

Registered pharmacy inspection report

Pharmacy Name: H.A. McParland Ltd t/a David Pharmacy, 24 New Road, ASCOT, Berkshire, SL5 8QQ

Pharmacy reference: 1028898

Type of pharmacy: Community

Date of inspection: 15/01/2020

Pharmacy context

This is a community pharmacy situated in a residential area of Ascot. It is part of a small independent chain of pharmacies. The pharmacy mainly supplies NHS prescriptions and it sells a small range of over-the counter (OTC) medicines and other retail products. It also offers seasonal flu vaccinations and some other NHS funded services including Medicine Use Reviews (MURs), New Medicines Service (NMS) and the Community Pharmacist Consultation Service (CPCS).

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

Overall, the pharmacy's working practices support safe and effective care. Pharmacy team members record and review their mistakes so that they learn from them. They know how to keep private information safe and support vulnerable people. The pharmacy has written instructions to make sure team members understand the working procedures. But there are rare occasions when they don't follow them, which means they might not complete tasks in the right way.

Inspector's evidence

The pharmacy had company issued standard operating procedures (SOPs) which covered the main activities and working processes. Team members' responsibilities were outlined in the SOPs. Team members could explain their role and worked under supervision. Some of them wore uniforms and badges so they could be readily identified. Most of the team had signed to indicate they had read and agreed them, but the ad-hoc Saturday assistant had not. Some SOPs were always consistently followed in practice, so the team might not always work effectively. For example, in relation to medicines waste management.

There were some risk management processes in place in relation to the dispensing process. Baskets were used to segregate prescriptions during the assembly process. Dispensing labels were initialled by team members involved in the assembly and checking process, so there was a dispensing audit trail. There was a dispensing error reporting process, and these were escalated to head office. A chart was used to record near misses which identified learning points. The team usually discussed errors and tried to identify any contributing factors. The company circulated any collated learning so everyone could learn from it. There was a complaints procedure. Any concerns were referred to the pharmacy manager in the first instance but could be escalated to head office if needed. The pharmacy participated in annual patient satisfaction surveys and usually received positive feedback.

Professional indemnity insurance was provided by the NPA and a current certificate was available. A responsible pharmacist (RP) notice was displayed. The pharmacy used a recognised patient medication record (PMR) system to record prescription supplies. And the team maintained all the required records, including RP logs, controlled drugs (CD) registers, private prescriptions and emergency supply records, and specials records. Records checked were generally in order, but private prescription records were sometimes inaccurate; for example, the wrong prescriber details were recorded. And private CD prescriptions (FP10PCD) were not routinely submitted to for auditing purposes as required by law, and some were found dating back to supplies made in 2017. The pharmacist these would be submitted at the end of the month. CD running balances were maintained and these were audited periodically. A couple of balances checked were found to match the quantity in stock.

A recently recruited team members had been briefed on data protection and understood the importance of maintaining patient confidentiality. Dispensary staff had individual NHS smartcards, and these were used correctly. Confidential paper waste was segregated and shredded. Other confidential material was generally stored out of public view, although some confidential paperwork was left in the unlocked consultation room, which potentially risked unauthorised access and the pharmacist agreed to remove this when it was highlighted as an issue.

The pharmacist was level 2 safeguarding accredited and had access to local safeguarding contacts. There was a safeguarding SOP explaining how concerns should be dealt with. Team members said they would report any concerns about patients to the pharmacist.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to cope with its workload and members of the pharmacy team work well together. Team members generally have the right training for their roles. They get complete some ongoing learning, but this is not structured, so gaps in their knowledge might not be identified.

Inspector's evidence

The staff profile included a full-time pharmacy manager who worked as the regular responsible pharmacist. The pharmacy also employed a full-time dispenser, a pre-registration student and a full-time counter assistant. The pharmacy manager and dispenser had worked at the pharmacy for several years, so were experienced. In addition, the pharmacy employed a part-time counter assistant who worked on Saturdays and provided occasional cover during the week, and a school-age student provided ad-hoc cover as a Saturday assistant. A company driver undertook deliveries on weekdays. Holidays were planned, and any absences were usually covered by other team members working extra hours or by requesting additional pharmacist support from head office.

At the time of the inspection all the full-time team members were working. The team managed the steady workload and footfall during the inspection without any major issues. People were greeted promptly and courteously. The team worked well together and talked openly about their work. They felt able to make suggestions or raise issues with the pharmacists and could contact head office directly if needed.

The dispenser had completed accredited training. The counter assistant had been recruited to provide maternity cover and had only worked at the pharmacy for around 5 weeks. She confirmed she had been briefed on the pharmacy's procedures and was due to be enrolled on a healthcare assistants' course. The regular Saturday assistant had been enrolled on a healthcare course the previous summer and had completed a couple of modules. The pharmacist said the ad-hoc Saturday assistant usually undertook housekeeping tasks and did not work on the counter, but they did assist with putting dispensary stock away and sorting waste medicines, which was beyond their training and capabilities, so presented a risk. When this was pointed out, the pharmacist agreed to allocate these tasks to a trained team member in future.

