General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Harrisons Pharmacy, 1 Erith Town Square, ERITH, Kent, DA8 1RE

Pharmacy reference: 1032736

Type of pharmacy: Community

Date of inspection: 30/10/2019

Pharmacy context

The pharmacy is part of a large chain of pharmacies. It is located on a parade of shops in a pedestrianised area in a town centre. The pharmacy receives around 80% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations, the Community Pharmacy Consultation Service, a needle exchange service and it is a Healthy Living Pharmacy. It supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It learns from mistakes that happen during the dispensing process to help make its services safer. It largely protects people's personal information and it regularly seeks feedback from people who use the pharmacy. It mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. The responsible pharmacist (RP) said that near misses were not always recorded, but those that were recorded were reviewed regularly for any patterns by the pharmacy's head office. She said that she would ensure that near misses were recorded more consistently in the future. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. The pre-registration trainee explained about a recent incident that had occurred where the wrong strength of medicine had been supplied to a person. She said that the error had been highlighted by the pharmacy when replacement stock had been received. The person was notified of the error and they were given the correct medicine. The pre-registration trainee had completed the incident report form and this had been reviewed by the pharmacy's head office. Other team members were made aware of the incident and these medicines were kept separately when both strengths were in stock at the pharmacy. The pharmacy received posters from the pharmacy's head office, detailing medicines which 'look alike and sound alike'. These posters were displayed in the dispensary and team members had discussed these medicines.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The medicines counter assistant (MCA) said that the pharmacy would open if the pharmacist had not turned up. She confirmed that she would not sell any pharmacy-only medicines or hand out any dispensed items until the pharmacist was in the pharmacy. The dispenser knew that she should not carry out any dispensing tasks if there was no responsible pharmacist.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed medicine was made. And there were signed in-date Patient Group Directions available for the relevant services offered. The private prescription records were mostly completed correctly, but the date of the prescriptions and the

prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The nature of the emergency was not routinely recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacist said that she would ensure that the private prescription record and emergency supply record were completed correctly in the future. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The responsible pharmacist (RP) log was completed correctly and the correct RP notice was clearly displayed.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be accessed by people using the pharmacy but some information could potentially be viewed by people. The RP said that she would ensure that the information was safeguarded in the future. And following the inspection, the pharmacy provided evidence that the information was now not visible. The pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website. Results were positive and around 94% of respondents were satisfied with the staff overall. The complaints procedure was available for team members to follow if needed and details about it were available in the shop area. The pharmacist said that there had not been any recent complaints.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy's head office. The team members could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist gave an example of action she had taken in response to a safeguarding concern. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They are provided with some training to support their learning needs and maintain their knowledge and skills. The team discusses adverse incidents and uses these to learn and improve. Team members can raise any concerns or make suggestions. This means that they can help improve the systems in the pharmacy. They can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one regular pharmacist, one pre-registration trainee, two trained dispensers, two trainee dispensers, two trained MCAs, and one trainee MCA working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

A relief pharmacist started working in the pharmacy in the afternoon on the day of the inspection. She explained that she worked one afternoon each week at the pharmacy, to allow the pharmacy manager to catch up on other tasks. She worked at other pharmacies throughout the organisation for the rest of the week. The professional services co-ordinator was at the pharmacy on the day of the inspection to train the pre-registration trainee on the New Medicine Service (NMS). The pre-registration trainee explained that she was allowed two and a half hours of protected study time each week. She said that she attended one study day each month at the pharmacy's head office. This gave her the opportunity to speak with other pharmacy students about the training and any issues. She confirmed that she felt supported by her mentor and the pharmacy's head office.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she confirmed that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacists were aware of the continuing professional development requirement for the professional revalidation process. The RP said that she had completed declarations of competence and consultation skills for the services offered, as well as associated training. The RP explained that she had recently carried out some training about the shortage of some medicines and she had informed all team members about these. This meant that people could be informed at the earliest opportunity when they came to the pharmacy. The RP said that team members were not provided with ongoing training on a regular basis, but they did receive some. Including, training about the Falsified Medicines Directive and over-the-counter sales of medicines. They were given the opportunity to attend training evenings provided by external agencies. The pharmacy's head office provided additional pay and travel expenses for those who attended these events.

The RP explained that a person had been requesting their multi-compartment compliance packs before

they were due. She explained that said that she had contacted the person's GP as there may have been a reason that they did not have enough of their medicines left.

Team members had yearly appraisals and performance reviews carried out by the pharmacist. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The RP said that information from the pharmacy's head office and from the regional meetings was passed on informally to team members.

Targets were set for Medicines Use Reviews and the NMS. The RP said that she carried out these services for the benefit of the people who used the pharmacy and did not feel under pressure to achieve the targets. She explained that the pharmacy's head office would provide additional cover to help the pharmacy meet the targets if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available; the room temperature was suitable for storing medicines. Pharmacy-only medicines were largely kept behind the counter, but there was no barrier to restrict access behind the medicines counter. And, some reduced lines were kept on the medicines counter at the start of the inspection. These were removed by the MCA during the inspection, and she said that she would remind other team members not to place pharmacy-only medicines in the reduced basket. The MCA said that some people accessed the area behind the counter and could then potentially access some of the pharmacy-only medicines. This was discussed with the pharmacy's superintendent office following the inspection. And the inspector was provided with evidence that a barrier had since been installed.

There were four wipe-clean chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. A notice was displayed asking people to ‘notify the counter staff when returning to collect prescriptions’, as their name may have been called while they were not in the pharmacy. Barriers and notices were used to encourage people not to approach the medicines counter until they were called forward. This helped to give privacy to people who were being served at the counter.

The pharmacy's main consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened from people using the pharmacy, but not from people in the dispensary. It was kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area.

Toilet facilities and the kitchen were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. The pharmacy highlights prescriptions for higher-risk medicines and gives people advice on how to take them safely.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with a power assisted door. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available.

The RP said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had warning stickers available and these were added to dispensing boxes when needed. But it did not have the relevant patient information leaflets or warning cards available. The pharmacist said that she would order replacements from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months was marked. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacist said that uncollected prescriptions were checked regularly and items left uncollected after around three months were returned to dispensing stock where possible, and the prescription returned to the NHS electronic system or the prescriber.

The pharmacy underwent a minor refit around six months ago and a room was created for assembling multi-compartment compliance packs. This helped to minimise distractions when assembling and checking the packs. The RP said that people had assessments carried out by their GP to show that they needed the packs. Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that people ordered these when if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were largely labelled correctly and there was an

audit trail to show who had dispensed and checked each tray. But, the backing sheets were not attached to the trays and this could increase the chance of them being misplaced. The dispenser said that she would ensure that the backing sheets were attached in the future. The additional cautionary and advisory warnings were not on the backing sheets. The dispenser contacted the software provider and the backing sheets were amended so that all the relevant information was recorded. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible but there were multiple people's personal details on each sheet. The dispenser said that she would check with the driver how he protected people's personal information when signatures were recorded. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive and it was being used. Team members had undertaken some training on how the system worked. The MCA explained that there was no scanner at the medicines counter so team members had to scan bagged items in the dispensary before handing out and this increased the time taken to serve people.

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

Suitable equipment for measuring liquids was available. Separate liquid measures were marked for methadone use only. Triangle tablet counters were available and clean; a separate counter was marked for methotrexate/cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was replaced at regular intervals. And the weighing scales and the shredder were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked.

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.