General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lingfield Pharmacy, Unit 34, Evans Business Centre, Lingfield Way, Darlington, Durham, DL1 4QZ

Pharmacy reference: 9011267

Type of pharmacy: Internet

Date of inspection: 11/08/2020

Pharmacy context

This is a distance selling pharmacy. It is not open to the public. People access the pharmacy's services through its website or by telephone. The premises are in a self-contained unit on an industrial estate on the edge of the town centre. The pharmacy dispenses NHS prescriptions and delivers people's medicines to their homes. It supplies some medicines in multi-compartment compliance packs to help people take their medicines. This inspection took place dung 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	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 processes and written procedures that the team members follow to help them work safely and effectively. The pharmacy team members have a clear understanding of their roles and tasks. The pharmacy keeps all the records as required by law, in compliance with standards and procedures. It provides people using the pharmacy with the opportunity to feedback on its services. The pharmacy team members look after people's private information. And they have the knowledge required to recognise and report a concern to help safeguard the wellbeing of vulnerable people. They record, report and learn from errors and mistakes made during the dispensing procedure.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which the pharmacy team members had read or were in the process of reading. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as dispensing of prescriptions and controlled drugs (CD) management. The pharmacist had used the NHS England and NHS Improvement (NHSE & I) SOP for community pharmacies in relation to the COVID-19 pandemic. The pharmacist had plans in place should he require to be absent from work due to COVID-19. He had undertaken a risk assessment for the pharmacy and undertaken one for himself and the trainee dispenser. He had not undertaken one for the new starter but was intending to offer this.

The pharmacy had two islands, one was used for general dispensing and the other for the preparation of medicines for the multi-compartment compliance packs. It had two computer terminals more than two metres apart. Medicines were stored on shelves round the main dispensing area. The working conditions and number of staff allowed the team members to maintain social distancing. They frequently washed their hands, used hand sanitiser and maintained good hygiene. They wore face masks at times. The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. The pharmacy was generally working on prescriptions for supply to people the next day. And once items were checked and bagged, they were placed into box under postcode location for the delivery driver to prepare the delivery route.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The team members recorded their own mistakes on a specific template. They had continued to record these during the pandemic as the pharmacist felt it was important to capture them all as the dispenser was in training. Also, now a new member had joined the team, it was important for her to learn from any mistakes. At the start of the pandemic reasons for mistakes had mostly been recorded as being busy. Now the team were trying to complete with more detail to benefit the learning. Examples included items missing from the compliance packs, wrong quantity and wrong formulation. The dispenser advised she was learning how to process the dispensing of the compliance packs and she tried to use the mnemonic "HELP" when she checked her dispensing. She advised that this helped her focus on all the necessary checks to be made. She discussed that "Help" stood for H "How much", E "Expiry date" check, L "Label" check and P "Product" check. The team had placed some shelf alerts at items such as aspirin gastro-resistant and ordinary to minimise picking errors due to the formulation.

The pharmacy had a complaints procedure which people could access through the menu page on the website. It provided detailed information about the process. The practice leaflet was also on the website and this included information on 'Comments, Suggestions, Complaints and Compliments'. The

pharmacist advised that they spoke to people over the phone if people had any issues. The pharmacist gave an example when an item had been delayed and the person had not understood the process. This had been resolved to the satisfaction of the person. There was a procedure to record and report dispensing errors and the team members advised of this procedure. And showed a folder, with documents, for this purpose. The pharmacy had current indemnity insurance with an expiry date of 1 January 2021.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records as required. A sample of CD registers looked at found that they met legal requirements. The pharmacist checked CD stock against the balance in the register at each time of dispensing. This helped to spot errors such as missed entries. The CD registers had headings completed and running balances maintained. The register showed that regular stock audits were undertaken. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy kept a record of CDs which the driver had collected from people for disposal. The pharmacy had a revised process for this since the beginning of the pandemic.