Staff had access to some additional training material, and they were encouraged to attend occasional company training events in the evenings including a recent one about the changes to the Pharmacy Quality Payments Scheme. Pharmacists had annual appraisals, but other team members did not, so gaps in their knowledge and any learning needs might not always be identified.

The company set some soft targets for the team relating to pharmacy services but the pharmacist did not feel under pressure to meet them, and able to exercise her professional judgement in the best interests of patients.
the annual MUR target as this was generally achievable.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides. But the generally worn appearance and lack of organisation detracts from the overall professional image, and makes the working environment challenging.

Inspector's evidence

The pharmacy was situated in an older retail unit. There was a retail area and small dispensary to the rear. It had less than three metres of workbench, so space was limited considering the volume of work, and benches were cluttered and untidy. The layout of the dispensary was not conducive to the work flow.

A basically equipped consultation room was situated at the front of the premises and was accessible from the retail area. There were two stock rooms located behind the dispensary. These were used to store excess stock, as a staff rest area and a small table was being used to for compliance pack assembly. Basic staff toilet facilities were also accessible from this area.

The retail area was reasonably tidy. But the pharmacy's fixtures and fittings were old and worn, and the general décor needed updating. The dispensary sink and the desk in the consultation room were stained with age. The lack of space hampered general organisation in the dispensary and some areas were cluttered. Boxes were stored on the floor which presented a trip hazard. There was no air conditioning to control the room temperature and rear stock areas were not well-lit. The general presentation and poor layout detracted from the overall professional image and the made the working environment challenging.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy generally manages its services safely, so people receive appropriate care. It sources medicines from licensed suppliers, and team members complete checks to make sure they are in good condition. But they don't always do this systematically, which means they manage some medicines less effectively. And they do not always identify people receiving high risk medicines, so they can make extra checks to make sure these are suitable to supply.

Inspector's evidence

Opening times were displayed. There was a single non-automated door at the entrance. Staff could offer assistance if needed. There was a limited amount of health promotion material in the retail area. The team dispensed a mixture of walk-in and repeat electronic prescriptions. They reported a good working relationship with the local surgery which accounted for the majority of their prescriptions. Dispensed medicines were appropriately labelled, and patient leaflets were routinely supplied. The team managed repeat prescriptions for some patients and audited using a system within the PMR, so they could be tracked, and requests were sent to the surgery by NHS email. Home deliveries were signed for, so these were also auditable.

Around 20 people received their medicines in weekly compliance packs. Each person had a record chart showing how packs should be assembled and noting medication changes and preferences. Packs were suitably labelled. The pharmacist was able to access summary care records where patients consented, and she completed regular MURs, NMS and made CPCS consultations. There had been positive uptake of the flu service during the current season. The team members were aware of the valproate pregnancy prevention programme, and they had the relevant manufacturer's literature. Audits had been completed for NSAID, lithium and valproate.

Interventions were usually recorded on the PMR. During a random check of private records, one instance was noted where a patient had been supplied a schedule 4 CD by a private doctor and their GP within a short time frame, and no intervention had been made to confirm it was safe to supply. And there was no system to flag CD prescriptions to make sure they were only supplied within the legally valid 28-day period.

The bulk of medicines were sourced and distributed from the company's central warehouse which had a wholesale licence. Other items were obtained from licensed wholesalers. The pharmacy had a large stock holding and shelves were untidy in places. Expiry date checks were completed periodically but these were not documented. So, there was no record to show when stock had last been checked or identify whether any had been missed. A random check of dispensary found no expired items other than an open bottle of morphine solution which had not been dated in keeping with its limited expiry; this was immediately discarded. And several expired CDs had not been segregated in the CD cabinet. A booklet was used to record destruction of patient returned CDs. Other waste medicines were segregated in designated bins kept in the stock room. Some obsolete and patient returned CDs requiring denaturing were found in these bins indicating they had not been properly sorted, potentially as a consequence of untrained team members completing this task. The pharmacist subsequently confirmed that moving forward only the pre-registration student or dispenser would complete this task.

Furthermore, a CD date check had been completed, obsolete CDs has been destroyed by the company's authorised witness and all CDs were now stored in the cabinet.

Pharmacy medicines were stored behind the counter, so sales could be supervised. The counter assistant understood what questions to ask and when to refer to the pharmacist and was aware of the restrictions on codeine containing medicines. Cold chain medicines were stored in a fridge and the temperature was monitored and recorded to ensure it was within the required range. Drug and device alerts and recalls were received by email and actioned by the pharmacist. Confirmation was sent to head office when this had been completed. Recent alerts had been received and the pharmacist explained how they had quarantined and returned affected ranitidine stock in relation to previous recalls.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

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

Inspector's evidence

The pharmacy team had access to the internet and appropriate reference books, including a current BNF. Disposable medicines containers were used. Triangles were available for counting tablets and a range of crown stamped conical measures were available for preparing liquid medicines. Patient Medication Records stored on the pharmacy computer were password protected. There was a single PMR terminal in the dispensary which was used for all dispensing and administration of prescriptions, so it was in constant use. All electrical equipment appeared to be in working order. The consultation room was used to enable confidential discussion and consultation. A domestic fridge was used to store medicines. A standard CD cabinet was in use.

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.