General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ruislip Manor Pharmacy, 53 Victoria Road, RUISLIP, Middlesex, HA4 9BH

Pharmacy reference: 1035097

Type of pharmacy: Community

Date of inspection: 12/12/2019

Pharmacy context

This is an independently owned community pharmacy on a busy high street running through the centre of Ruislip. As well as the NHS Essential Services it provides Medicines Use Reviews (MURs), New Medicines Service (NMS), a delivery service and multi-compartment compliance aids for people living in the local community. The pharmacy provides a travel vaccination and malaria prophylaxis service and a supervised consumption service for substance misuse clients.

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

In general, the pharmacy's working practices are safe and effective. Its team members listen to people's concerns and try to keep people's information safe. They discuss any mistakes they make and share information to help reduce the chance of making mistakes in future. But team members do not do enough in the way that they gather information and use it to learn and improve. And they are not thorough enough with their record keeping.

Inspector's evidence

Staff worked under the supervision of the RP whose sign was displayed for the public to see. There was a set of standard operating procedures (SOPs) in place. And staff had read and signed the SOPs relevant to their roles. The pharmacy had procedures for managing risks in the dispensing process, but staff said that mistakes were relatively rare. All incidents, including near misses, were discussed at the time. The team also had regular meetings to review and discuss any mistakes and ways of preventing a reoccurrence. The pharmacist described how the stocks of various look-alike-sound-alike drugs (LASAs), such as pantoprazole and propranolol, had been re-organised and separated to help prevent them from becoming mixed up. The team also tried to manage risk in the early stages of the dispensing process by highlighting products which may be at risk of error such as Metformin and Metformin SR products and Epilim GR and Epilim chrono products. Staff highlighted drug names and forms on the prescription to draw the attention of colleagues dispensing them.

This was small close-knit team and it was clear that discussions about the tasks in hand were integral to the day to day running of the pharmacy. However, in recent months, near miss records did not show what the follow up actions were and did not identify what the contributory factors might have been. So, although all near misses were discussed at the time, not all the information was captured for review. Those which had been recorded showed who was involved but did not show what should change as a result of the mistake or what had been learned from it. However, it was clear that staff had reflected on their individual dispensing process to help identify any specific steps or checks which could have prevented the mistake from happening in the first place.

The pharmacy had a documented complaints procedure. A SOP for the full procedure was available for reference. Where possible, customer concerns were dealt with at the time by the regular pharmacist and superintendent. And formal complaints were recorded. But staff said complaints were rare. Several years ago, the pharmacy had received a complaint about a prescription delivery. This led to a full review of driver training and delivery procedures. The pharmacy team had a positive approach to customer feedback. A previous survey demonstrated a high level of customer satisfaction. The team described how they ordered the same brands of medicines for certain people to help meet their needs. Customer preferences included the Almus brand of loperamide and the Teva brand of bisoprolol 5mg. Another patient preferred the Mylan form of alendronic acid 70mg as she couldn't swallow other brands due to their shapes and sizes. Notes were added to patients' patient medication records (PMRs) as a reminder for staff. 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 September 2020 when they would be renewed for the following year.

All the necessary records were kept and were in order including Controlled Drug (CD) registers and

records for private prescriptions. Records for emergency supplies were generally in order although several did not provide a clear reason for supply. RP records were also generally in order but not all entries showed the time at which responsibilities ceased. Records for unlicensed 'Specials' did not all show labelling details and details of the prescriber. The pharmacy had records for CDs which had been returned by people, for destruction. Records of returned CDs were kept for audit trail and to account for all the non-stock CDs which RPs had under their control. But the pharmacy had 42 morphine sulphate 10mg/ml ampoules and 63 MST 5mg tablets which had been returned but not yet recorded. The pharmacy had recently begun using an electronic CD register but had not yet marked the old registers as closed.

Staff had had been briefed on information governance and GDPR. They had also been briefed on confidentiality as part of their employment contracts. Discarded labels and tokens were disposed of in a confidential waste bin for collection by a licensed waste contractor. Completed prescriptions were stored in the dispensary where patient details could not be viewed from customer areas. The pharmacist and pre-reg had completed level 2 CPPE training. Other staff had been briefed and knew to alert the pharmacist with any concerns. All staff had completed dementia friends training. The pharmacy team had not had any specific safeguarding concerns to report. Contact details for the relevant safeguarding authorities were available online.

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 one another which helps the pharmacy maintain the quality of its services.

Inspector's evidence

The pharmacy had two regular responsible pharmacists (RP)s one of which was also the superintendent. the other worked a regular two days per week. The rest of the team included a pre-reg, a full-time dispenser, a full-time medicines counter assistant (MCA), a newly appointed, part-time trainee MCA and a part-time delivery driver. On the day of the inspection the RP was supported by the pre-reg, the full-time dispenser and the newly appointed trainee MCA. Team members were observed to work well together. They assisted each other when required and discussed matters openly. The daily workload of prescriptions was in hand and customers were attended to promptly.

The dispensing assistant described being able to raise concerns. She said she had regular informal discussions with the pharmacist superintendent and all pharmacists whom she found to be approachable. She had continued her training as a dispensing assistant after completing her MCA training. She had also completed her training as a stop smoking advisor. Staff kept their general pharmacy knowledge up to date by attending training courses provided by Numark and had recently attended a training evening on mental health. Staff had also recently read the Numark counter skills training packages on retail law, dry sin and eczema and the cardiovascular system.

