

Registered pharmacy inspection report

Pharmacy Name: Tee Kay Enterprises Ltd., 427 Bushey Mill Lane,
Bushey, WATFORD, Hertfordshire, WD23 2AN

Pharmacy reference: 1032405

Type of pharmacy: Community

Date of inspection: 21/08/2019

Pharmacy context

The pharmacy is co-located with a post office in a parade of businesses in a residential area. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include prescription collection and delivery, stop smoking, substance misuse and seasonal flu vaccination. The pharmacy has healthy living status.

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 generally safe and effective. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy team generally manages risk but it does not always record mistakes so they can learn from them. The pharmacy has written procedures which tell staff how to complete tasks effectively. The pharmacy generally keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team members keep people's information safe and understand their role in protecting vulnerable people.

Inspector's evidence

Near miss records were seen. There was a procedure for dealing with near misses but most recent records were not available.

Workflow: the pharmacist generally worked alone. Labels were generated and medicines were picked from reading the prescription. The pharmacist performed the final check of all prescriptions prior to transfer to the patient. The dispensing audit trail was not completed but the pharmacist explained that both dispensing and checking were by the same person. Taking a mental break between dispensing and checking was discussed.

There was a procedure for dealing with outstanding medication. The original prescription and labels were retained, but an owing slip was not issued to the patient. For "manufacturer cannot supply" items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance aids were prepared for a small number of patients. The pharmacy managed prescription re-ordering on behalf of patients. Changes in medication were checked with the surgery. Labelling included a description to identify individual medicines but patient information leaflets (PILs) were not seen with the set of compliance aids awaiting collection. Ensuring that PILs were provided with each set of compliance aids was discussed so patients have the latest manufacturer's information to take their medicines safely.

High-risk medicines such as alendronate and controlled drugs (CDs) were supplied separately from the compliance aid. The dates of CD prescriptions were managed to ensure supply within 28-day validity of the prescription. The pharmacist said the stability of sodium valproate was checked with the manufacturer and one compliance aid was supplied at a time.

The practice leaflet was on display and included details of how to comment or complain. The annual patient questionnaire was conducted. The standard operating procedures (SOPs) included responsible pharmacist and complaints procedures and were due to be reviewed and training records updated at the time of the visit.

To protect patients receiving services, there was professional indemnity insurance in place provided by NPA expiring 5 Sept 2019. The responsible pharmacist notice was on display and the responsible pharmacist log was completed. Records for private prescriptions and emergency supplies were

electronic. Some private prescription and specials supply records did not include prescriber details, but emergency supply dispensing labels included the wording 'Emergency Supply'.

The CD registers were complete and the balance of CDs was audited regularly although not always monthly in line with the SOP. A random check of actual stock of one strength of MST reconciled with the recorded balance in the CD register. A check of a second strength of MST did not reconcile with the recorded balance. The pharmacist later reported that despite an investigation, the discrepancy was not resolved and thus reported to the CD accountable officer. Footnotes correcting entries were not all signed and dated. Invoice number and supplier name and address were recorded for receipt of CDs. Methadone registers were complete and methadone was audited monthly. Footnotes correcting entries were signed and but not all dated. Invoice number and supplier name and address were recorded for receipt of methadone.

Staff were aware of procedures regarding General Data Protection Regulation (GDPR). There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. The pharmacist used her own NHS card. The computer was password protected and backed up regularly. There were 'Your data matters to the NHS' leaflets on display. The pharmacist was accredited at level 2 in safeguarding training.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy. The team members are supported in keeping their knowledge up to date. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: one regular full-time pharmacist and one part-time trainee dispenser enrolled on an accredited training course. Three family members were pharmacy students who helped out on a part-time basis. Ensuring dispenser training was completed in a timely manner was discussed. There was a no formal system of appraisal to monitor staff performance, but the trainee dispenser said he felt able to provide feedback on improving services and had suggested ensuring dispensary benches were kept clear of clutter to free up space. Targets and incentives were not set in a way that affected patient safety and wellbeing.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are clean, secure and suitable for the provision of its services. The pharmacy presents a professional appearance.

