

Registered pharmacy inspection report

Pharmacy Name: Britannia Pharmacy, 414-416 Green Lane, Seven Kings, ILFORD, Essex, IG3 9JX

Pharmacy reference: 1031271

Type of pharmacy: Community

Date of inspection: 11/08/2020

Pharmacy context

This is a branch of a group of pharmacies. It is situated on a main road in a parade of shops. It dispenses NHS prescriptions and offers a range of private services including travel vaccinations, malaria prophylaxis and emergency hormonal contraception (EHC). It supplies medication in multi-compartment compliance packs to a number of people who need help managing their medicines. The inspection was undertaken during the COVID-19 pandemic.

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 appropriately identifies and manages the risks associated with providing its services. When something goes wrong, team members take action to help prevent a recurrence. The pharmacy generally keeps the records it needs to by law, to show that medicines are supplied safely and legally. People who use the pharmacy can provide feedback and raise concerns. Team members know how to protect vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which were available electronically. The responsible pharmacist (RP) said that team members had read and signed SOPs relevant to their roles. Team roles were defined within the SOPs. The team had been routinely ensuring infection control measures were in place and cleaned the pharmacy regularly through the day. Team members had been provided personal protective equipment (PPE). The RP explained that the necessary risk assessments to help manage COVID-19 had been completed and this included occupational ones for the staff. These had been carried out by the pharmacy's head office over a video conferencing application.

The pharmacy recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were brought to the attention of the team member who had made the mistake by the RP or the accredited checking technician (ACT). The error was discussed, rectified and a record was made on the near miss log sheet. At the end of each month the RP completed a patient safety review, as part of which near misses were analysed. Findings from this were shared with the team and a copy of the review was also faxed to the pharmacy's head office. Previously, the team had attached warning stickers on drawers which contained medicines which looked similar or sounded similar. Posters had also been displayed in the dispensary highlighting common medicines that fell into this category. The RP had obtained these from the National Pharmacy Association. Near misses were observed to have been recorded consistently.

In the event that a dispensing error was reported the RP described the steps that he would take. This included completing an incident report form electronically and notifying head office. Following a previous incident, team members had been asked to ensure all packages were checked to confirm the person's name and address to ensure it was the correct bag. The team had also identified people with similar names and as a result confirmed people's details before handing out any medicines.

An incorrect RP notice was initially displayed; this was changed to the right one during the course of the visit. 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 said that he would try and resolve complaints in store where he could. A complaints notice was displayed in the retail area with contact details for head office. The RP said where possible team members were trained after an incident had occurred to avoid repetition. There had been an increase in the number of people feeding back at the start of the pandemic that the pharmacy phone was not being answered. The RP had explained that this had been because the pharmacy had been very busy but the levels of business had settled over time.

Records for private prescriptions, emergency supply records, unlicensed medicines, RP records and controlled drug (CD) registers were well maintained. CD balance checks were completed routinely. 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 so that they were not visible to people using the pharmacy. Team members who needed to access NHS systems had individual smartcards. The RP had access to Summary Care Records. Consent to access these was gained verbally and recorded on the patient medication record. An information governance policy was in place and team members had all signed the confidentiality SOP.

The RP had completed the level 2 safeguarding course and other team members had completed internal training and were able to describe the actions that they would take in the event that they had any concerns. Contact details for local safeguarding boards were available.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members for the services provided, and they do the right training for their roles. They work effectively together and are supportive of one another. The pharmacy supports its team members with ongoing structured training. This helps them keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the RP, a second pharmacist, a registered technician who was training to become an ACT, four trainee dispensers, a trained medicines counter assistant (MCA) and two trainee MCAs. Shift patterns had been changed to cope with the additional workload and the team were also being supported by relief staff. All new recruits who were due to work in the dispensary were given a 'Get to know your dispensary' workbook by the company. The pharmacy also had an ACT who was on leave at the time of the inspection, the second pharmacist had been provided as cover by head office.

The RP felt that there was an adequate number of team members for the services provided. Holiday cover was arranged by head office. A booking system was used which notified the head office team of any upcoming planned leave. For unplanned leave the team were able to call head office and they would try and arrange cover. Head office had sent more staff to the pharmacy during the peak of the pandemic to help manage the workload.

