General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kry-Ba Pharmacy, 21 Goresbrook Road, DAGENHAM, Essex, RM9 6XA

Pharmacy reference: 1031138

Type of pharmacy: Community

Date of inspection: 13/02/2020

Pharmacy context

This pharmacy is in a parade of shops in a residential area. The pharmacy dispenses NHS prescriptions and offers health-checks. It supplies medicines in multi-compartment compliance packs to a number of people to help them take their medicines safely. It supplies medicines to some people as part of a substance misuse service.

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 largely manages the risks associated with its services. The pharmacy asks its customers for their views. It largely keeps the records it needs to so that medicines are supplied safely and legally. Team members protect people's private information. And they know how to safeguard vulnerable people. When things go wrong, the pharmacy team responds well. But the team members always don't record all the mistakes picked up during the dispensing process. So, they may be missing opportunities to learn.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which had been read and signed by team members. Team roles were listed on individual SOPs. The core dispensing SOPs did not incorporate the Falsified Medicines Directive (FMD).

Near misses were said to be recorded in a book as they were identified. The only records available during the inspection had been made in August 2018. The responsible pharmacist (RP) had picked up a few near misses in the weeks that she had worked at the pharmacy. Team members agreed to start recording near misses as they occurred. As a result of past mistakes, the team had labelled shelf-edges with warning labels and team members had completed the Centre for Pharmacy Postgraduate Education (CPPE) training on 'look-alike sound-alike' (LASA) medicines.

Dispensing incidents were investigated and recorded with learning shared with the team. As a result of past incidents ramipril tablets and capsules had been separated on the shelves and as a result of a separate incident were someone who was prescribed a medicine was supplied with two different medicines in the same box, the team had separated both items on the shelves and attached LASA stickers near where both were stored. The team had also been re-briefed on LASA medicines.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaint procedure and also completed an annual patient satisfaction survey. As a result of feedback received previously about delays in people's prescriptions being ready to collect the team members now used the 'repeat scheduling' programme to set reminders on the electronic recording system when someone dropped off a paper repeat slip. Notes were also added onto the system when batch prescriptions were supplied by the surgery for some people.

Records for unlicensed medicines supplied, controlled drug (CD) registers and RP records were well maintained. Private prescription records did not always have the correct prescriber details recorded and emergency supply records did not always have the nature of the emergency recorded. This could make it harder for the pharmacy to find out the correct details if there was a query. A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received.

Assembled prescriptions were stored behind the medicines counter and people's private information was not visible to other people using the pharmacy. Team members who accessed NHS systems had individual smartcards. The RP had access to Summary Care Records (SCR) and consent to access these was gained verbally from people.

Team members and the RP had completed training on safeguarding. A safeguarding folder was available in the dispensary. Team members described an example of where they had contacted the police a number of years ago due to a concern about a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for its services. And they undertake the right training for the jobs that they do. They work closely together and share information with each other to ensure services are provided safely. They undertake some ongoing training to help keep their knowledge and skills up to date.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP, two trained dispensers (one was the pharmacy manager and the other worked part-time and only dispensed multi-compartment compliance packs). Other team members included the pre-registration trainee (pre-reg) and a trained Medicines Counter Assistant (MCA). One of the dispensers who did not work regularly covered when other team members were off work or when a number of compliance packs were due.

Team members were observed to have an effective working relationship and described being able to give feedback and raise concerns to the superintendent. The RP felt that there were an adequate number of staff for the services provided. Most items dispensed by the pharmacy were part of the multi-compartment compliance pack service.

The dispenser completed independent training as part of another role he had. He supported team members who were ongoing formal training and brought additional resources for them if there was an area that they were struggling on. He enrolled them on the newest courses to make sure they gained the most from their training. The dispenser also informed the team of changes to guidance and legislation and asked them to sign the briefing sheet to demonstrate that they had understood this.

Team members had a short briefing early in the morning before starting work. The owner worked at the pharmacy every alternate Saturday and provided team members with changes that could made. The dispenser (pharmacy manager) communicated with the owner over the telephone or via messages daily.

The counter assistant counselled patients on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. When unsure she would refer to the pharmacist. The counter assistant also handed out prescriptions and would obtain an additional signature where prescriptions were annotated with the words ‘CD.’ She was unclear on how long a prescription for diazepam was valid for and was informed by the inspector.

