General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: dp Pharmacy, 84 Albert Road, ILFORD, Essex, IG1 1HW

Pharmacy reference: 1031254

Type of pharmacy: Community

Date of inspection: 13/06/2019

Pharmacy context

This pharmacy is in a parade of shops in a residential area. Most people using the pharmacy are registered at a GP practice which is located further down the road. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance aids. And it offers a travel vaccination service.

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	4.1	Good practice	The pharmacy team actively promotes and raises awareness of conditions which effect the local community such as diabetes.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally identifies and manages the risks associated with its services. It largely maintains the records that it must keep by law. It asks people who use the pharmacy for their views. Team members use the procedures in place to safeguard vulnerable people. The pharmacy's team members do not always record their mistakes. So, they may be missing opportunities to learn and prevent the same errors happening again.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) available. The responsible pharmacist (RP) was in the process of reviewing and implementing a new set of SOPs, team members read each SOP relevant to their role once it had been reviewed by the RP. Team roles were defined within the SOPs.

The RP and dispenser said that near misses were either recorded in a book or on the electronic patient medication record (PMR). There was one near miss recorded in the book. The RP said that he had made a mistake whilst preparing a multi-compartment compliance aid. To help prevent this happening again, he now only prepared three compliance aids in an hour then took a break before preparing others. He also said that if he found he had lost concentration he would take a break. Both the RP and dispenser said that near misses were relatively rare as the workload was low.

The RP described that process he would follow if a dispensing incident was reported, which included making a record. The RP said that these were recorded on the PMR. The RP was unable to bring up a previous report and tried to call the system helpdesk for assistance but was unable to reach them.

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 complaints procedure and also completed an annual patient satisfaction survey. The RP would try and resolve complaints in store where he could and discuss these with the team. The pharmacy had scored 100% positive on their last patient satisfaction survey. Most feedback received had been about changes in colours of tablets and brands. Some people had also given feedback about the time taken for repeat prescriptions to be prepared. As a result of this the team had tried to explain to people that prescriptions were issued by the surgery. And that the pharmacy needed the prescription before they could supply the medication.

Records for private prescriptions, emergency supplies, unlicensed specials, RP records and controlled drug (CD) registers were well maintained. CD balance checks were usually carried out when the medicines were used or every three months. However, there was no record kept. 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. However, this was not done as they were received. This could make it harder for the pharmacy to keep a full audit trail for the medicines.

Assembled prescriptions were not visible to people using the pharmacy. Team members had individual Smart cards. The RP did not use Summary Care Records. An information governance policy was in place which was reviewed annually. The RP had attended training for the General Data Protection Regulation

held by the Local Pharmaceutical Committee (LPC).

The RP had attended a safeguarding course and was in the process of completing the level two course. Team members had been briefed on safeguarding. The medicines counter assistant (MCA) had attended a training session held by Perrigo on GPhC inspections which had briefly covered safeguarding. Contacts for local safeguarding boards were not available but the dispenser said that she would find these.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services provided. They have the appropriate skills, qualifications and training to deliver the pharmacy's services safely.

Inspector's evidence

The pharmacy team consisted of the RP who was also the superintendent pharmacist, a dispenser who was in the process of becoming a technician and a trained MCA who was enrolled on the dispenser training course. At any given time, the pharmacy was staffed by the RP, dispenser and MCA. The RP said that there were enough staff for the services provided.

Staff performance was informally managed. The team was small and worked closely together. The RP gave team members feedback on the spot and the team were also able to provide the RP with feedback.

The MCA counselled patients on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She would always refer to the pharmacist if unsure or for any requests for multiple sales. The MCA also handed out prescriptions and was aware that prescriptions for pregabalin were valid for 28 days. The MCA had been enrolled on the dispenser training course, she said that she was well supported by the RP and dispenser and was given study time.

To keep up to date team members were given books covering over-the-counter topics which were sent by suppliers. Team members were also encouraged to attend courses, which were either run by the LPC or arranged by manufacturers with the RP. Team members also attended training sessions held by Perrigo, twice a year. The last one had been attended by the MCA and had covered GPhC inspections. She had brought back reference material for her colleagues who had been unable to attend.

As the team was small, formal meetings were not held. Things were discussed as they came up or on Thursday afternoon when the pharmacy closed early. Incidents and near misses were discussed straight away. No numerical targets were set for the services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services.

Inspector's evidence

The pharmacy was clean and bright. A complete refit was completed in 2015. The dispensary was clean, spacious and with plenty of bench space. Stock was arranged neatly on shelves. There was a clean sink in the dispensary which was used for the preparation of medicines. Cleaning was carried out by the team. The retail area was clean, professional in appearance and had a large cushioned bench for people waiting for a service.

The consultation room allowed for conversations to be held inside which could not be overheard. And it was clean and comfortably accommodated the pharmacist and patient. The room was kept locked at all times and had a Digi lock. There was access into the room from the dispensary. Some multi-compartment compliance aids were found to be stored in the room. The RP said that these had temporarily been placed there as the pharmacy were preparing for an event the next day. The RP said that people would never be left unaccompanied in the room.

The premises were kept secure from unauthorised access. The room temperature was appropriate for the for the provision of pharmacy services. And lighting was good throughout the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy. The pharmacy actively promotes services and runs campaigns to meet the health needs of the local community. Pharmacy services are largely delivered in a safe and effective manner. The pharmacy obtains medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use.

Inspector's evidence

The pharmacy was easily accessible and had a step-free, wide front entrance, with an automatic door. The MCA would go and assist people who required help. There was easy access to the medicines counter and there was a large bench for sitting in the waiting area. The pharmacy had medicine packs with braille and had the ability to produce large print dispensing labels. English was not the first language for many local residents; team members were multilingual and spoke a range of South Asian languages which helped serve the local population.