Inspector's evidence

The pharmacy shared premises so the pharmacy was on one side and the post office counter on the opposite side. The pharmacy had been re-fitted since the previous visit and presented a professional image. The new layout had provided more storage space and dispensary bench space although this was cluttered in places. The premises were generally clean. Lavatory facilities were outside the rear of the pharmacy and handwashing equipment was provided. The lavatory door required repair along the bottom edge. The consultation room was located at the front of the pharmacy and protected patient privacy. The consultation room was spacious but cluttered. There was sufficient lighting and ventilation.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective, and it gets its medicines from reputable sources. The pharmacy team takes the right action if any medicines or devices need to be returned to the suppliers. The pharmacy's team members are helpful and give advice to people about where they can get other support. They also make sure that people have all the information they need so that they can use their medicines safely. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe and effective.

Inspector's evidence

The automatic entrance door was wide and there was a small step. Staff went to the door if necessary to assist people with mobility issues. Large font labels could be printed to assist visually impaired patients. Staff could converse in Gujarati and Yoruba to assist patients whose first language was not English.

Patients were signposted to other local services including walk-in centre and podiatrist. Interventions were recorded on the patient medication record (PMR). The pharmacist was aware of the procedure for supply of sodium valproate to people in the at-risk group and recording the intervention on the PMR. Information was given to people regarding the pregnancy prevention programme (PPP). The pharmacist explained the procedure for supply of isotretinoin to people in the at-risk group and recording of the intervention. Prescriptions for schedule 4 CDs were highlighted to ensure CDs were not supplied after the 28-day validity period and CD prescriptions for more than 30 days' supply of CD were queried with the prescriber as good practice and the intervention recorded on the PMR.

Counselling was provided by the pharmacist to people with prescriptions for high risk medicines. When supplying warfarin people were asked about blood test dates and for their record of INR which was recorded on the PMR. The dose of the warfarin was explained. Advice was given about side effects of bruising and bleeding. Advice was given about over-the-counter medicines including herbal medicines and diet containing green vegetables which could affect INR. Patients taking methotrexate were reminded of the weekly dose and taking folic acid on a different day. Advice was given regarding gastric side effects and to visit the doctor if sore throat or fever developed.

In line with healthy living status, the pharmacy had provided a stand at a local community event to increase health awareness including mental health. Members of the public could have blood pressure and body mass index measured and explained. There were health related books on display at the pharmacy for people to purchase and health related posters to increase public awareness such as stroke campaign and Call NHS 111 before visiting A&E. Staff had participated in the quality payments scheme and trained in children's oral health and risk management. The pharmacy had risk assessed what items were left in the public area of the pharmacy such as empty tote boxes waiting to be collected by the suppliers and how medicines to be returned to suppliers were dealt with.

Medicines and medical devices were obtained from Alliance, AAH, Phoenix, Colorama and Sigma. Floor areas were generally clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and there had been a recent stock take. No date-expired medicines were found in a random check. Some liquid medicines were not marked with the date of opening. Medicines were generally

stored in original manufacturer's packaging although there were some loose tablets in a dispensing container and the label included expiry date but no batch number. There were some unlabelled dispensing containers of aspirin 75mg tablets which had been packed down from a large pack for ease of dispensing. There was a discussion about ensuring medicines were stored in appropriately labelled containers as this could mean the pharmacy was not able to identify all stock affected by drug recalls or alerts. Stability may be affected when medicines were not stored in original manufacturer's packaging. Cold chain items were stored in the medical fridge. Waste medicines were stored separately from other stock. Falsified medicines directive (FMD) hardware and software was not operational at the time of the visit.

Medicines and medical devices were delivered outside the pharmacy by staff. There was a delivery audit trail and patient signatures were obtained where possible indicating a successful delivery. The locum pharmacist was unable to locate the drug recall folder but explained that upon receipt of a recall, stock would be checked for affected batches to quarantine. A record of actions would be maintained for future reference.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

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

Inspector's evidence

Current reference sources included BNF and Drug Tariff. There were British standard glass measures to measure liquids including methadone. One measure could have been more clearly marked to avoid mix ups when selecting a measure for methadone. The dispensary sink and measures required treatment to remove lime scale. Minimum and maximum fridge temperatures were monitored daily and found to be within range two to eight Celsius.

The CD cabinet was fixed with bolts. Stop smoking equipment was provided and maintained by Hertfordshire County Council. The blood pressure monitor was due for re-calibration. There were old chemicals in bottles stored on a shelf in the garage which may be hazardous if unstable and arranging safe removal of the chemicals was discussed. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. The computer was password protected and backed up regularly.

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.