number of examples where appropriate use of this facility had enabled the pharmacist to identify when people hadn't been taking their medicines as prescribed and alerted the care home management as a result.

The pharmacy used a third system for labelling the assembled compliance packs. The labels had the facility to include a photograph of each tablet or capsule. This wasn't used in all cases as the shape or colour often varied from one delivery to the next owing to current fluctuations in the supply chain. Product descriptions were added by hand if they weren't already on the label. As none of the three systems were directly linked, the SI ensured that every prescription token was carefully cross-checked against the current entries on each of the other two systems before anyone produced any dispensing labels. Any discrepancies between the prescription token and the previously recorded entry on the labelling system were noted on a form which was then checked with either the care home or GP, whichever was appropriate. The compliance packs were then assembled and placed in racks according to the specific needs of the care home.

A final accuracy check was carried out by the ACT to recheck that everything was as prescribed by the

GP, and as expected by the care home. Those care homes who did not use eMAR charts were provided with a paper MAR chart generated by the labelling system. All items that could not be supplied in full were noted on a collated owings form provided to the care home with the delivery. There was a forward planner on the wall detailing a re-ordering schedule and the delivery schedule for each of the care homes, and for the individual deliveries to those people receiving compliance packs at home. Patient Information Leaflets (PILs) were provided with the compliance packs.

The delivery service was previously tailored to the individual needs of each care home. But since the onset of the pandemic, the pharmacy had standardised its delivery service and had created a new COVID delivery policy. The pharmacy would only deliver to one care home at a time and would make separate journeys to collect any returns. The drivers were provided with masks, gloves and aprons which they changed after each delivery. They were also provided with cleaning materials which they used to clean the van after each delivery. Delivery records were electronic and enabled the team to track each bag of medicines. Each bag was barcoded so that when the care home checked it in on their system a complete audit trail was visible.

Staff were aware of the risks involved in dispensing valproates to women who could become pregnant. The RP confirmed that they did supply valproates to a small number of people in the at-risk group, but they hadn't recently checked whether they, or their carers, were aware of the importance of using long-term contraception.

Medicines were obtained from recognised licensed wholesalers including unlicensed specials. Fridge temperatures were recorded daily and those examined were seen to be within the correct temperature range. The ACT described the action she would take if the temperature was found to be out of range. The shelves would be checked to ensure air could flow easily and that nothing was touching the back of the fridge. They would then recheck the temperature after 30 minutes to see if it was back in range.

The pharmacy provided each care home with a laminated sheet illustrating what they could return to the pharmacy and which items they had to dispose of themselves. Returned medicines or other items from the care homes were quarantined as described under principle 1. Any CDs were appropriately recorded by the pharmacist before being denatured and disposed of safely. The pharmacy encouraged the care homes to obtain their own CD destruction kits and dispose of them themselves.

Controlled Drugs (CDs) were stored securely in two approved cabinets bolted to the wall in accordance with the regulations. One cabinet was used for storing stock for dispensing, and the other was for unwanted items that had been returned to the pharmacy or were out of date. The keys to the cabinets were kept on the pharmacist's person.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the necessary equipment for the type of services it provides. And it makes sure that it is kept clean and suitably maintained. The pharmacy keeps people's private information safe.

Inspector's evidence

The pharmacy's equipment and facilities were seen to be appropriate for the services provided. The pharmacy had a set of clean crown-stamped conical measures for measuring liquids and appropriate equipment for counting tablets and capsules. It also had sufficient computer terminals and printers for its workload. None of the computer screens were visible to visitors at the pharmacy entrance. They were all password protected, and individual passwords were not shared. The pharmacy had internet access to online reference sources.

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.