General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Touchwood Pharmacy, 84a London Lane, BROMLEY, Kent, BR1 4HE

Pharmacy reference: 1032619

Type of pharmacy: Community

Date of inspection: 31/05/2019

Pharmacy context

This is a busy community pharmacy on a large roundabout next to a doctor's surgery. It is close to the town centre. It offers a range of services, including travel vaccinations and Medicines Use Reviews. It supplies medicines in multi-compartment compliance aids to help people take their medicines. People can receive a throat swab test to see if they have a bacterial throat infection.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.7	Standard not met	The pharmacy doesn't secure people's personal information properly. This increases the risk that it can be accessed by unauthorised people.
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 is good at making its services accessible, for example by making the premises easier to access for people with wheelchairs or pushchairs.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy generally manages the risks associated with its services so that they can be provided safely. Team members are clear about their own roles and responsibilities, and they know how to protect vulnerable people. They largely keep the records they need to by law to show that supplies are made safely and legally. The pharmacy doesn't secure people's personal information properly. This increases the risk that it can be accessed by unauthorised people.

Inspector's evidence

A log was available to record near misses, but the most recent records found were from 2018. The pharmacist accepted that not all the near misses had been recorded. This could make it harder for the pharmacy to review them for any patterns and could mean that team members are missing out on opportunities to improve safety. The pharmacist gave an example of a near miss which had occurred between the 250mg and 500mg strengths of amoxicillin and he showed that the strengths had been segregated as a result. He said that he had undertaken an audit on the levels of business in the evenings and found that they had a lot of people coming in with acute prescriptions. Following on from this, they had moved the fast-moving lines to a closer area in the dispensary to make the process more efficient.

Dispensing errors were recorded on the patient medication record (PMR) system. One of the examples seen did not include much information, and the pharmacist said that he would start to use the 'incident report' section on the PMR instead. He gave an example of a person who had both electronic and paper prescriptions but had only been given out the medicine on the paper one. The person was then supplied the right medication and the complaint had been referred to head office. The pharmacist had entered a note on the PMR to explain what had happened, and to help prevent a repetition.

A range of standard operating procedures (SOPs) was available electronically. The pharmacist did not have access to a summary of which team members had gone through which ones. But he said that head office kept a record and informed the pharmacist if there were any outstanding. He said that the team members had been through the SOPs, and people had access to them before they started work at the pharmacy. The trainee medicines counter assistant (MCA) was unable to access her online record during the inspection but believed she had read through the SOPs relevant to her role.

There was an audit trail for when medicines were delivered to people, but only a record of when the package had left the pharmacy. The pharmacist said that he would review the system and ask recipients to sign a bag label before putting it in a book. This would help the pharmacy to show that the medicines had been safely delivered.

The pre-registration student (pre-reg) and trainee MCA were clear about their roles and responsibilities. And they were able to explain what they could and couldn't do if the pharmacist did not turn up in the morning.

The pharmacy did an annual patient survey and the results from the latest one were on the NHS website. The results were positive, with over 96% of respondents rating the pharmacy as very good or excellent overall. The pharmacist explained how he had referred to the complaints procedure when referring a complaint to head office. A sign was displayed in the shop area to inform people how they

would make a complaint or provide feedback.

A current indemnity insurance certificate from the NPA was displayed. The right responsible pharmacist (RP) notice was displayed. The RP log was largely complete but there were a few gaps where the RP had not signed out. This meant that it could be harder to find out who the pharmacist had been if there was a query. The RP had also not signed in on the morning of the inspection, and this was immediately rectified. Some emergency supply records did not show the reason as to the nature of the emergency. The pharmacist said that he was not sure how to record these details on the PMR and would contact the PMR provider to find out. Private prescription records seen complied with requirements. Only one record for an unlicensed 'special' medicine was found, and it did not contain all the required information. The pharmacist said that he would look at the relevant MHRA guidance note and ensure the details were recorded.

