General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Howletts Pharmacy, 81 Howletts Lane, RUISLIP, Middlesex, HA4 7YG

Pharmacy reference: 1035092

Type of pharmacy: Community

Date of inspection: 30/05/2019

Pharmacy context

This is an independently owned pharmacy. One of two owned by the same company. It situated on a small shopping parade in a residential area of Ruislip. The pharmacy provides NHS essential services and provides medicines in multi-compartment compliance aids for 59 people. Other services include: Medicines Use Reviews (MURs), the New Medicine Service (NMS) and seasonal influenza vaccinations. The pharmacy also has a prescription delivery service and a smoking cessation service and has a post office on the premises.

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

In general, the pharmacy's working practices are safe and effective. Its team members generally understand their roles and responsibilities and they keep people's information safe. The pharmacy's team members log any mistakes they make during the dispensing process. They learn from these and take action to avoid problems being repeated. But, they could do more to reflect on what had gone wrong so that they could improve their procedures.

Inspector's evidence

Staff worked under the supervision of the responsible pharmacist (RP), whose sign was displayed for the public to see. Staff had standard operating procedures (SOPs) to follow, and the dispenser was in the process of reading them. There was a procedure in place for managing risks in the dispensing process, whereby all incidents, including near misses, were discussed at the time and recorded. The superintendent then reviewed the records each month, to help prevent the same mistakes being repeated. She then produced a patient safety report. Near miss records indicated that staff had 'mis-read' the prescription on several occasions. Follow up action was for staff not to rush when dispensing. Subsequent near misses reiterated the same reason and follow up actions (indicated by ditto marks), and so it was not clear whether staff had adequately reflected on what had gone wrong so that they could prevent similar mistakes in future.

Monthly patient safety reports advised the team to take more care to read the prescription especially where multiple forms and strengths exist. They also advised staff to self-check all prescription details when dispensing, including strength and form. However, near miss records indicated that compliance with these follow up actions was not always put into practice and may need closer monitoring. But, it was clear that the team identified risk and made changes to prevent reoccurrence in other ways. This included the separation of simvastatin 20mg tablets and the 40mg tablets following several near misses between the two.

The pharmacy team had a positive approach to customer feedback. The superintendent described how they had trained staff to be more proactive in giving customers healthy living advice. They did this by keeping the healthy living pharmacy (HLP) display up to date, in accordance with local campaigns. At the time of the inspection the HLP display was focused on health advice for women who were pregnant or hoping to become pregnant and had information leaflets for people to take away. The MCA was observed standing at the side of counter with a carbon monoxide (CO) monitor, inviting people to try it. Those with low CO readings were asked if they smoked. This led to a conversation about the stop smoking service. The pharmacy also provided a weight loss support service with the sale of Lipotrim products. Staff said they found that they were getting more engagement from customers by encouraging conversations about healthy lifestyle choices.

The team described how they ordered the same brands of medicines for certain people to help with compliance. Customer preferences included the Teva brand of atorvastatin 20mg and the Zentiva brand of omeprazole GR 20mg capsules. Notes had been added to the relevant patient medication records (PMRs) and details were printed on patients' labels as an additional prompt for staff.

The pharmacy had a documented complaints procedure. A standard operating procedure (SOP) for the

full procedure was available for staff to refer to. Customer concerns were generally dealt with at the time and recorded for the attention of the superintendent. Details of the local NHS complaints advocacy service and PALs could be provided on request. The pharmacy had professional indemnity and public liability arrangements so, they could provide insurance protection for staff and customers. Insurance arrangements were in place until 30 November 2019 when they would be renewed for the following year.

All the necessary records were kept and were generally in order including controlled drug (CD) registers, and records for, private prescriptions, unlicensed 'specials', responsible pharmacist and emergency supplies. But reasons for emergency supplies were not always clearly explained. The pharmacy had records for patient returned CDs. Records of returned CDs were kept for audit trail and to account for all the non-stock CDs which RPs had under their control.

