General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Osbon Pharmacy, 55 High Street, StMary Cray, ORPINGTON, Kent, BR5 3NJ

Pharmacy reference: 1032874

Type of pharmacy: Community

Date of inspection: 22/10/2019

Pharmacy context

This is a community pharmacy in a parade of shops in a suburb of Orpington. It offers a needle exchange service and provides substance misuse services to a few people. And uses patient group directions to provide a range of services including emergency hormonal contraception, chlamydia treatment, and flu vaccinations. It supplies medication in multi-compartment compliance packs to people who live in their own homes and need help taking 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services. It asks people who use it for their feedback. It generally keeps the records it needs to by law to show that medicines are supplied safely and legally. Team members protect people's personal information appropriately. And they know how to protect vulnerable people. Team members record mistakes that happen during the dispensing process to help them take action to prevent a repetition.

Inspector's evidence

A system was in place for recording near misses that occurred during the dispensing process, but there were some months where no records had been made. Team members said that a few near misses may have occurred and not been recorded, and the pharmacist said that they sometimes only recorded the more serious ones. However, records had started to have been made again recently and the pharmacist said that they were now recording all the near misses. He gave an example of a near miss which had occurred with different strengths of sitagliptin due to the similar pack designs. He showed that the strengths had been separated on the shelf. The different strengths of citalopram had also been separated to help avoid a picking error. The trainee technician explained how she went through the shelves to ensure that different medicines and strengths were not mixed up, and the stores medicines were observed to be kept tidy and orderly.

Dispensing errors were recorded in a book if they occurred. The pharmacist gave an example of an error where aripiprazole had been dispensed instead of olanzapine. The incident was discussed in the team and they were made aware to be more vigilant when dispensing these medicines.

A range of standard operating procedures (SOPs) was present, but some were overdue for review. For example, the SOP around the delivery of medicines to people's homes had been implemented in 2012 and there was no documented review. The pharmacist said that he would go through and ensure that they were reviewed. Team members had signed a sheet at the front of the SOPs to indicate that they had read the SOPs relevant to their roles. But from the sheet, it was not clear which SOPs these were, as the individual SOPs did not often indicate which roles they applied to. The pharmacist said that he would make this clearer as he went through and reviewed them.

The medicines counter assistant (MCA) could describe what she could and couldn't do if the pharmacist had not turned up but thought that she could sell General Sales List medicines. The inspector reminded her of the requirements. Team members were observed referring queries to the pharmacist as appropriate.

The pharmacy undertook an annual patient survey and was currently handing out the current survey sheets. The results from the 2017 to 2018 survey were positive, with over 94% of respondents rating the pharmacy overall as very good or excellent. The pharmacy's complaints procedure was in the SOPs. The pharmacist said that they received frequent positive comments from people who came into the pharmacy and was not aware of any recent formal complaints. Details of how people could make a complaint or provide feedback were in the practice leaflet and on a sign in the shop area.

The pharmacy had a current indemnity insurance certificate displayed. And the right responsible

pharmacist (RP) notice was clearly visible. The RP log had largely been filled in correctly and private prescription records seen complied with requirements. Most emergency supply records had been completed correctly, but some did not indicate the nature of the emergency. This could make it harder for the pharmacy to show why the medicine had been supplied if there was a query. Most records for unlicensed medicines contained the required information but a few did not. The pharmacist said that he would discuss this in the team to make sure that they were recorded correctly in the future. Controlled drug (CD) registers examined complied with requirements and the CD running balances were routinely checked.

Other people's personal information was not visible to people using the pharmacy. A shredder was used to destroy confidential waste, and the computer terminal screens were turned away from customers. Passwords were required to access the computers. Some team members did not have NHS smartcards to access the NHS electronic systems, and the pharmacist said that he would ensure these were obtained. Staff had signed individual confidentiality agreements and the pharmacist said that they had been provided with some initial training on the General Data Protection Regulation, but this had not been documented. He showed a folder containing a presentation he had used to talk about this. There was an information governance policy but it not all sections of it detailed in the contents page were found.

The pharmacy had a safeguarding policy, but due to the way that team members signed to say that they had read and understood the SOPs it was not clear if they had been through it. Team members said that they would refer any safeguarding concerns to the pharmacist and said that the pharmacist had discussed potential signs to look out for with them. The pharmacist explained that the delivery driver had completed the level 1 safeguarding training, and the trainee technician said that she had completed safeguarding training had part of her previous job. The pharmacist confirmed that he had completed the level 2 safeguarding training but was unable to find the certificate. He explained that he had completed it as part of the sexual health services the pharmacy provided. He was able to explain what he would do if he had any safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They can raise concerns or make suggestions to help improve the pharmacy's services. And they are able to take professional decisions to make sure that people are kept safe. They get some ongoing training which helps them keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection there was one pharmacist, one trainee technician, one trained MCA, and a trainee dispenser. There were also two new members of staff. One had started a few weeks ago and was registered on the MCA course. The other had worked at the pharmacy for under three months and the pharmacist had discussed the course with them. In addition to the staff present, there was an MCA who had worked at the pharmacy for around six months and had not yet been registered on an accredited course. Following the inspection, the pharmacist confirmed that this member of staff had now been registered on an appropriate course.