Team members undergoing training were well supported by the pharmacist who had weekly catch-ups with them to monitor how they were doing. The pre-registration trainee had a structured study programme with Propharmace and attended external study days. However, she was not provided with any set-aside study time in the pharmacy. The RP had recently become the pre-reg’s tutor since joining the pharmacy and planned to do training on how to be a pre-reg tutor. The pre-reg felt able to give feedback and suggestions and since starting at the pharmacy had set up a number of spreadsheets to help the team manage the multi-compartment compliance pack service. The pharmacist encouraged team members to read up information on websites to keep up to date and refresh their knowledge. She also briefed them about new products and updates from emails.

Staff performance was managed informally by the pharmacist or the dispenser who gave on-the-spot feedback to team members. This covered how they were doing and individual's knowledge of products. The RP and dispenser also briefed colleagues when new medicines were launched or when some medicines changed classification and would be available for people to buy over the counter. Team members were able to go to the pharmacist with any issues, concerns or suggestions that they had and these were actioned where possible. The owner also welcomed feedback.

Targets had not been yet set for the RP; the owner had arranged for the RP to attend training so that she was accredited to provide additional services. Team members did not think that there were many areas that targets could be set for.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are mostly clean. People can have a conversation with a team member in a private area. But the pharmacy could do more to make sure that it keeps all areas tidy and free from clutter.

Inspector's evidence

At the time of the inspection the pharmacy was undergoing an extension. A larger consultation room had been created as well as additional space for stock and for team members. Rooms upstairs had also been prepared for future use as consultation rooms and for the management and preparation of multi-compartment compliance packs. Due to the work being carried out the dispensary was dusty and cluttered in places. There was little clear space available for dispensing with counters being used to store paperwork, assembled prescriptions and other items. The bench used for preparation of the multi-compartment compliance packs was also cluttered with other baskets and medication in close proximity, these were kept some distance away leaving a small clear space for the preparation of the packs. A small sink was available in the dispensary. Medicines were currently being stored in the dispensary but a stock room was being built.

The consultation room was accessed via a hallway next to the dispensary. This was not being used at the time of the inspection due to the extension. The room had been available to use until the day prior to the inspection. The RP described that she would take people to a quiet corner whilst the room was being completed. Some boxes stored in the hallway had bag labels and prescriptions clearly visible, team members said that these had only been placed there as the work was being completed and usually the hallways were clear to ensure it was accessible to people in mobility aids.

The premises were kept secure from unauthorised access when the pharmacy was closed. The room temperature was appropriate for the for the provision of pharmacy services. And lighting was good throughout the pharmacy. To help regulate the temperature in summer the rooms at the back had windows and a portable air conditioning unit was brought in.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely delivers its services in a safe and effective manner. It obtains its medicines from reputable sources. And it generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts to make sure that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services. The pharmacy does not always give people information leaflets that come with their medicines. This means that people may not always have all the information they need to take their medicines safely.

Inspector's evidence

There was step-free access from the street to the pharmacy and team members assisted people who required help. There was easy access to the medicines counter and chairs were available for people waiting for their prescriptions. The local population predominantly spoke English. However, on the occasion that someone did not speak English the team tried to use online translation applications; team members were also multilingual. The team had the ability to produce large print labels and ensured braille was not covered on packs for people who had sight issues. The range of services offered by the pharmacy was adequately promoted. Team members were aware that signposting may be necessary where people required an additional or alternative service and used the internet to find details of local services.

The team felt that the minor ailments had the most impact on the local population. Team members described that the area was socially deprived and there were two schools situated within walking distance of the pharmacy. The service was popularly used for children's medicines and head lice treatment. This service was due to be decommissioned soon.

New services were launched if there was a demand noted locally. The pharmacy was due to launch a travel vaccination service and the RP was due to attend training for the treatment of removal of warts and verruca. There were plans to introduce more services as three consultation rooms were being built.

The pharmacy had an established workflow. Walk-in prescriptions were mainly received in the morning and afternoon. Prescriptions were taken in at the counter, placed in a red basket and handed to the dispensers. prescriptions were generally dispensed by the dispensers or the RP printed labels in batches and then dispensed these through the day and left them aside to check later. Dispensed and checked by boxes were routinely used by team members to ensure that there was complete audit trail in place.

The pharmacist and pre-reg were aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). The pharmacy had in the past completed an audit on the use of sodium valproate and had identified two people who fell in the at-risk group. Both had been counselled and were part of the PPP. The pharmacy tried to dispense sodium valproate in its original pack where possible and staff were aware of the need to use the warning labels where sodium valproate was not dispensed in its original pack.

