General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Safedale Ltd, 197 Rush Green Road, ROMFORD, RM7 0JR

Pharmacy reference: 1031354

Type of pharmacy: Community

Date of inspection: 10/10/2019

Pharmacy context

This is a Healthy Living Pharmacy co-located with a post office, in close proximity to a GP practice and health centre. The pharmacy is located on a main road within a parade of shops in Romford and serves people who live locally. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs including to people residing in a care home. It also provides flu vaccinations, Medicines Use Reviews (MURs) and the New Medicine Service (NMS). The pharmacy also offers a range of services via private patient group directions (PGDs) including hair loss, erectile dysfunction, weight loss and malaria prophylaxis.

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	1.2	Good practice	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
2. Staff	Standards met	2.2	Good practice	Team members get time set aside for ongoing training and the pharmacy monitors their training.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy tailors health campaigns and the health information it provides for the local population, it reaches out to other organisations to help promote health and well-being locally.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy identifies and manages the risks associated with its services. It asks people who use it for their feedback and it largely keeps the records it needs to by law. It generally protects people's personal information appropriately. Team members know how to protect the welfare of vulnerable people. They are good at recording and learning from any mistakes. This helps them make the pharmacy's services safer.

Inspector's evidence

Standard operating procedures (SOPs) were up to date. These were reviewed by head office. Team members had read and signed SOPs relevant to their roles with the exception of one team member who had started working three weeks prior to the inspection. The responsible pharmacist (RP) said that he would ensure she read the SOPs relevant to her roles within the next few days of the inspection. Following the inspection the RP confirmed that this had been done. Team roles were defined within the SOPs.

When a near miss was identified during the checking process the medication was handed back to the team member who had dispensed the prescription and they were asked to identify their mistake after which a record was made on the near miss log. At the end of the month a patient safety report was completed with a copy sent to the Superintendent pharmacist (SI). A review of any dispensing incidents that had occurred was done as part of this report. The review was discussed at the weekly team meeting and a discussion was held to see how reoccurrence of the mistake could be avoided and to identify any trends and patterns. Following a patient safety review and a near miss with amlodipine and amitriptyline, warning labels had been attached near where 'look alike sound alike' (LASA) medicines were kept. Team members were also asked to check the name and address on the prescriptions and bag label before handing medication out.

Dispensing incidents were logged electronically and a copy was sent to the SI. The team received recommendations from head office on next steps. The incident and next steps were discussed at the team meeting. An incident had occurred where a patient was given allopurinol 100mg instead of the prescribed amitriptyline which they took for one month. The pharmacy had identified that the allopurinol had been dispensed for someone else and had fallen into the person's basket. As a result, the team had obtained larger baskets and team members were briefed to use the correct size basket. Team members also carried out a 'shake test' and if anything spilled out of the basket when it was shaken it indicated that the basket was too small. When bagging prescriptions team members were also asked to initial the bag label so that there was an audit trail. From time to time the pharmacist deliberately placed an incorrect item into the basket to see if team members picked this up during the bagging process and he ensured that if it was not identified, the mistake was highlighted to the team member.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure in place with a notice displayed, this explained to people how they could make a complaint. Annual patient satisfaction surveys were also carried out. As a result of past feedback on waiting times, the team had been briefed to ensure people were not kept waiting and the seat in the waiting area was also cleaned routinely.

The correct RP notice was displayed. Team members were aware of the tasks that could and could not be carried out in the absence of the RP.

Records for unlicensed medicines supplied, responsible pharmacist (RP) and CD registers were well maintained. CD registers were electronic and CD balances were checked regularly. 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. Five private prescriptions dispensed from the beginning of October had not been recorded in the private prescription book. Records were automatically made electronically. However, electronic records did not have the correct prescriber details and the date that the prescription was issued was not always correct. Emergency supply records did not always have the reason for supply recorded. And this may mean that this information is harder to find out if there was a query.

Assembled prescriptions were stored in the dispensary and were not visible to people using the pharmacy. Computers were password protected and screens also faced away from people. The pharmacy had an information governance policy in place; this was reviewed by head office. Team members with the exception of Post Office Staff who were employed by Safedale and passed through the dispensary to access the staff room had read and signed a confidentiality agreement. The RP said that he would ensure that the Post Office team also read through the agreement; and confirmed that this had been done after the inspection. Relevant team members who accessed NHS systems had smartcards. The two regular pharmacists had access to Summary Care Records (SCR); consent to access these was gained verbally. Team members had completed training when the General Data Protection Regulation had come into place as part of which they had to pass a test. Pharmacists also reinforced at the weekly meetings the importance of confidentiality and ensuring conversations could not be overheard.