Controlled drug (CD) registers examined mostly complied with requirements, but a small number of headings had not been filled in. CD running balances had been checked around a week before the inspection, but the most recent one before this for most balances was October 2018. The pharmacist said that he had already been aware that they needed to be checked more frequently and said that he would do this in the future. A random CD balance check done showed that the amount in the register matched the amount in the cabinet.

There was some personal information and medicines found in unsecured parts of the premises. The pharmacist said that these areas would be kept locked but he was unable to find the keys during the inspection. Confidential waste was mostly placed in a designated bin and sent offsite for secure disposal. But one dispensing label was found in with general waste; this was immediately removed.

Computer terminal screens were turned away from the view of people using the pharmacy. The pharmacy technician was not currently working in the pharmacy, but her Smart card for accessing electronic prescriptions had been left in the computer. Team members had access to her password. The pharmacist said that he had left his card at home and would ensure he brought it with him in the future. The MCA's Smart card did not let her access the electronic prescription service, and the pre-reg did not yet have one.

During the inspection, one of the GPs from the next-door surgery came into the dispensary. Staff did not ask him to wait in the shop area, and in the dispensary people's personal details were potentially visible. The pharmacist confirmed that some people registered with other surgeries visited the pharmacy for their prescriptions.

The pharmacist confirmed that he had completed the level 2 safeguarding course and was able to describe what he would do if he had any concerns. Other team members were familiar with the confidentiality and safeguarding SOPs. Contact details for local safeguarding agencies were available online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They undertake some ongoing training, but they are not always given time set aside to do this. This could make it harder for them to keep their skills and knowledge up to date. They can make suggestions and raise any concerns.

Inspector's evidence

At the time of the inspection there was one pharmacist, one pre-reg, and one trainee MCA. The trainee MCA had started working in the dispensary around six weeks ago and was on an accredited MCA course. The pharmacist was reminded of the GPhC policy on the training of support staff, which meant that the trainee MCA would need to be registered on an accredited dispensing course within three months if they were to continue working in the dispensary. The pharmacy also employed a trained MCA, a dispenser (on long-term leave), and a pharmacy technician (who was also an accuracy checking technician).

Dispensing was up to date, and although the pharmacy was busy the staff were coping with the workload. The pharmacist felt that the staffing levels were sufficient, but that it would be helpful to have another full-time member of staff to help cover for holidays and other absences. The pre-reg attended periodic external training sessions to support his professional development and was given time set aside during the day to complete other training. He was able to have sit-down meetings with his tutor and felt able to ask any questions as they arose. He described being asked questions regularly by the pharmacist to check his knowledge and felt supported whilst doing his training.

The trainee MCA didn’t usually get time set aside for training and said that she usually did her course at home. She was progressing through it, but sometimes found it hard to find the time. Ongoing training packages on a variety of subjects were available online on the e-Learning system. She was aware of the training packages but said that she didn’t always look regularly to see if new packages had been released. She said that she had recently done additional training on the new guidance for valproate medicines.

There was a small team in the pharmacy. Team members felt comfortable about raising any concerns or making suggestions and they said that they communicated well in an open and honest culture. The pharmacist felt able to talk with the superintendent about any issues that arose. He gave an example of a team member who had trouble standing, and they were provided with a seat to help.

Team meetings took place at the beginning of every month, and the pharmacist said that they discussed any updates or matters arising. Team members had some numerical targets, based around the services provided. The pharmacist did not feel under any undue pressure to meet them and said that he delivered the services for the benefit of people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally clean, tidy, secure, and suitable for the pharmacy's services.

Inspector's evidence

The dispensary was relatively small with limited storage space. But there was adequate clear work space available and lighting was generally acceptable. The pharmacy was busy at the start of the inspection, and more work space was cleared by the end.

The pharmacy was generally clean and tidy. The carpet behind the counter was heavily marked, and this detracted from the overall appearance of the pharmacy. The consultation room was crowded with some boxes, but there was still enough space for people to use it.

