

Registered pharmacy inspection report

Pharmacy Name: Harris Chemist, 165 a/b Dunstable Road, LUTON, Bedfordshire, LU1 1BW

Pharmacy reference: 1028855

Type of pharmacy: Community

Date of inspection: 12/02/2020

Pharmacy context

The pharmacy is located on a busy road in a mainly commercial area in central Luton. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy supplies medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include: prescription collection and delivery, travel and seasonal flu vaccinations, substance misuse, needle exchange, stop smoking and emergency hormonal contraception. The pharmacy has healthy living status.

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

The pharmacy's working practices are generally safe and effective. The pharmacy team manages risks in provision of its services. The pharmacy has written procedures which tell staff how to complete tasks safely. It keeps the records it needs up to date to show medicines are supplied safely and legally. The pharmacy team members make sure that people have the information they need so that they can use their medicines safely. They understand their role in protecting the welfare of vulnerable people and keeping people's information secure.

Inspector's evidence

Near misses were recorded and reviewed and there was an annual audit to identify trends in near misses. A patient safety review was compiled. Trends had been identified in 'lookalike soundalike' (LASA) picking errors and failing to mark open packs of medicines. Action points included separating LASA medicines and highlighting unusual forms of medicines on the patient medication record (PMR) to ensure the correct medicines were selected and supplied. Key learning points included double checking the quantity and form of medication requested. Medicines were stored on the dispensary shelves as fast-moving lines or under A-Z if not fast-moving lines. To minimise picking errors, bisoprolol 2.5mg and bendroflumethiazide 2.5mg tablets had been separated. Amitriptyline and amlodipine were in separate locations and allopurinol and atenolol were separated too.

Workflow: baskets were in use to separate prescriptions and medicines during dispensing and checking procedures. Different coloured baskets were used to separate acute, delivery, repeat, owing and compliance aid prescriptions. The pharmacist performed the clinical and final check of prescriptions. The dispensing audit trail was completed by staff to identify who dispensed and checked the prescription. Interactions between medicines for the same patient were shown to the pharmacist. There was a procedure for dealing with outstanding medication. The original prescription was retained, and an owing slip was issued to the patient. For 'manufacturer cannot supply' items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance aids were prepared on a rolling basis according to a matrix. There was a separate area to prepare compliance aids. The pharmacy managed prescription re-ordering on behalf of some patients and checked new prescriptions against the previous prescription and backing sheet for changes. There was an audit trail of any query regarding changes on the PMR and on the backing sheet in the folder of information which included discharge summaries following a stay in hospital. A record of communications with the prescribers was maintained. The pharmacy liaised with the doctor's surgery when new patients were identified who would manage administration of medicines better if supplied in a compliance aid. If appropriate, a risk assessment was completed to establish suitability of the patient to have medicines supplied in a compliance aid.

Backing sheets included a description identifying individual tablets and capsules. Patient information leaflets (PILs) were routinely supplied with each set of compliance aids. High-risk medicines such as sodium valproate and alendronate were generally supplied separately from the compliance aid. Some controlled drugs (CDs) were included in a compliance aid and managed to ensure supply within the 28-day validity of the prescription. Levothyroxine tablets were supplied separately if the patient could

manage special instructions.

There was a folder of standard operating procedures (SOPs) which included responsible pharmacist, CD and complaints procedures. SOPs were signed by the pharmacist who prepared and reviewed, and staff had signed and dated training records. Staff members working on the medicines counter said they would not give out a prescription or sell a pharmacy only medicine if the pharmacists were not on the premises. They said they would not sell Nurofen Plus and Solpadeine Max to the same patient because they both contain codeine. Patients could provide feedback via the community pharmacy patient questionnaire and the practice leaflet was displayed.

To protect patients receiving services, there was professional indemnity insurance in place provided by National Pharmacy Association (NPA) expiring 31 Mar 2020. The responsible pharmacist notice was on display and the responsible pharmacist log was completed although ensuring the log was completed at the end of the session was discussed. Records for supplies of private prescription, emergency and 'specials' medicines were complete. Patient group directions (PGDs) which were seen were in date. The CD and methadone registers were electronic and complete. There was an audit trail of who accessed the registers, who dispensed a CD and which pharmacist was on duty. CDs were audited monthly and methadone was audited weekly. A random check of MST 10mg tablets stock reconciled with the recorded balance. FP10MDA prescriptions were endorsed at the time of supply. A record was maintained of patient-returned CD destruction.

The pharmacist had undertaken General Data Protection Regulation (GDPR) training. A privacy notice was displayed. Staff were using their own NHS cards. Staff had signed confidentiality agreements. Confidential waste paper was collected for shredding. The Data Security and Protection (DSP) toolkit was due to be completed. The pharmacy computer was password protected and backed up regularly. There was a safeguarding SOP and the pharmacists had completed Centre for Pharmacy Postgraduate Education (CPPE) level 2 safeguarding training. Staff had completed safeguarding and dementia friends training.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team members effectively manage the workload within the pharmacy and work well together. They are comfortable about suggesting ways to improve the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time and two part-time pharmacists, one full-time pre-registration pharmacist, one full-time dispenser, one part-time trainee pharmacy technician, four part-time trainee dispensers who were also accredited medicines counter assistants, one full-time apprentice (Skills4) and three part-time delivery persons who the RP confirmed had read the delivery SOP.

The responsible pharmacist (RP) was the pre-registration tutor and the pre-registration pharmacist was enrolled on the ProPharmace training course. There were training days once a month and training topics included BNF chapters, Drug Tariff and calculation. There was one hour protected learning time daily and appraisals every thirteen weeks to monitor progress. Other staff had a verbal appraisal to monitor performance and progress.