The MCA explained how she provided advice to people buying medicines over the counter. She said that if someone requested multiple packs she always referred this to the pharmacist.

Team members felt comfortable about raising any concerns or making suggestions. The trainee technician said that they had staff meetings as and when they needed to. She gave an example of a meeting she had called the previous day, where she had discussed picking medicines for dispensing multi-compartment compliance packs. She made the suggestion that different team members should do each stage of the process to help prevent any mistakes occurring, as they would check each other's work. Team members were observed to communicate well together, and the workload was up to date and well managed.

Team members received some ongoing training, including articles from pharmacy magazines, discussions with the pharmacist, and when manufacturer's representatives came in. The training was not formally recorded. Team members said that they were usually able to do it during working hours.

There were no formal targets set for team members, but there was an aim to work towards the NHS Quality Framework. The pharmacist did not feel under any undue pressure and felt able to take any professional decisions. He gave an example of a child who had been prescribed a dose of ranitidine which was too high. He referred the child's parent back to the surgery and a new prescription was written.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and mostly tidy. There were some delivery boxes on the floor in the dispensary, but these had been moved away to the side to reduce the chance of team members tripping over them. There was a storage area at the rear of the pharmacy which was crowded, but it was kept in a relatively orderly manner. There was a sufficient amount of clear workspace for dispensing, and lighting was good throughout. The premises were secure from unauthorised access.

Staff had access to handwashing facilities. The room temperature was suitable for the storage of medicines and was maintained with air conditioning. There were two consultation rooms, and both were clean and tidy. They allowed people to have conversations inside which would not be overheard. One of the consultation rooms was unlocked and contained some unsecured items inside; the pharmacist said that the room would be kept locked in the future.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages and provides its services well. It obtains its medicines from reputable sources and stores them 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. It dispenses medicines in multi-compartment compliance packs safely. And people with a range of needs can access the pharmacy's services. The pharmacy doesn't always highlight prescriptions for higher-risk medicines and this could mean that opportunities to speak with people taking these medicines are missed.

Inspector's evidence

There was a small step from the street into the pharmacy. Team members on the counter could see who was outside the front of the pharmacy and said they helped people in as needed. Inside the shop area there was a large open area to help people with wheelchairs or pushchairs manoeuvre more easily. A range of leaflets about healthcare matters was available to people. A list of the pharmacy's services was displayed on its website.

Deliveries of medicines to people's homes were done by a delivery driver. The pharmacist explained how the driver obtained people's signatures on individual address labels which were then stuck into a book. The book was with the driver during the inspection and was not examined.

Some people had their medicines dispensed into multi-compartment compliance packs. People were assessed for the service by the local medicine optimisation service, to see if the packs would help them or if other solutions were better. The optimisation service also monitored how the people were managing their packs. Dispensed packs were labelled with a description of the medicines to help people or their carers identify them. An audit trail was present on the packs to show who had dispensed and checked them, and patient information leaflets were routinely supplied. Any changes in people's medicines or communication with the prescriber was documented.

Prescriptions for higher-risk medicines such as warfarin or methotrexate were not routinely highlighted, and this could mean that opportunities to speak with these people are missed. The pharmacist said that he would discuss it with the team and highlight prescriptions for higher-risk items in the future. He was aware of the updated guidance about pregnancy prevention for valproate and said he had spoken with one person in the at-risk group. The relevant cards and stickers for valproate could not be located, and the pharmacist said that more would be ordered in.

A bag containing some dispensed pregabalin was found on the shelf and there was no prescription with it. This made it harder for the team member handing the item out to know if the prescription was still valid. The pharmacist said that the team would highlight dispensed CDs in the future. He said that most prescriptions were electronic and could be looked up on the computer system if there were any queries. Signed in-date copies of patient group directions were available, and the pharmacist described the training he had done to be able to provide services under these.

The pharmacy had the equipment to comply with the Falsified Medicines Directive but were not using it routinely. The pharmacist said that he was intending to train the staff how to use it. Medicines were obtained from licenced wholesale dealers and specials suppliers, and stock was kept in an orderly

manner in the dispensary. The date-checking routine was recorded, and from the shelves examined no date-expired medicines were found. CDs were kept securely. Medicines that needed cold storage were stored in suitable fridges, and the temperatures were recorded daily. Records seen were within the correct temperature range. Bulk liquids were marked with the date of opening to help staff know if they were still suitable to use. Medicines for destruction were appropriately separated from stock and stored in designated destruction bins and sacks.

The pharmacy received drug alerts and recalls and kept a record of the action taken. This helped it show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

A range of calibrated measures was available, with separate marked ones used for liquid methadone which helped avoid cross-contamination. The electronic tablet counter was clean, and a shredder was used to destroy confidential information. The phone could be moved somewhere more private to protect people's personal information.

Adrenaline pens in different strengths were available for use when vaccines were administered. There was a blood pressure meter in the consultation room. But the pharmacist said he didn't use it and people instead used the free-standing one in the shop area which was regularly calibrated under a service contract.

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.