People's multi-compartment compliance aids were prepared in the dispensary, and team members said that an area was cleared to help them do this. Around 50 people received their medicines in these packs. The room temperature was suitable for the storage of medicines and was maintained with air conditioning. Staff had access to handwashing facilities. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is good at making its services accessible, for example by making the premises easier to access for people with wheelchairs or pushchairs. It generally provides its services safely. It obtains its stock from reputable sources and largely manages it well. It takes the right action when safety alerts are received. This helps ensure that people get medicines that are safe to use.

Inspector's evidence

The pharmacy had step-free access from outside. The pharmacist explained how there had been shelves with stock near the entrance, and showed he had moved these to better help people with wheelchairs and pushchairs to come in. This had helped make a larger space in front of the counter. He had also brought a locksmith in to fix one of the doors, so that they could now open both of the double doors to help people come in. The computer system had a large print facility to help people who had problems with their vision.

Baskets were used during the dispensing process to help avoid mixing up people's medications. There was a clear workflow through the pharmacy.

Only one multi-compartment compliance aid was available to be examined. The pharmacist said that the compliance aid had not yet been completed. The compliance aid was not labelled with descriptions of the tablets and capsules, or an audit trail to show who had dispensed and checked the item. He said that these would be added before it was completed. He said that patient information leaflets (PILs) were not usually given to people receiving the compkiance aids. But said that they would do this in the future. The pharmacist showed how they recorded changes in people's medicines on the PMR.

The pharmacist was aware of the updated guidance about pregnancy prevention for people taking valproate. He had done an audit and they had no people in the 'at-risk' group. He could not find any of the associated stickers or cards and said that he would reorder these from the supplier. Prescriptions for schedule 3 and 4 CDs were not routinely highlighted. One prescription awaiting collection was found on the shelves from February 2018, so had expired by the date of the inspection. This could increase the chance that medicines are handed out when the prescription is not valid. The pharmacist said that they would discuss this in the next team meeting. He said that he counselled people taking higher-risk medicines such as warfarin and lithium. The pre-reg could clearly describe the counselling information he would give to people taking warfarin. But people's INR readings were not routinely recorded, and this could make it harder for the pharmacy to keep track of people's previous results. Prescriptions for higher-risk medicines were not routinely highlighted. This may make it harder for the team members to make sure that people get all the information they need to take their medicines safely.

A selection of patient group directions (PGDs) was examined. They were in date and the signed versions were available electronically. The pharmacist described a time when a person had come in when the surgery was closed, and he had been able to offer the medicine under one of the PGDs.

Medicines were obtained from licensed suppliers and stored in an organised way in the dispensary. The pharmacist said that a date check of the stock had been done recently but could not find the records. He said that the pharmacy technician organised the date checks and she was not in on the day of

inspection. No date-expired medicines were found in with stock on the shelves sampled. Medicines for destruction were segregated from stock and placed into designated bins and sacks for offsite disposal.

Medicines that needed cold storage were kept in a medical fridge. The temperatures were monitored daily and previous records were within the required range. The current maximum temperature on the fridge was 12.1 degrees Celsius. The pharmacist said that the fridge had been opened a lot during the day and he would monitor it. He was not entirely sure how to obtain the temperature readings from the fridge but said that he would check with another team member or look online.

CDs were kept securely. Drug alerts and recalls were received via email. The pharmacist described how they had checked the stock for a recent recall of chloramphenicol eye drops. A record was not usually made of the action that had been taken as a result of the alert or recall. This could make it harder for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment it needs for its services.

Inspector's evidence

There were calibrated glass measures available, but they were not all clean. One had a tiny bit of mould at the bottom. The pharmacist had ordered new replacement cylinders already and showed that they had arrived in that day.

There was an anaphylaxis kit available in the dispensary drawer and the pharmacist said that he took it into the consultation room when he did injections. Up-to-date reference sources were available. The fax machine was away from the shop area, and the phone could be moved somewhere more private to help protect people's personal information.

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.