Staff would have informal discussions during which they could make suggestions and raise concerns. The dispenser described how, as the stop smoking advisor, she had reviewed all patients on the programme. She had reviewed them to assess whether or not they should go back on the programme after having been unsuccessful on more than two occasions. Consequently, several patients had been referred to their GPs so that they could be provided with support before going back on the pharmacy's stop smoking programme. The pharmacist felt able to make his own professional decisions in the interest of patients. He would offer an MUR or NMS when he felt it beneficial for someone.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a safe, secure environment for people to receive healthcare services. But the general décor in the pharmacy’s staff area does not look fresh.

Inspector's evidence

The pharmacy’s premises were on the local high street. They had a traditional appearance with a double front. They had full height windows and a glass door to provide natural light. And had step -free access from outside. The shop floor was to the front with the dispensary behind. The shop floor was clear of obstructions and wide enough for wheelchair users. There was a small seating area for waiting customers. Items stocked included a range of baby care, healthcare, beauty and personal care items.

The pharmacy had a consultation room which the pharmacist used for private conversations and services such as MURs. The door to the room was to the side of the counter and was open. People could stand directly outside the door into the room. The sharps waste bin for the flu service had been left on the top of the bench rather than being locked away in a cupboard. The room was compact, but the pharmacist gave assurances that it could be used by wheelchair users.

The dispensary was relatively spacious. It had an eight to nine metre U-shaped run of dispensing bench to three sides with a run of shelves above and opposite. The longest run of bench space was where most of the dispensing and checking took place. This included multi-compartment aid dispensing. Work surfaces were well used but there was a clear work flow.

The dispensary was clean, tidy and organised. To the rear of the premises, the pharmacy had a staff room, a storage area and a door to the outside. The pharmacy had an outside toilet with hand washing facilities. Staff areas were generally clean, although the paintwork was scuffed and marked. In general, the pharmacy had a professional appearance. Shelves, worksurfaces, floors and sinks were generally clean.

Principle 4 - Services ✔ Standards met

Summary findings

In general, the pharmacy provides its services safely and effectively and tries to make its services available to everyone. The pharmacy generally manages its medicines safely and effectively. The pharmacy's team members check stocks of medicines regularly to make sure they are in date and fit for purpose. But it does not carry out all of its checks thoroughly enough. And, it does not always provide all the information which would help people take their medicines properly.

Inspector's evidence

A selection of the pharmacy's services was advertised at the front window and on promotional TV monitors. The pharmacy had a small range of information leaflets for customer selection. The consultation room was small but just big enough for wheelchair access, which meant that wheelchair users could access services requiring a private consultation, such as a MUR. The pharmacy's healthy living pharmacy display area was not up to date with the current NHS health promotion message; 'help us to help you' and was still displaying the previous message on antibiotics awareness.

There was a set of SOPs in place and in general, staff appeared to be following them. CD stock was audited regularly as per the CD SOP. And the quantity of stock checked (Zomorph 100mg capsules) matched the running balance total in the CD register. Multi-compartment compliance aids were provided for people who needed them. Patient information leaflets (PILs) were offered to patients with new medicines but were not provided regularly with repeat medicines. And the medication in the compliance aids were not all given a description, including colour and shape, to help people identify them.

The pharmacy had procedures for targeting and counselling all female patients taking sodium valproate. The RP said he had checked the pharmacy's records and found no patients in the at-risk group taking the drug. All packs of sodium valproate in stock bore the updated warning label, and the pharmacist had extra warning labels to apply to packs if needed. The pharmacy had up-to-date PGDs and service specifications for both the private and NHS flu vaccination services. People were briefed on what to expect when receiving a vaccination and asked to complete a consent form. Records were kept of the consultation for each vaccination, including details of the product administered. The pharmacy had procedures in place for managing an anaphylactic response to vaccinations.

Medicines and Medical equipment were obtained from: AAH, Alliance Healthcare, Sigma, Phoenix, Colorama and DE Pharmaceuticals. Unlicensed 'specials' were obtained from Thame Laboratories. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. A CD cabinet and a fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read and recorded daily. Stock was regularly date checked and records kept. Short-dated stock was generally highlighted. But there was a pack of Intuniv 1mg, expiring at the end of the current month, which had not been highlighted. The pharmacy also had a dispensed pack of Zomorph 100mg in the CD cabinet which had been labelled as containing 28 tablets. But when the contents were counted it was found to contain only 26. The pharmacy had the equipment for scanning products in accordance with the European Falsified Medicines Directive (FMD). Staff were aware of FMD requirements and were scanning products with a unique bar code.

Waste medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. But staff did not have a list of hazardous waste to refer to or a separate container, so they could ensure that they were disposing of all medicines appropriately. Drug recalls and safety alerts were generally responded to and records were kept. Faulty stock had been identified in the recent recall for Emerade. Two packs of 500mcg and one pack of 150 mcg had been set aside for return. Details of recalls were logged on the online system; pharmadata.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

In general, the pharmacy, has the right equipment and facilities for the services it provides. Its facilities and equipment are clean and used in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures and tablet triangles were of the appropriate BS standard and generally clean, although one triangle had a dusty residue. Precautions were taken to help prevent cross contamination by using a separate triangle for counting loose cytotoxic tablets. And amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris. CD denaturing kits were used for the safe disposal of CDs. There were up-to-date information sources available in the form of a BNF, a BNF for children and the drug tariff. Pharmacists also used the Numark advice line service and had access to a range of reputable online information sources such as NHS, NICE and EMC websites.

There were four computer terminals available for use, two in the dispensary and one and an additional laptop in the consultation room. All computers had a PMR facility, were password protected and were out of view of patients and the public. It was noted that the RP was using her own smart card when working on PMRs. Staff used their own smart cards to maintain an accurate audit trail and to ensure that access to patient records was appropriate and secure. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was collected for safe disposal.

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.