General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Delmergate Limited, Unit 1 & 2 CedarParade, Repton Park, Ashford, Kent, TN23 3TE

Pharmacy reference: 9011353

Type of pharmacy: Community

Date of inspection: 08/06/2021

Pharmacy context

The pharmacy is near a new housing estate. The pharmacy serves a mixed population of which most are younger. It receives most of its prescriptions electronically. And it provides a range of services, including the New Medicine Service and seasonal influenza vaccines. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a very small number of people who live in their own homes to help them manage their medicines. The inspection was carried out during 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 adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And people using the pharmacy are able to complain or provide feedback. Team members take appropriate action to ensure that vulnerable people are safeguarded. The pharmacy 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 adequately identified and managed the risks associated with its activities. It had documented, up-to-date standard operating procedures (SOPs) and team members had signed to show that they had read, understood and agreed to follow them. The pharmacy had carried out workplace risk assessments in relation to Covid-19.

The pharmacist said that near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. She explained that she pointed the mistake out to them and they did not have to identify their own mistakes. But they did rectify their own mistakes. A near miss record was available and the pharmacist said that she completed this. There had not been any records made for several months and the pharmacist said that this was due to having two qualified team members working full time at the pharmacy, so there were very few mistakes made. The dispenser said that she would start to record mistakes she had made, which she had realised and rectified before they had reached the pharmacist. The pharmacist said that she would review the record for patterns when there had been several entries made. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong strength of medicine had been supplied to a person. The incident had been reported to the pharmacy's head office and the pharmacist said that the error had likely occurred because the medicine was on the wrong shelf. Team members were reminded to take care when putting stock away.

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.

Team members' roles and responsibilities were specified in the SOPs. The dispenser said that the pharmacy would not open if the pharmacist had not turned up. She knew what tasks she should not do if there was no responsible pharmacist (RP) and if the RP was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not routinely recorded. The CD running balances were checked at regular intervals and the recorded quantity of one

CD item checked at random was the same as the physical amount of stock available. The pharmacy had not made any emergency supplies of a prescription-only medicine without a prescription for several months. The pharmacist showed where she would record the nature of the emergency on the pharmacy's computer system. The private prescription records were largely completed correctly, but the prescriber's address was not always recorded correctly. This could make it harder for the pharmacy to find these details if there was a future query. The pharmacist provided assurances that the CD registers and private prescription register would have all the necessary information recorded in the future.

Confidential waste was sent to the pharmacy's head office for disposal. 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 team had completed training about protecting people's personal information.

The pharmacy had not yet carried out a patient satisfaction survey because of the pandemic. The complaints procedure was available for team members to follow if needed and details about it were prominently displayed in the shop area. The pharmacist was not aware of any complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (level 2) training about protecting vulnerable people. And the dispenser had completed safeguarding training provided by the pharmacy's head office. She could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The dispenser gave an example of action the pharmacy had taken in response to a safeguarding concern. 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. And they are allowed time during work hours to complete it. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. And are able to discuss any issues with the pharmacy's head office. Team members are able to take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one regular pharmacist and one dispenser working during the inspection. The dispenser had completed an accredited course for her role and they had a good working relationship. They communicated effectively to ensure that tasks were prioritised, and the workload was well managed. Targets were not set for team members. The pharmacist said that the services were carried out for the benefit of the people using the pharmacy. Team members had received both doses of the Covid-19 vaccination and carried out twice weekly lateral flow tests. The inspector discussed with the pharmacist about the reporting process in the event that a team member tested positive for the coronavirus.

The dispenser appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine-containing products. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She used effective questioning techniques to establish whether the medicines were suitable for the person.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. The pharmacist felt able to take professional decisions and had a good working relationship with the pharmacy's head office. She could contact them to discuss any issues. She said that she kept up to date with pharmacy-related matters and had recently undertaken some training about antibiotic resistance, and the NHS Discharge Medicines Service. The dispenser said that she had access to online training provided by the pharmacy's head office. She had recently completed some training about suicide prevention and was allowed time during quiet periods to complete training at work. She explained that she was due to attend training about weight management and the stop smoking service. The pharmacist said that he had completed declarations of competence and consultation skills for the flu vaccination service, as well as associated training.