Team members had completed safeguarding training courses and read the SOP on safeguarding. Posters detailing how concerns had to be reported were displayed in the dispensary and consultation room. The team were aware of how to identify safeguarding issues.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They have completed or are doing the required accredited training for their roles. They do ongoing training to help keep their knowledge and skills up to date. And they feel comfortable about raising any concerns.

Inspector's evidence

At the time of the inspection there were two regular pharmacists, three trained dispensers (one who worked in the multi-compartment compliance pack unit), a trainee dispenser and two trained medicines counter assistant (MCA) and one team member who had started working at the pharmacy three weeks prior to the inspection.

The regular pharmacist said that there were enough team members for the services provided. The pharmacy had two pharmacists working together on three days a week during the pharmacy's busier days. The pharmacy had a rota which was displayed on a notice board and was updated on a daily basis to clearly identify which team member was involved in the labelling, dispensing, picking and bagging up of prescriptions. This meant that prescriptions where checked by several team members and therefore minimising the risk of handing out an incorrect item.

Staff performance was managed by head office and a manager came into the pharmacy every six months to review this. The manager from head office first spoke to the pharmacy manager to see if there were any concerns. Following the review, he informed the pharmacist if there were any areas that needed to be worked on. The pharmacy manager also provided team members with feedback.

The MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She checked with the RP before selling certain medicines such as those containing pseudoephedrine or when someone wanted to purchase multiple items.

All team members were registered with MediaPharm, an online training portal both for formal courses and for ongoing training modules. Two team members were enrolled on the NVQ Level 2 dispenser training and two members were enrolled on the MCA training course. Team members were given set-aside time to complete their formal training and any ongoing training. The RP was sent information from head office when medicines were going to switch from 'prescription-only' (POM) to 'pharmacy-only' (P) or available for 'general sale' (GSL). The RP briefed the team and in some cased devised inhouse training.

The team held weekly meetings and received regular memos from head office. The pharmacy manager cascaded information to the team and then notified head office once this had been done. Head office also sent emails if there was an urgent issue.

Team members felt comfortable about raising concerns and said that they worked well together. The pharmacist said that the superintendent pharmacist was receptive to any suggestions or issues that came up and that feedback was valued and acted upon. There were no numerical targets set, but the pharmacist said the team were encouraged to provide services.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are clean and tidy and well maintained. Space is effectively managed to improve the work flow. People can have a conversation with a team member in a private area.

Inspector's evidence

The dispensary was large, spacious, organised and clean. There was ample workbench space available which was allocated for certain tasks. The pharmacy had a designated room to manage the multi-compartment compliance packs service. Cleaning was done by the team with a rota in place. Medicines were arranged on shelves in a tidy and organised manner. A clean sink was available for the preparation of medicines.

There was a clearly signposted consultation room which was clean and tidy. And allowed for conversations to take place inside which would not be overheard. The room was fitted with a keypad lock and was kept locked at all times. There was no confidential information held within the room. A basket of prescription-only medicines (POMs) which were used as part of the malaria prophylaxis service were stored in the room. These were moved by the RP during the course of the inspection.

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 in the dispensary. Lights had recently been changed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and effectively. It gets its stock from reputable sources and mostly stores it properly. 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.

Inspector's evidence

There was step-free access in to the pharmacy and automatic doors with rails on either side. Services offered by the pharmacy were advertised on window and the team were aware of the need to signpost people to other providers if a service was not available at the pharmacy. A signposting folder was available and the internet was also used. Team members used a book to record any signposting given as well as any significant incidents. A list of languages spoken by colleagues in all the branches and their contact numbers was displayed in the dispensary. The pharmacy team were able to produce large print labels and the RP would verbally reinforce what the label said to people in the consultation room.

The pharmacist described that the pharmacy was very community orientated as the SI had been at the pharmacy for over 30 years. And had built relationships with the local community. People would come to the pharmacy first on many occasions to seek advice. The RP said that people held the SI in high regard. The RP felt that the MUR service benefited people, he said that a number of people who used the pharmacy were older and were usually taking a number of medicines. This allowed the pharmacists to reinforce to people what they were taking their medicines for. There were two surgeries close to the pharmacy one of which had two practices based within it. The pharmacy had a good relationship with the surgeries.

The team had a say in new services to be offered. Previously the pharmacy had been asked by head office to offer the travel vaccination service but the pharmacy team did not feel that this was needed locally. The RP said that the head office team were guided by the pharmacy.