The RP was the healthy living champion. Training had been completed in line with the Pharmacy Quality Scheme (PQS) in Community Pharmacist Consultation Service (CPCS), sepsis, safeguarding, 'lookalike soundalike' LASA picking errors and risk management.

There were staff meetings when staff training was provided in topics such as Tena products or multivitamins. Company representatives sometimes provided new product training. During the meetings staff could provide feedback. Minutes were kept and feedback had included removing clutter from the medicines counter, increasing the number of fast-moving medicines in the dispensary and keeping the painkillers in one location in the dispensary. Dispensary feedback to staff had included double checking patient details for prescriptions due to people with similar names and referring members of the public to the pharmacist if they had been referred to the pharmacy by NHS 111 via the CPCS. Staff said targets and incentives were not set in a way that affected patient safety.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are clean, secure and generally suitable for the services provided. The pharmacy prevents people accessing the premises when it is closed and keeps medicines and information safe.

Inspector's evidence

Although there were older fixtures and fittings the pharmacy premises were generally clean. The dispensary was on a slightly elevated level above the public area. The flooring and some ceiling tiles in the public area had been damaged due to a flood in the property upstairs but the superintendent pharmacist (SI) said the pharmacy was in the process of assessing and repairing damage. The lavatory was generally clean and handwashing equipment was provided. The consultation room was signposted in the retail area and it was not always locked when not in use. The consultation room was cluttered. There was sufficient ventilation and lighting.

Principle 4 - Services ✓ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and makes sure they are stored securely at the correct temperature. The pharmacy team members take the right action if any medicines need to be returned to the suppliers. They highlight prescriptions for high-risk medicines and provide people with the information they need to take their medicines safely. The pharmacy team give advice to people about where they can get other support.

Inspector's evidence

There was level access to the pharmacy premises via double doors to assist people with mobility issues. Large font labels could be printed to assist visually impaired people. Staff could converse in or understand Hindi, Urdu, Gujarati and Bangladeshi to assist patients whose first language was not English. Patients were signposted to other local services such as optician, the dentist and walk-in centre. Two staff members were trained to deliver stop smoking service and nicotine replacement therapy could be supplied via vouchers to people accessing the service. Members of the public could access treatment for minor ailments and emergency supplies via the CPCS.

The pharmacist explained the procedure for supply of sodium valproate to people in the at-risk group. Information on the pregnancy prevention programme (PPP) would be explained. There was information to give to patients on PPP. The intervention was recorded on the PMR. The pharmacist was aware of the procedure for supplying isotretinoin following a negative pregnancy test result and within seven days of the date on the prescription. Information on the PPP would be explained. The treatment would be initiated by a consultant. The pharmacist said she would contact the prescriber and record the intervention regarding prescriptions for more than 30 days' supply of a CD. CD prescriptions were highlighted with CD stickers to ensure supply within the 28-day validity period. Interventions were generally recorded on the PMR.

The pharmacist said when supplying warfarin, people were asked for their record of INR along with blood test due dates. INR was recorded on the PMR. Advice was given about side effects of bruising and bleeding along with advice about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were reminded about the weekly dose, when to take folic acid and care when handling methotrexate tablets. People were advised to seek medical advice if they developed an unexplained fever.

An audit had been conducted to identify people in the at-risk group taking sodium valproate and to explain the PPP. An audit had been completed to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking non-steroidal anti-inflammatory drugs (NSAID). Current audits included monitoring dates of last foot checks and retinopathy screening for diabetic people and people taking lithium to ensure they understood signs of toxicity and attended regular blood tests. Risk management training had been completed. The pharmacy had healthy living status. Health campaigns to raise public awareness included stop smoking and health checks to measure blood pressure, cholesterol and glucose. Sexual health advice and chlamydia screening were available to people accessing emergency hormonal contraception.

Medicines and medical devices were delivered outside the pharmacy by the three delivery persons. Delivery items were placed in a delivery basket. Patients signed a spare duplicate bag label which was then attached to the delivery record sheet indicating a safe delivery. There was a separate CD delivery book which the patient signed upon receipt of a CD.

Medicines and medical devices were obtained from Alliance, AAH, Phoenix, Sigma and Colorama. Floor areas were mostly clear, and stock was neatly stored on the dispensary shelves. Stock was date-checked and recorded. No date-expired medicines were found in a random check. Medicines were stored in original manufacturer's packaging and the date of opening was marked on liquid medicines. Cold chain items were stored appropriately between two and eight Celsius. Uncollected prescriptions were cleared from retrieval monthly. Prescriptions containing CDs and fridge items were highlighted. Waste medicines were stored separate from other stock. Falsified medicines directive (FMD) hardware and software was not operational at the time of the visit. Drug alerts were received, printed, annotated and filed.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It uses these appropriately to keep people's private information safe.

Inspector's evidence

Current reference sources included BNF, EMC and Drug Tariff online. The dispensary sink was clean. There was a range of clean stamped measures to measure liquids including separate marked measures for methadone. Minimum and maximum fridge temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinets were fixed with bolts. The stop smoking equipment was supplied and maintained by Total Well Being in Luton. The blood pressure monitor was replaced annually. The sharps bin was in the consultation room. Storing it more securely between vaccination appointments was discussed. Adrenaline ampoules to treat anaphylaxis were in date. Staff were using their own NHS cards. Staff had signed confidentiality agreements. Confidential waste paper was collected for shredding. The pharmacy computer was password protected and backed up regularly.

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.