When people were collecting warfarin, team members asked to see people's yellow book and checked the INR, this was recorded. Team members also asked for a copy of the yellow book when ordering repeat prescriptions for people. People who requested prescriptions for methotrexate needed to send

information to the surgery. The pharmacy team also checked when the person had last had their blood tests and counselled on warning signs.

The pre-reg had generated a new spreadsheet to manage the multi-compartment compliance pack service. This automatically highlighted who was due after which prescriptions were then ordered. Dates of when the packs were due to be ordered, prepared and supplied were all automatically flagged by the system. Once a prescription was received the backing sheet was prepared. The care home notified the team of any changes or when people were admitted into hospital, discharge summaries were sent and the person's Summary Care Record (SCR) was checked. Consent for accessing the SCR for people in the care home had been given by the care home. Other people would bring in their own discharge summary. A record of any confirmed changes was made on the person's electronic record and any discharge summaries were filed. Packs were usually prepared by one of the dispensers and checked by the RP. Packs were only prepared after the prescription was received. The team worked a few days in advance. Depending on the number of tablets in the pack, these were either sealed by the RP or dispenser.

Prepared packs observed were labelled with product descriptions and there was an audit trail in place to show who had prepared and checked the packs. However, mandatory warnings were not included on the labels. The dispenser assured that he would speak to the systems provider and ensure these were included. Care homes had been supplied with the patient information leaflets once; one or two people were provided with the original packs and leaflets regularly and others were not routinely supplied with leaflets. The dispenser gave an assurance that these would be given out monthly.

Medication administration records (MARR) were provided to the care home. If there was a minor change the care home introduced these. Acute prescriptions were received by the pharmacy and supplied to the care home with MARR charts. The care home produced their own records for medicines which were administered on an 'as required' basis. The pharmacy did not carry out routine reviews to see if the service was appropriate for people who had been using the service long term. However, in the past some people had asked to have their medicines supplied in original packs. The local GP reviewed people and had requested some people to be switched to original packs. The pharmacy offered a delivery service. Records were kept for medicines delivered. Medication was returned to the pharmacy if someone was not available.

Medicines were obtained from licensed wholesalers and generally stored appropriately. Medicines requiring special consideration such as Controlled Drugs (CDs) and those requiring cold storage were generally stored appropriately. The fridge temperature was monitored and recorded daily. This was observed to be within the required range for the storage of medicines. However, at the time of the medication the maximum temperature range was reading as 10 degrees Celsius, the minimum as 2 degrees Celsius and the actual temperature as 4 degrees Celsius. Records from earlier that day showed that the temperatures had been within the required range. Team members were not aware as to why the discrepancy had occurred and gave an assurance that the temperature probe would be reset and the temperature checked again. The pharmacy was due to get a new fridge once the work was complete.

Medicines were stored on shelves running across the dispensary. Some medicines on higher shelves were stored in baskets with different drugs and different strengths stored together in the same baskets. However, dividers were used to separate the medicines in the baskets.

Stock was date checked as it was received. Short-dated stock was marked with a sticker. Dispensers checked different sections each week. The dispenser had been at the pharmacy for a long time and was familiar with slow moving stock and checked this each month. The previous pre-reg had kept records,

but these were no longer kept. Team members gave assurances that they would start keeping records once the building work was completed. One date-expired medicine was observed on the shelves. Out-of-date and other waste medicines were disposed of in the appropriate containers and collected by a licensed waste carrier.

The pharmacy was compliant with the Falsified Medicines Directive and had been using the system, however, due to a system issue it had stopped working. The owner was working to rectify the issue.

Appropriate action was taken when there was reason to suspect that a medicine may not be fit for purpose. Alerts were received electronically or in the post. The recent alert which the team had checked for was for ranitidine. Alerts were checked by the dispenser and pre-reg.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use up-to-date reference sources when they provide the pharmacy's services.

Inspector's evidence

Several calibrated glass measures were available and clearly marked for use with methadone. Tablet triangles were available. A separate counter for use with cytotoxic medicines was available to avoid cross-contamination. A plastic measure was available, team members said that this was not used.

A small medical fridge was available. Up-to-date reference sources were available including access to the internet. The computers were password protected and most members of staff had individual smartcards to access the PMR system. Confidential waste was shredded.

The pharmacy had a blood pressure monitor and blood glucose monitor available. Both were used as part of the health checks service. The blood pressure monitor was new and test samples were used to calibrate the blood glucose monitor. The pharmacy was due to receive a carbon monoxide monitor.

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.