There was a small range of information leaflets in the waiting area. A list of the services provided by the pharmacy was displayed in the window of the pharmacy. Team members were aware of the need to signpost people to other providers. Team members used the internet to find other services if they were not familiar with the details.

The RP had developed an expertise on diabetes as this was a common condition affecting people from a South-Asian background. He said that people appreciated being able to talk to somebody about their medicines in their own language. The pharmacy was running an event to raise diabetes awareness the day following the inspection. This event was due to be televised on a local Pakistani television channel. And was due to be attended by the local mayor, other MPs and six councillors. The pharmacy was running this event in conjunction with Silver Star UK, a diabetes charity. They were due to bring a mobile unit outside the pharmacy. This contained testing equipment and the RP would be there in the role of an advisor and advise people on results obtained. A nurse was also due to be present. Results were analysed on the spot. The RP said that a similar event had been held in 2015, at that time 171 people had been tested, 11% were referred to their GP and 4% were diagnosed as having diabetes.

Following this event the RP had also run another project 'Dimple,' in which he had called people in on Saturday when the pharmacy was closed to carry out diabetes testing. The RP was the ambassador for the All-Party Parliamentary Group for diabetes and had also won an award for this. To keep up to date, he completed independent reading and had completed the Centre for Pharmacy Postgraduate Education (CPPE) training packs for diabetes.

The RP also worked closely with the Imam from the local mosque which was situated a few doors away from the pharmacy. He had given a talk on heart conditions and in Ramadhan had advised people on how to take their medication whilst they were fasting.

Prescriptions were mainly received electronically and others were barcoded and were scanned when they were received. The pharmacy had an established workflow in place. People were sent text messages when their prescriptions were ready to collect. The pharmacy did not automatically order repeat prescriptions, people were required to contact the pharmacy to initiate the process. Dispensing was done either by the RP or dispenser and both cross-checked each other's work.

Dispensed and checked by boxes were available on labels; these were initialled by team members when they were dispensing or checking. The patient medication record (PMR, electronic system) also recorded the code number of the person who had dispensed. The pharmacy team used baskets to ensure that people's prescriptions were separated, to reduce the risk of errors.

The RP was aware of the change in guidance for dispensing sodium valproate and had identified four people who fell into the at-risk group. The computer system automatically generated warning stickers.

The pharmacy did not dispense many prescriptions for high-risk medicines. All warfarin prescriptions were dispensed and supplied by a designated warfarin clinic locally. The local surgery did not issue repeat prescriptions for methotrexate and lithium until blood tests were done.

When people initially enrolled on the service to have their medicines supplied in multi-compartment compliance aids, a consultation was held to introduce them to the service. And the team checked when they took their medicines so that these could be packed appropriately. People were also required to sign a consent form to register on the service. A medication list was taken from the person and saved on the system. People were required to call the pharmacy when they were on their last compliance aid to trigger the start of a new cycle. The dispenser recorded dates of when prescriptions were due and this was flagged up on the system. In the event that there were changes the dispenser called the person to confirm these or confirmed them with the GP. If there were any missing items the person was notified. Usually the team received a call from the hospital if someone was admitted and the team member checked when they may be discharged. Discharge summaries were sent to the surgery and the pharmacy did not prepare any new compliance aids until a new prescription was received.

Assembled compliance aids observed were labelled with mandatory warnings. However, product descriptions were not included on all compliance aids. This could make it difficult for people or their carers to identify what each medication in their packs was. An audit trail was in place to show who had prepared and checked the compliance aids. Patient information leaflets (PILs) were not always supplied. This means that people may not always have the information they need to take their medicines safely. Backing sheets were placed loosely in the compliance aids. The dispenser said that she would ensure these were securely attached to ensure that there was no risk of these becoming displaced.

Deliveries were carried out by a designated driver and the RP. The driver used a delivery book to obtain signatures from people when their medication was successfully delivered. Other people's names were visible on the page on which signatures were obtained. The RP said that he would consider different ways to obtain signatures to ensure people's private information was not visible to other people. In the event that someone was unavailable, medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of medicines. CDs were kept securely.

Date checking was completed every three months. A date checking matrix was in place. Expired and short-dated stock were recorded. No date-expired medicines were observed on the shelves sampled.

The pharmacy was compliant with the Falsified Medicines Directive (FMD). The RP had attended training held by the LPC to prepare for this.

Out-of-date and other waste medicines were segregated at the back away from stock and then collected by licensed waste collectors.

Drug recalls were usually received from the wholesalers. The RP said that the last time the pharmacy

had to return affected stock had been in 2016. The team had not seen the latest alert for co-amoxiclav suspension and the RP said that he would sign-up to receive alerts directly from the Medicines and Healthcare products Regulatory Agency.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment and facilities it needs to provide its services.

Inspector's evidence

The pharmacy had clean glass calibrated measures. Tablet counting triangles were also available. The blood pressure meter and blood glucose monitor were both new. The RP was aware of the need to calibrate or replace these on a regular basis to ensure they were accurate. A fridge of adequate size was available; this was clean and stock inside was placed in an organised manner. A range of up-to-date reference sources was available.

Computers were password protected and were not visible to people using the pharmacy. Team members said that confidential waste was segregated in a box and shredded. Some torn confidential waste which had people's names was found in the general waste bin. The dispenser said that the shredder had stopped working and she would ensure that confidential waste was collected until a new shredder was obtained.

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.