General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Amal Pharmacy Direct, Workshop Office 4 (Ref Office WS02), Maidstone Innovation Centre, Gidds Pond Way, Weavering, Maidstone, Kent, ME14 5FY

Pharmacy reference: 9012047

Type of pharmacy: Dispensing hub

Date of inspection: 22/08/2023

Pharmacy context

The pharmacy is in an innovation centre near Maidstone town centre. It provides NHS dispensing services at a distance. And it supplies medicines in multi-compartment compliance packs to a large number of people who live in care homes. It receives all its prescriptions electronically.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It learns from mistakes that happen during the dispensing process to help make its services safer. It protects people's personal information well. And people using the pharmacy can provide feedback about its services. And it keeps its records up to date and accurate. Team members understand their role in protecting vulnerable people.

Inspector's evidence

Team members had signed to show that they had read, understood, and agreed to follow the pharmacy's standard operating procedures (SOPs). The pharmacy recorded its near misses, where a dispensing mistake was identified before the medicine had reached a person. The pharmacist explained that he highlighted the near misses to the team member involved at the time of the incident. And once highlighted, the team member was responsible for identifying and rectifying their own mistakes. Following a recent review of the near misses, the pharmacy had separated omeprazole capsules and tablets to help minimise the chance of the wrong medicine being selected. The pharmacist said that there had not been any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been supplied. He explained that he would record any incidents on a designated form and record them on the National Reporting and Learning System. If the mistake involved a controlled drug, he would report the incident to the relevant Controlled Drugs Accountable Officer.

There was limited workspace in the dispensary but there was clear workspace for dispensing and checking the medicines. An organised workflow helped staff to prioritise tasks and manage the workload. Team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacist explained that the dispenser would not undertake any dispensing tasks before he had arrived. And he said that items would not be handed to the delivery driver if he was not in the pharmacy. Team members' roles and responsibilities were specified in the SOPs.

The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The pharmacy had current professional indemnity and public liability insurance. The pharmacist explained that the pharmacy did not dispense private prescriptions or supply medicines in an emergency without a prescription. He said medicines could be obtained from the other pharmacy in the company if needed. And he said that the pharmacy worked around two weeks ahead, so that prescriptions for alternate medicines could be requested before the person needed their medicines. 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.

Confidential waste was shredded, and computers were password protected. Smartcards used to access the NHS spine were stored securely and the pharmacist used his own smartcard to access the NHS electronic services during the inspection.

The pharmacy's complaints procedure was available for team members to follow if needed. The

pharmacist said that there had not been any complaints. He said that if one was received, he would make a record of it and discuss it with the team.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. He said that the care home staff would deal with any safeguarding concerns at the care homes.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can openly discuss any concerns and team members can make professional decisions.

Inspector's evidence

There was one pharmacist (who was also the superintendent pharmacist) working on the day of the inspection and one of the directors visited the pharmacy during the inspection. The pharmacist said that the dispenser was on planned annual leave. The dispenser had completed accredited training courses for her role and the certificates were kept at the pharmacy. The pharmacy worked around two weeks in advance of people needing their medicines and it was up to date with its dispensing.

The pharmacist said that the dispenser had been enrolled on an accuracy checking dispenser course. And she had completed training in phlebotomy and ear syringing for use at the other pharmacy when providing cover there. The pharmacist was aware of the continuing professional development requirement for professional revalidation. He had recently passed the independent prescriber course. And had also undertaken some training about inhaler technique.

One of the directors frequently visited the pharmacy to ensure that the services were running smoothly. He explained that his office was in the same building, and he usually discussed any issued with the team face to face. The pharmacist said that he could make professional decisions and could discuss these with the director if needed. The director had been the educational supervisor for the pharmacist’s independent prescriber course and said that they had a good working relationship. The pharmacist said that he carried out ongoing informal performance reviews for the dispenser. And the director carried out the pharmacist’s appraisal. 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.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout. Air conditioning was available, and the room temperature was suitable for storing medicines. Toilet facilities were available in the building’s communal areas. These were clean and not used for storing pharmacy items and there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. 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.

Inspector's evidence

The pharmacy employed a call handler to ensure that phone calls were directed to the right pharmacy. The pharmacist said that he usually communicated with the care homes via email. And the pharmacy's email inbox was checked frequently throughout the day. The pharmacy ensured that deliveries to the care homes were made during the opening hours so that a suitable team member would be available to accept the medicines. The pharmacy obtained people's signatures for all deliveries, and these were recorded on a handheld electronic device. The pharmacist said that he could access the delivery app to ensure that the medicines were delivered. And he could check the delivery app while items were with the delivery driver if there were any queries.

The pharmacist said that care homes were responsible for monitoring and checking blood test results for people taking higher-risk medicines such as methotrexate and warfarin. Dispensed fridge items and CDs were clearly marked and highlighted to the care home staff member when handed over. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist said that he would check with the care home staff if he was unsure whether a person should be on the PPP. And he would ask that the person be referred to their GP if they were not on one and needed to be.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. 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. Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was recorded. The pharmacist said that items with a short shelf-life would be marked, but there were none found during the inspection. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

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 had been returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Fridge temperatures were continuously monitored. The pharmacist showed how he viewed the recorded temperatures and how he could check how long the temperature had been out of range for. The pharmacist said that he would be alerted if the temperatures went out of range, and he said that he would visit the pharmacy to check the fridge. Records indicated that the temperatures were consistently within the recommended range. And the fridge was suitable for storing medicines and was not overstocked.

The pharmacist said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. The pharmacy did not order prescriptions on behalf of all people who received their medicines in the packs. Most prescriptions were managed by the care homes and the pharmacist said that he would contact the care homes if the pharmacy had not received a prescription. And the pharmacist said that the care homes were responsible for requesting 'when required' medicine for their residents. For those managed by the pharmacy, the pharmacy ensured that the prescriptions were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacy kept a record for each person which included any changes to their medication, and it 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. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. The pharmacist said that the pharmacy routinely labelled bottles and outer cartons for liquid medicines so that the medicine was labelled if the box was thrown away in error. The pharmacy was made aware when a person was admitted to hospital. The pharmacist said that he chased up discharge letters to ensure that any changes were made before the packs were assembled.

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

Up-to-date reference sources were available in the pharmacy and online. The shredder was in good working order. Suitable equipment for measuring liquids was available but not for volumes less than ten millilitres. The pharmacist said that he would order a suitable measure. A separate measure was marked for use with certain medicines only. Triangle tablet counters were available and clean. Methotrexate came in foil packs and there was no need for the loose tablets to be counted out in a triangle. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

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.