General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chesterfield Delivery Pharmacy, 1st Floor, 26 High Street, Staveley, Chesterfield, Derbyshire, S43 3UX

Pharmacy reference: 9012116

Type of pharmacy: Internet / distance selling

Date of inspection: 07/11/2023

Pharmacy context

This pharmacy is located on the first floor of a retail unit in the town centre. People cannot visit the pharmacy in person unless they are attending a pre-arranged appointment, such as the ear clinic. The pharmacy dispenses NHS prescriptions, and it supplies medicines to care homes. The pharmacy has a website (www.chesterfielddeliverypharmacy.co.uk) which provides information about the pharmacy. It offers Covid-19 vaccinations from the retail unit, which is an associated site but not part of the pharmacy premises, and the service was not inspected.

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 generally manages risks to make sure its services are safe. It has written procedures, so the team understand their responsibilities, and they keep people's private information safe. Team members understand how they can help to protect the welfare of vulnerable people. The pharmacy generally completes the records that it needs to by law but some of the records are incomplete or inaccurate, which could cause confusion and makes audit more difficult.

Inspector's evidence

The pharmacy had started operating around five months ago. It had up-to-date standard operating procedures (SOPs) for the services it provided, with signatures showing that members of the pharmacy team had read and accepted them. The responsible pharmacist (RP) confirmed that the delivery procedure had been explained to the delivery driver. But the driver had not read any of the SOPs, so there was a risk that she might not fully understand her responsibilities. The delivery SOP had not been reviewed when a new electronic record for deliveries had been introduced, so it didn't reflect current practice. The RP agreed to review the delivery SOP and ensure that the driver read the relevant SOPs. Roles and responsibilities were set out in SOPs. The RP's name was displayed as required by the RP regulations.

The RP explained that the pharmacy's patient medication record (PMR) system had an additional patient safety feature. The medicine selected for dispensing was scanned and if this was not the same as the medicine prescribed, the system alerted the dispenser to the error. The system also checked that the medicine was within its expiry date. If a medicine would not scan for any reason, then the pharmacist took extra care when carrying out the accuracy check of the medication. The RP said that errors were minimal because of this system. He thought the system produced a record of the 'near misses', but he was unsure how to access this report. He believed one of the other regular pharmacists reviewed it. But he couldn't recall any learnings which had been shared with the rest of the team, so they might be missing out on additional learning opportunities. The RP said that he was not aware of any dispensing errors since the pharmacy started operating, but he would follow the 'Dealing with an incident' SOP and investigate and report any incident that occurred. The pharmacy's complaint procedure and the details of how to give feedback was available on the pharmacy's website. The RP described how he had dealt with a complaint about the Covid-19 vaccination service, when a person had been incorrectly booked in for a vaccine when it wasn't appropriate. The RP had identified that this was a mistake with the NHS's booking system, which he had explained to the person when he responded by email.

The RP confirmed that the pharmacy had insurance in place, but he wasn't able to provide the details about professional indemnity. The pharmacy superintendent (SI) subsequently provided further clarification about the professional indemnity insurance and confirmed it covered the pharmacy's services. The pharmacy had an electronic register to record private prescriptions and emergency supplies. The register didn't have any entries and the RP confirmed that the pharmacy hadn't dispensed any private prescriptions yet. The RP record was being completed each day, but the RP was absent at the start of the inspection and he had not recorded an absence. The RP completed the details when this was pointed out. The pharmacy had a small number of controlled drugs (CDs) in stock. Checks of CD

registers found some inconsistencies, some of which were not in keeping with the CD regulations. The CD cabinet contained a patient returned CD. The RP confirmed that he would order a book to record the destruction, and CD denaturing kits, as these couldn't be found during the inspection.

The pharmacy had Information Governance (IG) SOPs which included information on data protection and confidentiality. The pharmacy's privacy and cookie policies were on the website, but the privacy policy had not been fully completed, so people might not have all the required information in the event of a problem or query.

Confidential waste was collected in a designated place and shredded. Written consent was obtained when people nominated the pharmacy to receive their NHS prescriptions. The pharmacists had completed at least level 2 training on safeguarding children and vulnerable adults. There was a safeguarding SOP. The RP said that the SI was the pharmacy's safeguarding lead, so he would discuss any safeguarding concerns with him. But he also had the details of the local safeguarding team to report any concerns directly to if necessary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team and the workload is manageable. Team members have opportunities to discuss issues informally together.

Inspector's evidence

The pharmacy team consisted of the RP and three other pharmacists who worked at least one day each week in the pharmacy. One of the regular pharmacists was the SI. The RP explained that when possible one pharmacist would dispense the medicines and they would be checked by a different pharmacist the following day, but quite often pharmacists were required to self-check prescriptions. The pharmacy was in the process of recruiting a dispenser as the workload had increased, which would reduce the need for self-checking by the pharmacists. There was also a part time delivery driver. The RP explained that he and one of the other regular pharmacists had attended face-to-face training and were fully competent to carry out the ear clinic service. The delivery driver had not completed any formal training on delivering medicines, but the RP said she would be enrolled onto a suitable course now that she had completed three months in the role. The regular pharmacists used a diary to share notes with each other and had weekly meetings online where they could discuss issues. The RP confirmed that the pharmacists were empowered to exercise their professional judgement and could comply with their own professional and legal obligations.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally provides a suitable environment for the provision of healthcare services. It has a consultation room so people can receive services in private. The pharmacy's website has some useful information about the pharmacy, but some details are inaccurate which could cause confusion.