Staff understood the importance of safeguarding people's private information. They had received information governance training and GDPR training through the National Pharmacy Association (NPA). Discarded labels and prescription tokens were shredded. Although delivery records showed the names and addresses of several people on each page, the page was folded to conceal all the names and addresses when people were asked for a signature. The regular pharmacist had completed level 2 CPPE safeguarding training. Staff had also completed CPPE level 1 training and dementia friends training but had not had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload safely and effectively and team members work well together. They are comfortable about providing feedback to pharmacists and are involved in improving the pharmacy's services.

Inspector's evidence

In general pharmacy services were managed by superintendent, who worked three days per week, and two regular part-time locums. Support staff consisted of a dispenser (an EU qualified pharmacist, yet to register), and two part-time medicines counter assistants (MCAs). On the day of the inspection the pharmacy was run by a locum, the dispenser and a MCA who also ran the post office. The superintendent was also present for a short time. The inspection took place during a half term holiday when the pharmacy was relatively quiet.

The MCA had opportunities to enhance his knowledge. He could locate the regular publications of 'Training Matters' and said he used these to help keep his knowledge of ailments and counter products up to date. He had yet not read the last two issues. However, team members could all recall receiving training on oral health a month or two ago.

The team was up to date with the daily workload of prescriptions and customers were attended to promptly. The dispenser said she felt supported in her role and could raise concerns. She described having regular informal discussions with the pharmacists including the superintendent. She said she could make suggestions as to how things could be improved. She said that when she first took up her post she found a lot of short-dated stock so in order to improve turnover, she had improved stock management procedures. She did this by ensuring that staff were ordering less stock while still having enough to meet prescription demands. The number of short-dated items in stock had reduced as a result. She also took responsibility for the tidiness of shelves.

It was noted that completed, checked prescriptions were bagged and sealed by the MCA. SOPs described bagging of prescriptions as part of the dispensing procedure, but the MCA had neither read the procedure or received any formal dispensing training. However, he had been given verbal instructions on what to do. He described dealing with one prescription at a time. He described cross checking patients' names and addresses on the prescription with the dispensing labels and bag labels.

The pharmacist was set targets for Medicines Use Reviews (MURs). She said she tried to do two MURs per shift. She aimed to provide MURs for people who needed one but would not compromise her attention to the remaining workload. She aimed to provide a good service by ensuring that people's medicines were dispensed on time and the day's workload completed.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and suitable for the services it provides.

Inspector's evidence

The pharmacy was on a small parade of local shops in a residential area of Ruislip. The premises had a bright, modern, professional appearance. It had large windows across the front, providing a plentiful source of natural light.

The consultation room was situated to the side of the counter. The pharmacist used the room for MURs, and other services. Customers were asked if they wanted to use the room if they wished to talk in private. The pharmacy had a seating area for anyone waiting. It had a rope to pull across the entrance into the dispensary, which was meant to act as a barrier and restrict unauthorised access. But, it was not always in use. In general, access to the dispensary was restricted to authorised individuals only, and at the discretion of the pharmacist.

The dispensary was situated behind the counter. It had a wide L-shaped area of bench space, and small island in the middle. There was a further small bench which overlooked the shop floor. This was where the main pharmacy computer was, allowing the dispensing staff to easily see people at the counter. Most of the dispensing and checking took place on the longest area of bench space where there were separate areas for dispensing and accuracy checking. Once checked prescriptions were moved to the central island for bagging. The dispensary was clean and organised with clean sinks, floors, shelves, worktops.

The pharmacy stocked a variety of goods including items for health and personal care as well as a range of cosmetics, perfumery, gift items, baby care and household items. Overall, the pharmacy was adequately lit and ventilated with temperature control systems in place. It was suitable for the provision of healthcare services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes them available to everyone. Members of the pharmacy team give people the advice and support they need to help them use their medicines safely and properly. In general, the pharmacy manages its medicines safely and effectively. The pharmacy team checks stocks of medicines regularly to make sure they are in-date and fit for purpose and stores them appropriately, but it could do more to ensure that only authorised team members have access to controlled medicines and to ensure that all stock has sufficient information on the packaging. The pharmacy disposes waste medicines safely.