Team members completed annual self-appraisal forms which were sent to head office. The dispenser explained that there were ten questions which they needed to complete and there was also an option to give feedback. If there were any concerns these were either discussed within the team or the owner would come in and have a discussion with the individual and the team. The RP also provided team members with feedback and passed on feedback to the head office team if they asked. Members of the team felt that they were able to raise concerns. There was also an opportunity for people to progress further in their roles.

The trainee MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was aware of the maximum quantities of some medicines that could be sold over the counter. She described handing out prescriptions in line with SOPs and was aware that gabapentin was a CD. Changes which had been made to the process of handing out prescriptions included using hand gel before and after handing the medication to people and cleaning the pen and board. Team members said that PPE was changed every two hours after scheduled breaks.

The RP supported the team with ongoing training and testing their knowledge. Head office usually sent monthly quizzes for team members to complete; however, this had been stopped due to the pandemic. Training was also done on the company's portal. The team had completed training modules on safeguarding, oral health, dementia and the General Data Protection Regulation (GDPR). Before the pandemic team members were given set aside time in store to complete training. Prior to the pandemic team members also attended training sessions at head office where they were updated with information. The last training session covered dealing with computer systems, CCTV and GDPR. Team members also looked through magazines and emails from the pharmaceutical press, workbooks from

wholesalers and the RP discussed any new information with the team. Head Office sent email updates. Trainees were given set aside training time each week. The RP monitored their training and helped with exam preparation. The trainees felt well supported with their training.

A team meeting was held each Monday morning where team members were asked if they had anything to raise. The RP said that team members who started in the afternoon were not always briefed or asked for their input but any important information was passed on to them. If the team members were not happy, they would speak to the manager or RP. Small changes could be made in store and larger changes needed to be discussed with the head office team. The RP felt able to speak to the owner if he had ideas, suggestions or any concerns.

The RP said that there were no numerical targets for the services provided but the team were encouraged to provide as many services as they could. The RP said that targets did not affect his professional judgement. The pharmacy had stopped providing a number of services due to the COVID-19 pandemic.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean and bright. The dispensary was organised and there was ample workbench space available which had been allocated for certain tasks. Stock was arranged neatly in clearly labelled drawers. There was a clean sink in the dispensary which was used for the preparation of medicines. Cleaning was carried out daily by a cleaner and team members also disinfected surfaces. Clear plastic screens had been fitted at the medicines counter and a barrier had been placed in front of this to ensure social distancing was maintained.

Two clean and spacious consultation rooms were available which were easily accessible from the shop floor and had adequate audible and visual privacy. One of the rooms contained some items which were not secured as well as they should have been. This was discussed with the RP during the inspection. The RP explained that if he needed to see someone in the consultation room, he wore a mask and a face visor, and cleaned the room before and after. The room had adequate space to maintain a safe distance.

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services. Air conditioning was available to help regulate the temperature.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner and people with a range of needs can access them. It gets its medicines from reputable sources and stores them properly. The pharmacy's team members make sure people have all the information they need so that they can use their medication safely.

Inspector's evidence

There was step-free access to the pharmacy and there were automatic doors. There were chairs in the waiting area and a range of leaflets. The team had the ability to print large print labels. Team members would assist people who needed help and had completed training courses such as how to help people who had memory problems. To ensure social distancing was maintained the pharmacy limited the number of people allowed into the pharmacy at any time. A dedicated team member stayed at the front of the store to control the number of people in the shop.

Pharmacy services were advertised on the window and the team were aware of the need to signpost people to other providers if a service was not available at the pharmacy. Signposting posters were displayed at the front of the medicines counter and leaflets were available in the consultation room for particular services. The team members were aware of most local services or would refer to the RP or dispensers. The team was also multilingual and spoke a number of South Asian and Eastern European languages which covered the range of languages spoken locally. On some occasions translation applications were also used. Multilingual leaflets were also available. The pharmacy had a number of COVID-19 related posters displayed. Team members said that they had seen an increase in the number of people using the pharmacy as GP surgeries had closed.

