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: 16/01/2020

Pharmacy context

This is a community pharmacy next to a medical centre on a large roundabout in Bromley. The pharmacy mainly dispenses NHS prescriptions and offers other services such as a travel clinic, Medicine Use Reviews (MURs), and the New Medicine Service (NMS). It supplies medications in multi-compartment compliance packs to help some people manage their medicines.

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	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 adequately identifies and manages the risks associated with its services. People who use the pharmacy can provide feedback and raise concerns. Team members largely protect people's personal information. And they know how to protect vulnerable people. The pharmacy largely keeps the records it needs to up to date. And it has written procedures to explain its processes to staff. But it does not always make sure that staff have read them, which could mean that they may not know the right procedures to follow.

Inspector's evidence

Records of near misses (where a dispensing mistake was identified before it was handed to a person) were kept in the dispensary. But the most recent record was from September 2019. The pharmacist was not aware of any near misses that had occurred since then but said that he would ensure all near misses were recorded in the future. He said that he had completed a training course, and as a result the pharmacy had separated medicines such sounded or looked-alike, such as amitriptyline and amlodipine. This had been done to help prevent any dispensing mistakes. The pharmacist was not aware of any recent dispensing errors (where a dispensing mistake had been handed out to a person). But he could show how he would record one on the computer if one occurred.

A range of standard operating procedures (SOPs) was available electronically and included policies on safeguarding and dealing with complaints. Records were kept of when staff had been through the procedures relevant to their role, but this record was on their individual training records and the regular pharmacist did not have access to a summary. As some team members were not present on the day of inspection, it was difficult to check if they had been through the SOPs. However, records seen on the day showed that two team members present did not have a record to say that they had read the SOPs. The pharmacist said that he would go through this with all team members to ensure that they were familiar with the relevant SOPs.

The dispenser was clear about what she could and couldn't do if the pharmacist had not turned up. And she could explain what she would do if a person attempted to purchase multiple packs of an over-the-counter medicine.

The pharmacy undertook an annual patient survey, and the results from the most recent one were positive overall. A sign in the public area explained to people how they could make a complaint or provide feedback. The pharmacist was not aware of any recent complaints, except where there had been supply issues with people's medicines. He said that in these cases he liaised with the prescriber to find an alternative.

A current indemnity insurance certificate was displayed. The responsible pharmacist (RP) log largely complied with requirements, but at the start of the inspection the RP had left the pharmacy for around five minutes and had not made a record to show he was 'absent'. This was discussed with the RP during the inspection. The right RP notice was displayed. Most private prescription records seen had the right information recorded, but some did not have accurate details of the prescriber. This could make it harder for the pharmacy to find out these details if there was a future query. Not all emergency supply records had a full reason as to the nature of the emergency, and the pharmacist said that this would be

filled in in the future. Controlled drug (CD) registers examined complied with requirements, and the CD running balances were checked regularly. A random check of a CD medicine showed that the recorded balance matched the amount of physical stock held.

People using the pharmacy could not see other people's private information. On the previous inspection, some areas of the pharmacy were not secured properly and had people's private information stored in them. This had since been rectified, and these areas were now kept locked when not in use. A shredder was used to destroy confidential information. Computer terminal screens were turned away from people using the pharmacy, and access to the computers was password protected. Some staff had individual smartcards to access the electronic NHS systems, but there was some sharing of smartcards where team members were newer. The pharmacist said that he would ensure that team members who needed them obtained their own smartcards.

The pharmacist confirmed that he had completed the Level 2 safeguarding course. He could describe what he would do if he had any concerns about a vulnerable person and was aware how he could find out contact details of local safeguarding agencies. The pharmacy had a safeguarding policy, but it was not clear how many team members had been through it. The pharmacist said that he would ensure that team members went through it as part of reading the SOPs.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely, and they do the right training for their role. They can take professional decisions to make sure that people are kept safe. And they do some ongoing training to help keep their knowledge and skills up to date. They are comfortable about raising concerns or making suggestions to help improve the pharmacy's services.

Inspector's evidence

At the time of the inspection there was one pharmacist (regular pharmacist), one trained dispenser, one pre-registration student (pre-reg), and one trainee technician. There was also a pharmacy technician and a trained dispenser who left part-way through the inspection when their shift ended. Team members could explain what accredited training they had done or were doing for their roles. The pharmacy also employed a Saturday member of staff and the pharmacist said that the team member had worked there for just under three months and was not involved in medicines sales or dispensing. The pharmacy was up-to-date with its workload.

The pharmacist felt able to take any professional decisions as they arose. He said that they had a good working relationship with the nearby surgery, and he felt comfortable about contacting them with any queries. The pre-reg said that her training was going well, and she was able to undertake training during quieter periods in the pharmacy. The regular pharmacist was her tutor. She did not have many sit-down meetings with her tutor, but she felt supported through her training and able to ask any questions as they arose.

