General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Longwood Pharmacy, 162-166 Longwood Gardens, Barkingside, ILFORD, Essex, IG5 0EW

Pharmacy reference: 1031287

Type of pharmacy: Community

Date of inspection: 10/08/2022

Pharmacy context

This pharmacy is situated in a parade of shops on a main road. It changed ownership in 2019. As well as dispensing NHS prescriptions the pharmacy provides flu vaccinations. The pharmacy supplies medicines in multi-compartment compliance packs and provides the Community Pharmacy Consultation Service (CPCS).

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 largely safe and effective. The pharmacy generally keeps the records it needs to by law so that medicines are supplied safely and legally. It protects people's personal information well and people who use the pharmacy can provide feedback. Team members understand their role in protecting vulnerable people. Team members generally respond appropriately when mistakes happen during the dispensing process. But they don't consistently record or review near misses. So, this may mean that they are missing out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) available. The superintendent pharmacist (SI) planned to replace the current SOPs as the current ones had been inherited from the previous owner. However, due to the pandemic he had not been able to do so. Team members had read the SOPs which were relevant to their roles. The team member who had recently started was in the process of reading through the SOPs. The team had been routinely ensuring infection control measures were in place.

The pharmacy previously recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and always recorded those where the medicine was handed to a person (dispensing errors). The SI tried to record near misses as they were identified but this had not been happening recently. Near misses were highlighted to team members and rectified. The team discussed what had happened and how it had happened. The SI planned to restart recording near misses. As a result of past near misses medicines like amlodipine and amitriptyline were separated on the shelves. There had not been many dispensing errors reported. The SI would investigate any error and make a record of these electronically.

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 complaints were dealt with by the SI. The SI planned to restart the annual patient satisfaction surveys which had been stopped during the peak of the pandemic.

Records for emergency supplies, RP and controlled drug (CD) registers were well maintained. The pharmacy had not dispensed unlicensed medicines for some time but the SI was able to describe the records he would keep. Private prescription records were generally well maintained but the prescriber details were missing on some of the entries. Controlled drugs (CDs) that people had returned were recorded in a register. A random check of a CD medicine quantity complied with the balance recorded in the register. CD balance checks were carried out regularly.

Assembled prescriptions were stored in the dispensary and people's private information was not visible to others using the pharmacy. The pharmacy had an information governance policy available. Team members had read relevant sections and the team discussed data protection. Relevant team members who accessed NHS systems had smartcards. Pharmacists had access to Summary Care Records (SCR) and consent to access these was gained verbally.

Team members had completed safeguarding training. The SI had completed the level two training. Details were available for the local safeguarding boards.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to dispense and supply its medicines safely, and they work effectively together and are supportive of one another. Team members do 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 SI who was also the RP and a trained medicines counter assistant (MCA). Staff who were not present included a trained dispenser who worked in the mornings and another part-time MCA. The SI explained that prescription item numbers had increased and a new dispenser had been recruited to help with the additional workload. The team were observed to manage the workload at the time of the inspection and were up to date with dispensing and other tasks.

Previously individual performance and development was monitored formally by the owner, who carried out appraisals with all team members. Since the change in ownership, the SI worked closely with the team and managed performance informally providing team members with on-the- spot feedback as well as recognising things team members had done well. The team member felt able to provide the SI with suggestions and feedback. They felt that he listened to what they had to say and took on board suggestions.

The 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 certain medicines which could be sold over the counter. She would refer to the RP before selling some medicines.

To keep the team's knowledge up to date the SI discussed information he had read. If team members expressed interest in completing any courses the SI would look into this and enrol them where suitable.

As the team was small and worked closely together, things were discussed as they arose. The SI had not set numerical targets for locum pharmacists, he asked them to complete training to help provide the services that were offered.

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 premises were large, bright, clean, and organised. The dispensary was spacious, there was ample workspace which was clutter-free and clear. Workbenches were also allocated for certain tasks. A sink was available for the preparation of medicines. Cleaning was carried out by team members.