The pharmacy had a privacy policy which explained what information the pharmacy collected and how it used this. And the steps taken to ensure the pharmacy kept information secure. This was available on the website. The pharmacy had information on General Data Protection Regulation (GDPR). The team kept records containing personal identifiable information securely in the pharmacy. And there was no public access. The pharmacy team shredded confidential waste. The pharmacy had a SOP for the protection of vulnerable adults and children. And access to contact numbers for local safeguarding teams. The pharmacist had undertaken level 2 Centre for Pharmacy Postgraduate Education (CPPE) training. The driver had received in-house training and reported back any concerns such as if people did not answer their door as expected. The pharmacy had no concerns of any note.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team. And the pharmacist and team members suitably provide the pharmacy's services. The pharmacy team members understand their roles and responsibilities. They support each other in their day-to-day work. And they feel comfortable raising any concerns they have. The pharmacy's team members work under supervision during formal training. And they receive support when they start working in the pharmacy. Pharmacy team members complete some further ongoing training on an ad-hoc basis. But the pharmacy does not record this training.

Inspector's evidence

There was one pharmacist, a trainee dispenser and a dispenser working in the pharmacy. The trainee dispenser had worked at the pharmacy since it opened. He worked full-time and generally spent the mornings working in the dispensary and undertook deliveries in the afternoon. He had commenced the Buttercups dispensing course and had made reasonable progress, but he had stopped this when the pandemic started. The pharmacist advised that now the workload had settled the trainee would be able to recommence the course. The pharmacist anticipated no issues with the course being completed in a timely manner. The pharmacy had employed a dispenser who had started at the beginning of August. She was employed for three days a week and also worked at another pharmacy. The pharmacist advised he was continually reviewing the workload and required staff. He had recently interviewed for another full-time dispenser and was hoping someone would start in September.

The team had received training through SOPs and policies which included safeguarding, data protection, delivery, confidentiality, patient consent and disposal of unwanted medicines. The pharmacist and trainee dispenser had read and signed these. The dispenser was in the process of reading the SOPs and received one-to-one coaching with the pharmacist. She advised that she was familiar with the computer system but preparing medicines for the multi-compliance medicines packs was new to her and the pharmacist was showing her how to prepare these.

The pharmacist told the team members of ongoing matters. They read some articles, but this was not recorded. This was discussed during the inspection and the pharmacist agreed it would be good to keep some records of ongoing training. The pharmacist ensured the team were kept informed of any requirements and relevant articles in relation to COVID-19. The pharmacist advised that he had not undertaken formal appraisals but continually discussed ongoing work and improvements with the team. The team members actively asked questions to improve their knowledge. They managed their workload in a competent manner discussing any issues which arose and dealing with any telephone queries. There was a formal whistleblowing policy and telephone numbers were available so the team members could raise concerns.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It offers a suitable environment for delivering the prescription dispensing services it provides.

Inspector's evidence

The pharmacy premises were not open to the public. People accessed its services via the pharmacy website. The pharmacy's website provided information about the pharmacy and its services. It provided details of the company, superintendent pharmacist (SI), the pharmacy's General Pharmaceutical Council (GPhC) registration number and contact information for the pharmacy. The pharmacy did not display the voluntary GPhC internet pharmacy logo. But it provided a link to the GPhC's registers when people clicked on the pharmacy premises code or the SI details. This provided reassurance to people that the pharmacy they were using, and pharmacist were currently registered with the GPhC.

The website displayed two Medicines and Healthcare Products Regulatory Authority (MHRA) logos. One had the wording 'Shopping' by it and the other had the wording 'Prescriptions'. One was linked to this premises for the supply of prescriptions. The other linked to a third party which provided pharmacy and general sale list products. This pharmacy did not provide these items and people dealt directly with the third party.

The pharmacy was located on small industrial estate. The pharmacy entrance led into the main pharmacy dispensing area. The pharmacy had a bell which rang if any person such as delivery drivers entered the premises. The pharmacy was clean, tidy and hygienic. And fitted out to a good standard with suitable space for dispensing and storing stock and medicines waiting delivery. The sink in the dispensary for preparation of medicines was clean. The benches, shelves and flooring were all clean and the team kept a cleaning rota to ensure they maintained this. The team undertook additional cleaning due to the coronavirus. The pharmacy had a dedicated table at the entrance which had supplies of face masks, gloves and hand sanitiser for people to use if required. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. Staff amenities were available for the team. The room temperature was comfortable, and the pharmacy was well lit.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides suitable access for people to obtain their medication, receive advice and to resolve any queries. The pharmacy provides its services using a range of safe working practices. It takes the right action if it receives any alerts that a medicine is no longer safe to use. The pharmacy team members take steps to identify people taking some high-risk medicines. And they provide these people with extra advice to help them take their medicines safely. The pharmacy stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy's website provided clear details of the pharmacy's opening times and services. It had a copy of the practice leaflet available for people. The home page displayed an alert message which directed people to government information regarding the COVID-19 pandemic should they want to look at this. It displayed an A to Z list of medicines which provided information on items for people. And it had a comprehensive list of health advice with conditions specified alphabetically. The pharmacy received telephone calls and provided information and advice as required. The team members signposted to other resources as required.

