General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** LP HCS, MHT Pharmacy, Maidstone Hospital, The Maidstone Hospital, Hermitage Lane, Maidstone, Kent, ME16 9QQ

**Pharmacy reference:** 9012158

**Type of pharmacy:** Dispensing hub

**Date of inspection:** 25/07/2024

## Pharmacy context

The pharmacy is in Maidstone hospital which itself is in a largely residential area. People are not able to physically access the premises and the pharmacy provides its services at a distance. It supplies medicines to several NHS hospitals with inpatient and outpatient clinics. And it supplies medicines in multi-compartment compliance packs to a large number of people to help them manage their medicines.

## 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 | 1.2 | Good practice | The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce future risks. |
| **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 identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce future risks. The pharmacy protects people's personal information well. And people can provide feedback about the pharmacy's services. The pharmacy keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

### Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. And their roles and responsibilities were specified in the SOPs. Team members knew which tasks they should not undertake if there was no responsible pharmacist (RP). And they knew that they should not hand over dispensed medicines to the delivery drivers if the pharmacist was not in the pharmacy.

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. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded and reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly during the regular team meetings. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Following a recent review of the near misses, the pharmacy had made a change to the way it dispensed medicines in multi-compartment compliance packs. Team members had to count the number of medicines that should be placed in each compartment before starting to dispense them. The quantities were then checked after the packs had been dispensed. The pharmacist said that this had helped to minimise the number of mistakes.

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 medicines were missing from a multi-compartment compliance pack due to the second page of the prescription not being printed. The error was noticed by a member of staff at the hospital. The pharmacist said that the pharmacy rectified the error before the person needed to take their medicines. He said that he now routinely checked the emails to ensure that all pages had been printed.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Trays were used to minimise the risk of medicines being transferred to a different prescription. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The pharmacy did not supply any medicines in an emergency without a prescription. Controlled drug (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.

Team members had completed training about protecting people's personal information. The pharmacy's confidential waste was removed by a specialist waste contractor and computers with people's personal information were password protected. Team members had individual log ins for the patient medication record to allow them to process prescriptions. There were no windows into the pharmacy from the hospital area.

The complaints procedure was available for team members to follow if needed. There had been a recent complaint where an owings slip had not been provided so the staff at the hospital were not aware that all the person's medication had not been received. The pharmacist had dealt with the complaint and supplied the person's medication. Team members had been reminded to always supply an owings note where a fully quantity of a person's medicine was not supplied.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about protecting vulnerable people. A dispenser described potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. And said that there had not been any safeguarding concerns at the pharmacy.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough 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 they can raise any concerns or make suggestions. The team members can make professional decisions to ensure people taking medicines are safe.

### Inspector's evidence

There were two pharmacists, four trained dispensers and three trainee dispensers working on the day of the inspection. The pharmacist said that a third pharmacist was due to start in a couple of months. He explained that the team members had to apply for leave well in advance and holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. Team members worked well together and the pharmacy was up to date with its dispensing. The team members wore smart uniforms with name badges displaying their role.

Team members completed monthly training modules and training was monitored by the pharmacy's head office. He said that he tried to allow team members time during the day to complete training when the pharmacy was quieter. And they could access the training modules at home if needed. The pharmacists were aware of the continuing professional development requirement for professional revalidation. The pharmacist had recently planned to undertake some training about clozapine, but the training had been cancelled. He plans to complete the training at the next available opportunity. The pharmacist felt able to make professional decisions.

The pharmacist said that there were informal team meetings held when information from the pharmacy’s head office needed to be passed on or if there was an issue that needed to be discussed. The pharmacy used a group chat to ensure that all team members received important information.

The pharmacist said that the pharmacy had been without a pharmacy manager for around three months. He said that performance reviews were usually undertaken by the manager. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. 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

People using the hospital could not see into the pharmacy room. The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. There was a sink with hot and cold running water. Air conditioning was available, and the room temperature was suitable for storing medicines. Toilet facilities in the hospital were clean and there were separate hand washing facilities available.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy services are accessible, and it provides them 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.

### Inspector's evidence

Opening times were advertised on the door to the pharmacy. People could contact the pharmacy via email or telephone. The pharmacy could produce large-print labels for people who needed them.

The pharmacist said that people had assessments to see if they needed their medicines in multi-compartment compliance packs. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. The batch number and expiry date were recorded on the dispensing labels. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs.

The pharmacist explained that he had recently started recording clinical interventions. A recent intervention had occurred when a person had received two prescriptions for their medicine but with different strengths. The pharmacy had queried this with the prescriber and the correct strength was confirmed and dispensed.

The pharmacist said that the hospitals monitored people taking higher-risk medicines and ensured that people were having relevant blood tests done at appropriate intervals. The pharmacy supplied valproate medicines in original packs. The pharmacist explained that the Trust provided people taking higher-risk medicines with alert cards and monitoring cards. He had received written confirmation from The Trust that these would be routinely provided to people. The pharmacy had additional cards if needed. One of the dispensers explained that fridge medicines were supplied in clear plastic bags with a fridge sticker on and these were transported in a cool box. CDs were transported in a sealed bag and handed separately to staff and a separate CD delivery sheet was signed.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office and the NHS Trust. 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. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next several months was marked. There were no date-expired items found in with dispensing stock during a random check, and medicines were kept in their original packaging. The pharmacy had a wholesale dealer's licence and a Home Office licence for the purpose of supplying stock medicines to other entities.

CDs were stored in accordance with legal requirements and denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges

were suitable for storing medicines and were not overstocked. The fridges sounded an alarm if the doors were not closed properly.

Part-dispensed prescriptions were checked frequently. ‘Owings’ notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

Deliveries were made by delivery drivers. The delivery driver was only allowed to hand over the medicines to a nurse or pharmacy technician and could not leave them at the receiving building's reception. And the pharmacy obtained signatures for these deliveries. Deliveries were only made when the receiving unit was open so there were no failed deliveries returned to the pharmacy.

## 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. Separate liquid measures were used to measure certain medicines only. 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 phone in the dispensary was portable so it could be taken to a more private area where needed.

## 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. |