Inspector's evidence

The pharmacy had an automatic door and wide step free access to enable wheelchair access. The shop floor area was uncluttered and wide enough for wheelchair users to move around and there was a repeat prescription collection service and a prescription ordering service. The service was offered to a small number of patients who needed help to manage their prescriptions. Services were advertised at the front window for people to see and there was a variety of information leaflets available for customer selection. Information leaflets were placed in a rack near the waiting area and HLP display.

In general services were delivered in accordance with SOPs. CDs were audited on a regular basis as per the SOP. Random samples of two CDs were checked during the inspection and the quantities checked were as stated in the register. Dispensing labels were initialled by the person dispensing and the person checking, to provide a dispensing audit trail. This was as per the SOP.

Multi-compartment compliance aids were provided for patients who needed them. Patient information leaflets (PILs) were offered with new medicines and on a regular basis thereafter. The medication in compliance aids was given a description, including colour and shape, to help people to identify them. The labelling directions on compliance aids gave the required BNF advisory information to help people take their medicines properly. Medicines summary sheets were created for each person and checked against prescriptions each time. Staff would pursue discharge letters after being informed that people had been in hospital.

The pharmacy had procedures for targeting and counselling all patients who may become pregnant taking sodium valproate. The pharmacist described including valproate warning cards with relevant prescriptions and referred to the guidance sheet for pharmacists which was on display on the wall. All patients in the at-risk group had been identified and counselled. But they had since been taken off the drug by their GPs. Packs of sodium valproate in stock bore the updated warning label and additional warning stickers were available for split packs.

Medicines and medical equipment were obtained from: AAH, Alliance Healthcare, Phoenix, Sigma, DE and Colorama. Unlicensed ‘specials’ were obtained from Thame Laboratories All suppliers held the appropriate licences and stock was generally stored in a tidy, organised fashion. A CD cabinet and fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read, recorded and monitored to ensure that the medication inside was kept within the correct temperature range. However, there was some stock of a CD which had been removed from its original packaging and the new pack did not show a product licence number, batch number or expiry

date. This means they could be missed if subject to a product recall or alert or could be handed out after their expiry. The pharmacy team were scanning products with a unique barcode in accordance with the European Falsified Medicines Directive (FMD).

Stock was regularly date checked and records kept. Short-dated stock was identified and highlighted using a red dot sticker. It was then listed so that it could be removed easily when the time came. Waste medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. A list of hazardous waste had been placed on the wall for staff so that they could dispose of hazardous waste medicines properly. Drug recalls and safety alerts were responded to promptly and records were kept. Two packs had been identified and returned to the wholesaler following the recent recall for Sandoz co-amoxiclav oral suspensions 125/31.25 and 250/62.5.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely and keep people's information safe.

Inspector's evidence

The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures were of the appropriate BS standard and clean. Staff used a separate triangle for counting loose cytotoxic tablets to help prevent cross contamination and in general amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris.

There were up-to-date information sources available in the form of a BNF, a BNF for children, the MEP and the Drug Tariff. The pharmacist said he also used the NPA advice line service. Pharmacists also had access to a range of reputable online information sources such as the NHS websites, EMC a BNF 'app' NICE and the Drug Tariff.

The pharmacy had three computer terminals. Two in the dispensary and a laptop in the consultation room. All computers had a patient medication record (PMR) facility. They were password protected and were out of view of patients and the public. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was shredded.

In general staff were using their own NHS Smart cards when accessing PMRs although, on occasion, the dispenser was observed using a computer with the pharmacist's card still in it. Staff use their own Smart cards to maintain an accurate audit trail and to ensure that access to patient records is appropriate and secure.

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.