The pharmacy had stopped providing a number of services due to the COVID-19 pandemic. Some travel vaccinations had been provided but the number of people accessing this service had also decreased. The RP felt that the New Medicine Service (NMS) had the most impact on people from the service offered before the pandemic. He said that it allowed him to explain to people why they needed to take their medication, explain any side effects and discuss issues that people may be having.

The pharmacy had an established workflow in place. Most prescriptions were received electronically. These were downloaded at regular intervals, printed and passed on to the MCA who checked them off against a list. After which they were passed back to the dispensary team who dispensed. People were sent a text message when their prescription was ready to collect. The RP clinically checked prescriptions and when they were dispensed there was a final check by the ACT.

Dispensed and checked by boxes were available on labels; these were initialled by team members when they were dispensing or checking. A 'quad stamp' was used on prescriptions, this showed the ACT which prescriptions she could check. The pharmacy team also used colour-coded baskets to ensure that people's prescriptions were separated, to reduce the risk of errors.

The computer system generated a warning label each time sodium valproate was labelled. The warning labels were also attached to dispensed boxes. Team members were aware of the change in guidance. The pharmacy did not have anyone who collected valproate regularly who was in the at-risk group.

Warning stickers were available and used for high-risk medicines. If the person collecting was using the pharmacy for the first time the RP would supply them with the relevant leaflets. The pharmacy's sister branch situated further down the road operated a warfarin clinic and most people collected their warfarin from there. The RP said that he normally checked the person's yellow book and tried to make a record of the details on the electronic patient record.

The pharmacy supplied medicines in multi-compartment compliance packs. The number of people enrolled on the service had increased during the pandemic as the RP said more people had needed help. Packs were prepared by a dispensary team member once the prescription was received from the surgery, checked for any changes and labelled. Prior to packs being prepared the RP checked to see if the doses were correct and if there had been any changes. Prepared packs were checked by either the RP or ACT. Any changes were confirmed with the GP or with the person prior to preparing packs and a record was made on the electronic patient medication record. The pharmacy was notified by either a family member or by the hospital when someone was admitted into hospital. The team requested for a copy of the person's discharge summary so that any changes could be followed up. Assembled packs observed were labelled with product descriptions and mandatory warnings. Patient information leaflets were handed out monthly and there was an audit trail in place to show who had prepared and checked the packs.

Medicines were delivered to people by one of two drivers. There had been an increase in the demand for the service since the start of the pandemic. The pharmacy had used volunteer services to help during the peak of the pandemic. Signatures were no longer obtained when medicines were delivered, this was to help infection control. In the event that someone was not available medicines were returned to the pharmacy.

The RP had carried out some vaccinations during the pandemic. The pharmacy had a relatively large consultation room which allowed distance to be maintained. When providing services, the RP wore full PPE and people were requested to wear a mask and gloves. Paperwork was completed in the retail area and the room was only used to provide the vaccination. The RP had completed online training for the flu vaccination service and said that head office had issued guidance on how to provide the service.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and recorded and the records were observed to be within the required range for the storage of medicines. Since the last inspection the pharmacy had been provided with new medical fridges. CDs were generally held securely.

Date checking was carried out following a prepopulated matrix from head office which showed which sections needed to be checked. The date checking matrix was up to date. An email was sent to other branches with a list of short-dated stock. No date-expired medicines were found on the shelves checked.

The pharmacy had all the equipment available for the Falsified Medicines Directive (FMD). The RP said this was not being used all the time. Out-of-date and other waste medicines were kept separate from stock and then collected by licensed waste collectors. Drug recalls were received by the pharmacy via email and these were accessible to all staff.

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

The pharmacy had clean calibrated measures, and tablet counting equipment. Equipment was clean and ready for use. A separate, clearly labelled, tablet counting triangle was used for cytotoxic medicines and separate measures were used for certain liquids to avoid contamination. An electronic tablet counter was used in the dispensary. The RP said that this was hardly used and from time to time was checked with a known quantity of tablets.

The blood pressure monitors used as part of the services offered were replaced annually. The blood glucose monitor was calibrated using a sample solution. The monitors were not being used at the time of the inspection.

Up-to-date reference sources were available including access to the internet. The computer in the dispensary was password protected and out of view of people using the pharmacy. Confidential waste was kept separate and sent to head office for destruction.

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.