The pharmacist advised that he spoke with surgeries if he had any queries or concerns over medication for people. He had spoken with a practice pharmacist after a phone call from a person. Following this the surgery had arranged for the person to see a dietician and she received a prescription for some food supplements. The person was grateful for the conversation with the pharmacist and outcome. The pharmacist phoned people prior to their delivery if there was any counselling required. There had been a supply issue with the liquid formulation of an item, so the pharmacy had arranged to provide the tablet formulation. The liquid had come back into stock and the surgery had asked for the man to be given this. The pharmacist ensured that the person realised that he required to stop taking the tablet formulation, to avoid double dosing. The pharmacist informed people if there were issues with the supply of their medicines and contacted the surgery for alternatives if required.

The pharmacy supplied medicines to around 31 people in multi-compartment compliance packs to help them take their medicines. It also supplied three small care homes, with 40, 25 and ten beds. It supplied medicines on racks for one of the care homes and the other two homes received the medicines in the Biodose system. The pharmacy had supplied the compliance packs weekly to all but one person who usually received four weeks together. The compliance packs were clearly labelled with the start date and each pack had a corresponding number for the week of the cycle. People found it easy to know if they were on week one, two, three or four and had commented that it was helpful. The pharmacy had folders for each person and kept good records of the medicines that they were taking. It documented any communication on a separate sheet in people's folder. The sheets showed the date, event and any action taken. The team banded together the patient information leaflets (PILs) and sent these out once during each four-week cycle.

There was a clear audit trail of the dispensing process. The team completed the 'dispensed by' and 'checked by' boxes which showed who had performed these roles. And a sample of completed prescriptions looked at found compliance with this process. The team members used CD and fridge stickers on bags and prescriptions to prompt the driver that some medication required to be added to the delivery. The driver planned his route taking the bags of medication from boxes which had been

separated into postcode areas. The driver placed fridge-line medicines into a cool box in the van. The pharmacy kept a delivery sheet as an audit trail for the delivery of medicines from the pharmacy to patients. The driver noted the times of the deliveries as a record due to no signatures being taken during the pandemic. He described how he delivered medicines to people and that he wore a face mask and maintained social distancing.

The pharmacy stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme and advice required. There was no one in the at-risk group taking this medication.

The pharmacy had a refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were checked. It had a slight break in the date checking rota at the start of the pandemic outbreak. The team had now returned to routine date checking due to the workload being more manageable and the new member had joined the team provided more time to complete tasks. The team members marked short-dated items and they took these off the shelf prior to the expiry date. The team members marked all liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use.

The pharmacy obtained medicines from reputable sources. The pharmacy used recognised wholesalers such as AAH, Alliance, DE pharmaceuticals and Phoenix. The pharmacy had set up a section near the entrance of the pharmacy and the wholesale delivery drivers placed deliveries in that section. This allowed them to have a little contact as possible with the pharmacy team and maintained good social distancing. The pharmacist was aware of the Falsified Medicines Directive (FMD) and waiting for the computer provider to give further information for the pharmacy to implement the process.

The pharmacy had boxes it used to keep patient returned medication in. And it quarantined these due to the COVID-19 pandemic. It was waiting for the collections to be arranged thought NHS England, but these had been delayed during COVID-19 pandemic. The pharmacist had contacted NHS England to remind them to arrange suitable containers and collections, via the waste management contractor. The pharmacy had a process to receive drug safety alerts and recalls. The team actioned these and kept records of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. And it manages equipment and facilities in a way to maintain people's privacy.

Inspector's evidence

The pharmacy team members had access to a range of up-to-date reference sources, including the British National Formulary (BNF). They used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It also had a few plastic measures which were not marked with the kite mark. It also had a range of equipment for counting loose tablets and capsules.

As mentioned in principle one and three, the pharmacy had resources and facilities in place, such as hand sanitiser, to manage infection control. The computer terminals were password protected. The driver maintained confidentiality during deliveries.

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.