General
Pharmaceutical
Council

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: Closed

Date of inspection: 04/07/2023

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. It supplies some of its medicines in multi-compartment compliance packs to help people and their carers manage their medicines. It also delivers some medicines to people who live in their own 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 has suitable written instructions for its team members to follow when carrying out their work. It keeps appropriate records of its mistakes and can show what it has learned to help reduce the chances of the same things happening again. It keeps its team members up to date on matters affecting the way they work. The pharmacy generally maintains the records that the law requires it to keep. And it keeps them in an easily accessible place so that they can be readily checked. Team members have an appropriate understanding of their role in safeguarding vulnerable people. And they know who to contact if they need to.

Inspector's evidence

There were up-to-date Standard Operating Procedures (SOPs) in place to support all professional standards, most of which had been updated in February 2021. Those relating to the management of controlled drugs (CDs) had been updated in January 2023, and those for deliveries in March 2023. Each SOP had a signature sheet signed by team members to show that they had read and understood it.

The pharmacy had made a number of changes to its processes to mitigate risks identified during and since the previous inspection. The responsible pharmacist (RP) was incorporating them into the SOPs as she updated them. Changes included the workbenches being divided into more clearly defined areas for each care home they were working on. Different colour baskets were used for assembling prescriptions for the individual wings within those care homes to reduce the risk of mixing them up. And stock for individual prescriptions was placed in individual baskets to reduce the risk of error. There was a risk management folder containing details of health & safety risk assessments that had been carried out.

There were new books for recording errors and near misses, with a page for each care home. Those sheets examined showed a small number of near misses which had been identified before leaving the premises. They showed who had made the error and a reflection upon the possible cause together with action taken to help prevent a repeat of the incident. They also showed when a care home cycle had been completed with no near misses or errors. There was a separate folder with records of ‘team huddles’ held each month to discuss incidents and other operational matters. The trainee dispensing assistant confirmed the process upon questioning, and also described a team meeting where a mistake was discussed. The RP agreed to ensure that these huddles would continue and that she would keep the records up to date. The managing director (MD) also confirmed that dispensing errors, which had not been identified until after the medicine(s) had left the premises, were reported to the NHS Learning from Patient safety Events (LFPSE) service via the Community Pharmacy England (formerly PSNC) website.

The pharmacy had a complaints procedure in place which showed how people could raise any concerns about the service provided. There was an out-of-date certificate of insurance on display, but evidence was subsequently seen online to show that the pharmacy had renewed it and continued to have the necessary insurance cover.

The pharmacy didn’t dispense any private prescriptions and the RP confirmed that they had stopped making any emergency supplies. The pharmacy hadn’t dispensed any unlicensed medicines (specials) for some time, and the historic records examined appeared to be in order.

The staff member present was able to describe what action they would take in the absence of the responsible pharmacist (RP) and 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, and the paper-based RP record was complete. The RP arrived shortly after the inspection had started, and the absence hadn't been recorded until prompted by the inspector. There were entries for previous brief absences, as permitted by the regulations.

Confidential waste was segregated from other waste and stored in large bins awaiting collection. The pharmacy was apparently unable to source a suitable waste contractor to securely dispose of this so was considering how they could deal with it appropriately themselves.

The police Controlled Drugs Liaison Officer (CDLO) accompanying the inspector examined the electronic CD register which had been put in place following the previous inspection. There were a number of discrepancies that were quickly resolved. The importance of conducting regular CD stock balance checks was emphasised and upon reflection the RP agreed to carry out a daily check until she was satisfied that it could be safely reduced to a lower and more sustainable frequency. There was a record of CDs that had been returned to the pharmacy for safe disposal. The CDLO witnessed the destruction of a small number of outstanding items. The pharmacy had an Information Governance policy in place and was in the process of completing its annual data security & protection (DSP toolkit) declaration. The was a folder setting out the pharmacy's safeguarding policy and contact details of the local agencies were on the noticeboard.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are appropriately trained, and the pharmacy keeps suitable records of their progress. They have a satisfactory understanding of their role, and they work well together.

Inspector's evidence

There was one trainee dispensing assistant, 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 trainee assistant confirmed that she had been registered on the NPA dispensing assistant course and was due to start it in August, at the end of her three-month probationary period. She had been provided with an induction and on-the-job training by the RP. Her role currently comprised mainly of selecting stock and assembling compliance aids. There was a staff handbook which included terms & conditions of employment. There was also a sheet for each team member setting out the tasks they were responsible for, with space for them to indicate whether they were competent or still needing further training. This was used to track their progress and was based upon the tasks in the relevant SOPs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are well suited for the services it provides. They provide a safe and secure environment for the pharmacy’s team to complete their tasks with few distractions. But the pharmacy doesn’t do enough to keep its premises tidy and free from excessive clutter.

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. All of the workstations contained work in progress, with separate defined areas for each home. All workspaces were covered in baskets of work, leaving little free space. Despite this, they were well organised in a logical fashion and the work appeared to be flowing smoothly.

The sink was reasonably clean and equipped with hot and cold running water. There were a large number of opened bottles of liquid medicines around the sink. The RP explained that they had been returned by some of the care homes and were awaiting safe disposal. The temperature in the pharmacy was maintained at a comfortable level and was suitable for the storage of medicines.

The entire premises were littered with piles of storage boxes and boxes of paperwork. 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

Overall, the pharmacy is providing its services safely. It uses its computer systems to securely make prescription information more easily accessible to the care homes it serves. This means the carers have more up-to-date information to help them safely give the medicines to those they care for. Pharmacy team members appropriately identify people supplied with high-risk medicines and give them the advice they need to take their medicines safely. The pharmacy sources, stores and generally manages its medicines appropriately. And it keeps satisfactory records to show what it includes in each delivery it makes.

Inspector's evidence

The pharmacy specialised in dispensing prescriptions for people living in care homes, or who needed their medicines in multi-compartment compliance packs. Controls were seen to be in place to reduce the risk of errors, such as using baskets to keep individual prescriptions separate. All the prescriptions for an individual care home were kept separate from those for other care homes as described under Principle One. And within each care home, prescriptions for those in separate wings were in different coloured baskets to help identify them.

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 its 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 was intended to help 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 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 according to the specific needs of the care home. The RP indicated that they were still investigating installing a single computer system to replace the three separate systems currently in use. This had become more significant recently as a result of one of the system suppliers changing ownership and reducing the level of support available.

A final accuracy check was carried out by the RP to recheck that everything was as prescribed by the GP,

and as expected by the care home. 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 pharmacy kept a paper record of deliveries it made to care homes and individuals. Controlled drugs and items requiring refrigeration were entered separately on the delivery record. The driver annotated the delivery sheet to confirm delivery, and to ensure that people didn't see other people personal information. The entries on the delivery record consisted of a barcoded label with a unique reference number. The barcode ensured that when the care home checked it in on their system a complete audit trail was visible to the pharmacy.

Staff were aware of the risks involved in dispensing valproates to women who could become pregnant. The SI confirmed that they did supply valproates to a small number of people in the at-risk group, and since the previous inspection had been providing them with additional information to highlight the risks.

Medicines were obtained from recognised licensed wholesalers. The pharmacy was still experiencing significant difficulties with one of its wholesalers in particular. This resulted in incomplete deliveries, delivery failures and deliveries arriving at unpredictable times. All of this made it harder for the pharmacy to meet the needs of the care homes and people it served. Fridge temperatures were recorded daily and those examined were seen to be within the correct temperature range.

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 records of returned CDs appeared to be in order. 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's computer systems were all backed up nightly to secure cloud-based servers. 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.