Inspector's evidence

The pharmacy premises were in an adequate state of repair. The temperature and lighting were adequately controlled. The pharmacy had been fitted out to a reasonable standard. It comprised of a dispensary, consultation room, kitchen and WC with a wash hand basin and hand wash. There was a sink in the kitchen area which could be used for medicines preparation. The RP confirmed that hot water was available although the boiler had not been turned on that day. The consultation room was uncluttered, clean and professional in appearance. This room was used when carrying out services such as the ear clinic. The pharmacy's website provided useful information about the pharmacy such as its contact details and practice leaflet. Some over-the-counter (OTC) medicines were displayed on the pharmacy's website, but it was not possible to purchase them through the website, which might be confusing for people viewing the website. And some services, which were not currently provided, such as treatments for infected insect bites and urine infections, were advertised, which was misleading. The RP said he would remove these from the website to avoid any confusion.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a small range of healthcare services, which are generally well managed. It gets its medicines from licensed suppliers and the team carries out some checks to ensure medicines are in suitable condition to supply.

Inspector's evidence

The pharmacy and its consultation room were on the first floor of the building. Wholesale delivery drivers and people with appointments for services were required to ring the front doorbell when they arrived, so they could be allowed access. The front door was fitted with a camera, so people in the pharmacy could see who was requesting access. There was a lift which could be used by people visiting the pharmacy including those with mobility difficulties and wheelchair users. People could communicate with the pharmacy team via the telephone or by email. Services provided by the pharmacy were advertised on the pharmacy's website. The pharmacy carried out Covid-19 vaccinations on the ground floor of the building which was an associated site. The regular pharmacists carried out the vaccinations. The clinics were held at weekend when the pharmacy was closed, so it did not interfere with the usual running of the pharmacy. The pharmacy had administered around 600 vaccines during the previous month.

All prescriptions were delivered. The delivery driver worked three days each week. If urgent prescriptions were required on one of the days when the delivery driver wasn't working, then the pharmacist would generally deliver them after work. There was an electronic audit trail for deliveries made to people in the community and people were sent a text so let them know when to expect the delivery. The pharmacy usually obtained signatures from the recipient to confirm the safe receipt. But this process was not used for care homes and neither the name or the signature of the person receiving the delivery was obtained, which limited the information available in the event or a problem or query. And this was not in line with the delivery SOP. The RP confirmed that he would review the delivery process for care homes. The pharmacy's procedure would be to post any prescriptions received from outside the delivery area using a Royal Mail tracked service.

Space was adequate in the dispensary. The dispensary shelves were well organised, neat, and tidy. The PMR system printed a QR code onto the medication label which provided a dispensing audit trail. This included the details of the pharmacist who carried out the clinical check as well as the person who labelled and dispensed the prescription. Tubs were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The RP was aware of the requirements for a Pregnancy Prevention Programme to be in place for people in the at-risk group who were prescribed valproate, and that people were required to have annual reviews with a specialist. He confirmed that original packs would always be supplied to ensure people in the at-risk group were given the appropriate information. The pharmacy supplied medicines to two small care homes. The people in both care homes received their medicines in original packs with medicine administration record (MAR) sheets. A small number of people in the community received their medicines in multi-compartment compliance aid packs. The RP explained the procedure for recording changes to medication in the compliance aid packs, which included checking with the patient and/or their prescriber to confirm any changes made. Medicine descriptions were usually included on the packaging to enable identification of the individual

medicines. Packaging leaflets were included so people were able to easily access additional information about their medicines. Disposable equipment was used.

The RP said he hadn't sold any OTC medicines and he would not sell any medicines which could be misused such as codeine containing products. CDs were stored in a CD cabinet which was securely fixed to the wall. Date expired, and patient returned CDs were segregated and stored securely. Recognised licensed wholesalers were used to obtain stock medicines. Medicines were stored in their original containers at an appropriate temperature. Dates had been added to opened liquids with limited stability. Expired and unwanted medicines were segregated and placed in designated bins.

Alerts and recalls were received electronically. These were read and acted on by a member of the pharmacy team and a record of the action taken was made so the team were able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date information. The RP used an App on his mobile phone to access the electronic British National Formulary (BNF) and BNF for children. There was a clean medical fridge for storing medicines, including Covid-19 vaccinations. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order. There was a clean glass liquid measures with British standard and crown marks. The pharmacy had clean equipment for counting loose tablets and capsules. Methotrexate was ordered in foil strips to avoid the need for handling. Medicine containers were appropriately capped to prevent contamination.

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.