As part of the Healthy Living service the pharmacy ran a number of campaigns. The Healthy Living Champion showed the inspector a campaign that had been done to raise awareness of blood pressure. The team had displayed a fake arm with a blood pressure monitor attached, a packet of cigarettes, a glass of wine and an apple with a tape measure to demonstrate health eating. Blood pressure tests were carried out as part of which some people were referred to their GP. The aim of the campaign was to provide advice to people. New campaigns were decided by looking at what the local pharmaceutical needs were, analysing prescriptions to see what conditions medicines were being prescribed for and also looking at the demographics. The champion said that she was looking into running a stop smoking campaign as she had noticed an increase in prescriptions for Champix and also as it was Stoptober. There was a high prevalence of smoking in the area and the smoking cessation service which the pharmacy had previously offered was decommissioned. People were either referred to the surgery or asked to go online. On many occasions the RP spoke to the GP on the person's behalf and suggested Champix to be prescribed. Prior to running campaigns team members were asked to familiarise themselves with the leaflets that would be displayed and the topic was discussed at the weekly meeting. The RP had visited Havering Mind to see if they could work in collaboration; during his visit he had picked up a number of leaflets on mental health to help raise awareness.

The pharmacy had an established workflow in place and used coloured baskets to manage the workload. Prescriptions were dispensed by the dispensers and checked by the RP. There was a designated checking area for waiting prescriptions and repeat prescriptions. Prescriptions were printed by one person, assembled by another, labels were attached by a different person and then the completed prescription was checked by the RP. The RP left the basket aside and a team member bagged the items whilst cross-checking and marking the medicines off on the prescription. Dispensed and checked by boxes were available on labels; these were routinely used by the team. A worksheet was in place which changed on a daily basis and had a record of the name of the dispenser responsible for completing the labelling and assembly. This was not retained and could make it difficult to identify people involved in the dispensing process if there was an error.

Prescriptions for Schedule 4 and 5 CDs were not highlighted in any way, these were handed out by the MCA and this could increase the change of these medicines being handed out when the prescription was no longer valid.

The pharmacy team were aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. The RP had completed an audit and one person in the at-risk group had been identified. The RP had counselled this person.

When taking a request for ordering a repeat prescription for warfarin the pharmacy team took a copy of the yellow book and the last INR reading. As this information was required by the surgery. A record of this information was not retained in the pharmacy. The RP said that when people were starting higher-risk medicines for the first time he would have a counselling session with them.
Supplies under PGDs were offered by the SI who worked at the pharmacy on a few days a week. People using the pharmacy locally were aware of the days that the SI worked. Otherwise the team would book an appointment or signpost the person to somewhere else.

Prior to people being signed up to have their medicines supplied in multi-compartment compliance packs the pharmacy spoke to the person's GP. Packs were prepared on a monthly basis and were allocated to weeks. Prescriptions were ordered a week in advance of the packs being due. Individual records were in place for each person which listed all the medicines they were taking and had a column for recording the start and stop date of items. On receiving the prescription, it was checked against the record of what was ordered and any missing items or new items were discussed with the surgery or person. A record of this was made on the electronic patient record and on the individual record. Packs were prepared by dispensers and sealed by the pharmacist after it was checked. When people were admitted into hospital the pharmacy were either notified by the hospital or by people's representatives. Any prepared packs were quarantined until further information was received. The pharmacy was notified of any changes via a discharge summary which was either sent by the hospital or brought in by a representative.

Prescriptions for packs supplied to the care home were ordered by the pharmacy. Medicine administration charts were supplied on a monthly basis. Team members understood that the SI carried out regular reviews and visited the care home as well as carrying out safety reviews. Acute medicines for the care home were collected by the staff from the home.

Assembled multi-compartment compliance packs seen were labelled with product details and there was an audit trail in place to show who had dispensed and checked the packs. Mandatory warnings were missing and the dispenser said that she would speak to the systems manager to have these print out onto the backing sheets. Information leaflets were supplied monthly.

Deliveries of medicines to people's home were carried out by a designated driver. Signatures were

obtained in a delivery book which had individual pages for each record to maintain confidentiality. In the event that someone was not home medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and recorded; these were observed to be within the required range for the storage of medicines. CDs were held securely.

Expiry date checks were carried out every three months by the team. Short dated stock was highlighted and in some instances was sent to head office. There were no date-expired medicines found on the shelves checked. A date-checking matrix was in place. The dispenser trainee had attached reminders to the shelf to remind colleagues to rotate stock.

The pharmacy had the equipment that it needed to comply with the Falsified Medicines Directive (FMD), but there were issues with the database. The RP said that once notification was received that the database was live the team would start using the system. The pharmacy team received information of drug recalls via email. The team kept an audit trail for the alerts and recalls and recorded the action taken and by whom. The recent alerts for different formulations of Zantac were seen.

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 calibrated glass measures, and tablet counting equipment. Equipment was mainly clean and ready for use. A separate tablet counting triangle was used for cytotoxic medicines and separate measures were used for liquid controlled drugs to avoid cross-contamination. Two fridges of adequate size were available. A blood pressure monitor and blood glucose monitor were available, both of these were fairly new. The RP said that the blood pressure monitor would be replaced in due course.

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 either shredded or segregated and collected by 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.