A consultation room was available. The room allowed a conversation at a normal level of volume to take place inside without being overheard. The door leading into the room was lockable. Assembled medicines for delivery were stored in the room close to the dispensary. The way the medicines were stored ensured that people’s private information could not be seen. The SI said people using the room were not left unaccompanied. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services. The lighting had recently been changed to brighten up the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely. It obtains its medicines from reputable sources, and it manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was a small step to access to the pharmacy. Team members helped people who needed to come into the pharmacy and if people preferred their medicines were brought out to them. The pharmacy was able to produce large font labels for those with visual problems. Some team members were multilingual. Team members described how there was a large South Asian population locally and a few of the team spoke a number of South Asian languages which helped with translating. The team also used online translation applications. Team members were aware of the need to signpost people to other services. They used the NHS service finder online and also had local knowledge as most of them lived locally.

The SI felt that the delivery service had the most impact on the local population as there was a large elderly population locally.

The pharmacy had an established workflow. Most of the dispensing was done by the dispenser in the morning who left dispensed prescriptions in baskets for the RP to check. Sometimes the SI had to self-check. On these occasions he double or triple-checked his work and tried to take a mental break in between dispensing and checking. He described using a clear bench and spreading the items out. One of the MCAs who had recently joined helped with dispensing, she had started a course at her previous employment but was unsure as to which course it was. The SI planned to check and enrol her on the dispensing course. Dispensed and checked-by boxes on labels were not consistently initialled by members of the team to create an audit trail for the dispensing and checking processes. The SI gave assurances that he would ensure these were initialled by all team members in the future. Baskets were used to separate prescriptions, preventing transfer of items between people.

The SI was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. The team generally dispensed sodium valproate in its original pack. Additional checks were carried out when people collected medicines which required ongoing monitoring. Local surgeries did not issue prescriptions for certain medicines such as methotrexate if people did not have their routine blood tests.

Some people's medicines were supplied in multi-compartment compliance packs. The pharmacy ordered prescriptions on behalf of people for this service. Individual record sheets were available for each person. Team members checked prescriptions for any changes and these were passed on to the SI who checked. Packs were prepared by the dispenser and then checked either by the SI or the locum pharmacist at the weekend. Some packs waiting to be checked from earlier in the week were not sealed. The SI identified the risks associated with this and said he would ensure team members sealed trays as soon as they are prepared. Assembled packs seen were labelled with mandatory warnings. Product descriptions were not included on the packs and this could make it difficult for people to

identify the medication. The backing sheet was not securely affixed to the tray. Patient information leaflets (PILs) were not routinely supplied. There was an incomplete audit trail to show who had checked the packs, the SI explained that packs were usually initialled when they were checked but it had been missed on the pack seen. The SI provided an assurance that he would ensure product descriptions were included and that backing sheets were stuck to the trays. He also agreed to ensure PILS were handed out monthly.

The pharmacy had a delivery driver, delivery records were kept and the driver marked the completed deliveries. In the event that a person was not home a note was left by the driver and the medicines bag was returned to the pharmacy. Signatures were no longer obtained when medicines were delivered and this was to help infection control.

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. At the time of the inspection the temperature probe was showing results outside of the required range. The SI reset the probe and provided assurance that he would check it again, and explained that the temperature had been within the required range in the morning when he had checked. The SI planned to replace the fridge. CDs were held securely.

Expiry-date checks were carried out by team members. Short-dated stock was highlighted with a sticker and recorded. There were no date-expired medicines found on the shelves checked. Out-of-date and other waste medicines were segregated from stock and then collected by licensed waste collectors. Drug recalls were received via email. These were checked and processed by the team, relevant alerts were saved by the SI.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment. Equipment was clean and ready for use. A separate tablet counting triangle was used for cytotoxic medicines to avoid contamination. A fridge of adequate size was available. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens faced away from people using the pharmacy.

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.