Team members felt comfortable about raising concerns or making suggestions. Most staff were registered on an e-learning platform for ongoing training, although a dispenser who had recently started was not. The pharmacist said that this person would be registered. The dispenser said that she had received some verbal training on how to do various tasks in the dispensary. Some of the team members present could show evidence of the courses they had completed on the e-learning platform. Staff were able to undertake ongoing training in work at quieter times, but this was not always possible. They explained how they discussed any incidents or issues at the time if they came up. The pharmacy had some targets in place, but the pharmacist did not feel under any undue pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy’s services and they are kept secure. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was built on a corner and had a curved design as a result. The room temperature was suitable for the storage of medicines and was maintained with air conditioning. The premises were generally clean and tidy, with good lighting throughout. The floor area behind the counter was a bit worn and marked, but there were no tripping hazards seen. Although the dispensary was relatively small, there was a sufficient amount of clear workspace to allow safe dispensing and to help staff manage the workflow.

The consultation room was kept locked when not in use, and it allowed a conversation to take place inside which would not be overheard. There were some items inside the room which were not stored in locked cabinets, but the pharmacist explained that people were always escorted to and from the room and not left in there alone. The room had a sink to allow handwashing. The premises themselves were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them adequately. It gets its medicines from reputable sources and generally stores them properly. People with a range of needs can access the pharmacy's services. It takes the right action in response to safety alerts so that people get medicines and devices that are safe to use. But it does not always record the action it has taken, which could make it harder to show what it had done in response. The pharmacy does not routinely highlight prescriptions for higher-risk medicines. So, it may be missing opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access from the street via a manual door. There were two seating areas for people waiting for their prescriptions. One seating area was quite close to the counter, which could mean that people at the counter could be overheard; the dispenser explained how they offered the use of the consultation room to people if they wanted. There was a large television in the window, and this ran adverts to make people aware of the pharmacy's services including travel vaccinations. There was an adequate amount of space in the pharmacy to help people with wheelchairs or pushchairs manoeuvre.

Baskets were used during the dispensing process to isolate people's medicines, and there was a clear workflow through the pharmacy. Prescriptions for higher-risk medicines such as warfarin and methotrexate were not routinely highlighted; this could mean that the pharmacy misses out on the opportunity to speak with people when they collect these medicines. There was an SOP detailing the additional guidance to be provided to people taking higher-risk medicines. The pharmacist said that he would go through the relevant SOPs again, and prescriptions for higher-risk medicines would be highlighted in the future. He described an audit they were undertaking on methotrexate, which included checking if people knew how to take it safely. He had identified a list of people taking the medicine and said he was counselling them as they came in. He was aware of the additional guidance around pregnancy prevention to be given to some people taking valproate medicines. And he confirmed that the pharmacy had no people in the at-risk group. He said that the pharmacy had the associated information literature such as cards and leaflets but was unable to find them during the inspection. He said he would order more in if needed. Team members said that they highlighted prescriptions for CDs, as these had a shorter validity date. No prescriptions for dispensed CDs were found on the shelves, so this could not be checked.

A selection of patient group directions was examined and signed in-date copied were available electronically. The pharmacist confirmed he had completed the associated training and said he was booked on to do training on yellow fever at the end of the month.

Dispensed multi-compartment compliance packs seen did not have a description of the medicines inside; this could make it harder for the person or their carer to identify the medicines. Packs seen did not have always have an audit trail to show who had dispensed and checked them, and this could make it harder for the pharmacy to show who had carried out these tasks. Patient information leaflets were not routinely supplied with the packs which could mean that people did not have all the information they needed to take their medicines safely. The pharmacist said that he would review how the pharmacy dispensed the packs to resolve these issues. People were assessed for the suitability of the

compliance pack service by the local Medicines Optimisation Service, and the pharmacist said that the service's decision was approved by the person's GP. The pharmacist explained how they recorded any changes in people's medicines on the person's electronic record but was unable to recall any recent examples.

The pharmacist said that he had spoken with the superintendent about the Falsified Medicines Directive (FMD). The pharmacy had the equipment and program on the computer to comply with FMD, and the pharmacist said that the superintendent was in the process of sorting it out.

Medicines were obtained from licensed wholesale dealers and specials suppliers, and they were stored in an orderly way in the dispensary. Date-checking of stock was done regularly, and this activity was recorded. No date-expired medicines were found on the shelves sampled. Bulk liquids had been marked with the date of opening so that staff knew if the medicine was still suitable to use. Medicines for destruction were separated from stock and placed into designated destruction bins. But the bins were stored unsealed in the toilet area, which could make them less secure from unauthorised access. This was discussed with the pharmacist during the inspection.

Medicines which required cold storage were stored in a suitable fridge. The fridge temperatures were monitored daily, and records seen showed that they had been kept within the appropriate range. CDs were kept securely.

Team members showed recent drug alerts and recalls they had received and explained what they had done in response. But the action taken was not always recorded, which could make it more difficult for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for its services and maintains it well. It uses its equipment to help protect people's personal information.

Inspector's evidence

An anaphylaxis kit was available for when vaccinations were done. There was a range of clean glass measures for use with liquids. Team members had access to up-to-date reference sources including the internet. Tablet counting triangles were clean, with a separate marked triangle for use with cytotoxic medicines to help avoid cross-contamination. The phone was cordless and could be moved to a more private area to help protect people's personal information. The fax machine was out of the view of 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.