The pharmacist said that the company organised yearly appraisals and performance reviews for its staff. The pharmacy had been open for just over one year and team members were due to have their reviews soon. The dispenser felt comfortable about discussing any issues with the pharmacist or making any suggestions. Any issues were usually discussed on an informal basis as they arose and so there was little need for formal meetings to be held. The pharmacy received information and regular updates from the pharmacy's head office. It had recently received an updated version of the SOPs and team members were in the process of reading them. The pharmacist said that the superintendent pharmacist usually visited the pharmacy once a month. So that any issues could be discussed face to face.

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, and this presented a professional image. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available and the room temperature was suitable for storing medicines.

There was a screen at the medicines counter, but there was no easy way for team members to assist people while remaining behind the screen. People were helped at the side of the screen and the dispenser said that she requested that people stand back from the counter to ensure that they were a suitable distance from her. There was a clearly marked one-way system in the shop area. One door was used as an entrance and the other as an exit to help minimise the chance of people walking past each other while accessing the pharmacy. There was a hand sanitiser station in the shop area at the entrance.

There were two chairs in the shop area. These were positioned to one side of the medicines counter to act as a barrier to shop people accessing the dispensary. The dispenser said that these had been positioned away from the counter before to help minimise the risk of conversations at the counter being heard. The dispenser said that people usually did not wait at the counter for their prescription to be dispensed. She explained that they usually went across the road to do some shopping or walked around the pharmacy’s shop area looking at items.

The consultation room was accessible to wheelchair users and was located to the side of the medicines counter and dispensary area. It was suitably equipped and well-screened. Access to the room from the shop area was restricted by the placement of the chairs. Conversations at a normal level of volume 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 it dispenses medicines into multi-compartment compliance packs safely. It gets its medicines from reputable suppliers and stores them properly. And 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.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the outside of the pharmacy from the medicines counter and dispensary. People could get the attention of a team members if they required helping into the premises. Services and opening times were clearly advertised and a variety of health information leaflets was available. A notice was displayed at the entrance to the pharmacy asking that people wear face masks where possible. The notice also provided information about Covid-19.

The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The dispenser said that prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that prescriptions for Schedule 3 and 4 CDs were highlighted, but a prescription for a Schedule 3 CD found waiting to be collected was not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The dispenser knew how long these prescriptions were valid for. The pharmacist said that team members checked CDs and fridge items with people when handing them out. The pharmacy supplied valproate medicines regularly to one person and they were not in the at-risk group. The pharmacist explained that she would make notes on the person's medication record if they needed to be on the Pregnancy Prevention Programme. The pharmacist could not find the relevant valproate patient information leaflets during the inspection and said that she would order these from the manufacturer. The warning cards were attached to the medication boxes and were supplied each time the medicine was dispensed.

Stock was stored in a well-organised manner in the dispensary. Expiry dates were checked monthly and this activity was recorded. Items due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

There were no part dispensed prescriptions at the pharmacy on the day of the inspection. The pharmacist said that 'owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. And prescriptions for alternate medicines were requested from prescribers where needed. The pharmacist confirmed that prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked monthly and any items remaining uncollected after around three months were returned to dispensing stock where possible. The pharmacist said that people were contacted to ask if they wanted their medicines before their medication record was updated. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber.

The pharmacy supplied medicines in multi-compartment compliance packs to a very small number of people who lived in their own homes. The pharmacist confirmed that people had assessments carried out by their GP 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 pharmacist said that people contacted the pharmacy 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. There were no completed packs available for the inspector to check. The pharmacist explained how the packs were dispensed and labelled. She confirmed that medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. And that 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, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy only made a few deliveries each week and used a delivery driver who mainly worked at another pharmacy within the company. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. 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 used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS, the MHRA and the pharmacy's head office. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. 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.

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 pharmacy was waiting for weighing scales and a blood pressure monitor to be delivered. The phone in the dispensary was portable so it could be taken to a more private area where needed. Team members wore face masks while in the pharmacy and hand sanitiser was available.

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.