General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Trio Pharmacy, 19-21 High Street, SHEPPERTON, Middlesex, TW17 9AJ

Pharmacy reference: 1035108

Type of pharmacy: Community

Date of inspection: 07/05/2019

Pharmacy context

A community pharmacy set in a row of shops in Shepperton town centre. The pharmacy opens six days a week. And most of the people who use it are older. The pharmacy dispenses NHS prescriptions and it sells a wide range of over-the-counter medicines and beauty products. It has a travel clinic and offers winter influenza (flu) vaccinations. It also supplies medicines in multi-compartment compliance packs to people who live in their own homes.

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

The pharmacy has written procedures to help make sure its team works safely. Members of the pharmacy team know what their roles and responsibilities are. They work to professional standards and identify and manage risks appropriately. The pharmacy adequately monitors the safety of its services. Its team members record the mistakes they make and learn from them to try and stop them happening again. The pharmacy has appropriate insurance to protect people when things do go wrong. The pharmacy generally keeps all the records it needs to by law. It acts upon people's feedback. And it keeps their private information safe. The pharmacy team understands its role in protecting vulnerable people.

Inspector's evidence

The pharmacy's consultation room was locked when not in use to ensure its contents were kept securely and safeguarded from unauthorised access. The pharmacy had procedures in place for the services it provided. And these had been reviewed since the last inspection. Whilst members of the pharmacy team followed the procedures, not all of them had signed them.

Staff responsible for the dispensing process tried to keep the workstations in the dispensary clear of clutter. And they used baskets to keep people's prescriptions separate from other prescriptions and to help them prioritise the dispensing workload. They referred to prescriptions when labelling and picking products. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by a pharmacist.

Systems were in place to review pharmacy services, including the recording of dispensing errors and near misses. Individual learning points were discussed and documented when a mistake was identified to help the pharmacy team strengthen its dispensing process and prevent similar mistakes happening again. Amitriptyline and amlodipine stocks were separated from each other on the dispensary shelves to reduce the risk of staff picking the wrong product.

A Responsible Pharmacist (RP) notice was on display. The pharmacy team understood what their roles and responsibilities were. But these weren't clearly defined within the pharmacy procedures. A trainee member of staff working at the pharmacy counter explained that requests for the morning after pill and repeated requests for the same or similar products were referred to a pharmacist.

A complaints process was in place. And this was published on the pharmacy's website. Patient satisfaction surveys were undertaken annually. And the results of these were displayed in the public area of the pharmacy. Steps were taken following people's feedback to better manage the pharmacy team's dispensing workload so prescription waiting times could be reduced.

The pharmacy had insurance arrangements in place, including professional indemnity, through the National Pharmacy Association (NPA). The pharmacy's controlled drug (CD) register was held electronically and was adequately maintained. The running balance of the CD register was checked regularly. The nature of the emergency wasn't always included in the records for emergency supplies made at the request of patients. The prescriber's details and the date of prescribing were sometimes incorrect within the private prescription records. The time at which a pharmacist stopped being the RP

was occasionally omitted from the RP records. The date a specials line was obtained wasn't included in the 'specials' records.

An information governance policy was in place. And whilst staff were required to read and sign it, some staff hadn't. A contractor visiting the pharmacy during the inspection was asked by one of the pharmacists to sign a confidentiality agreement. Arrangements were in place for confidential waste to be collected and sent to a centralised point for secure destruction. Prescriptions awaiting collection were stored in such a way to prevent people's details being visible to the public.

Safeguarding procedures were in place and key contacts for safeguarding concerns were available. The pharmacists have completed safeguarding training. And they could explain what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to deliver its services safely. The pharmacy's team members are suitably qualified or undergoing training for their roles. But some staff don't have time set aside so they can train whilst at work. The team members use their judgement to make decisions about what is right for the people they care for. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy opened for 58 hours a week and dispensed about 9,500 prescription items a month. The pharmacy team consisted of a full-time pharmacist (a company director), a full-time locum pharmacist, a part-time pharmacist (the RP), a full-time pre-registration pharmacy technician trainee, a full-time dispensing assistant, a full-time medicines counter assistant (MCA), a full-time pharmacy apprentice, a part-time trainee dispensing assistant, a part-time trainee MCA and two part-time delivery drivers. The pharmacy also employed other staff who didn't work within the pharmacy area. The company directors were based at the pharmacy and they managed the pharmacy business.

The RP, two pharmacists, a pre-registration pharmacy technician trainee, a dispensing assistant, a MCA and a pharmacy apprentice were working within the pharmacy area at the time of the inspection. The company directors and three other members of staff were also present during the inspection. But they weren't working within the pharmacy area.

Members of the pharmacy team have completed or were undertaking accredited training relevant to their roles. They relied upon each other or locum pharmacists to cover absences.

The pharmacy's team members supported each other so people were served and counselled in a helpful and knowledgeable way. The pharmacists supervised and oversaw the supply of medicines and any advice given. A sales of medicines protocol was in place which the pharmacy team needed to follow. The pharmacy apprentice described the questions he would ask when making over-the-counter recommendations and when he would refer people to a pharmacist; for example, requests for treatments for older patients, infants or animals.

Staff performance and development needs were discussed informally throughout the year. The pharmacy apprentice attended college once a month. Members of the pharmacy team could ask the pharmacists questions and familiarise themselves with new products. But they didn't routinely have time set aside whilst at work to complete any training, including accredited training, they needed to do. They were often too busy serving people or dealing with the dispensing workload to train. And their individual workloads have increased since the recent departure of an experienced full-time pharmacy technician. The company was trying to recruit a full-time dispensing assistant to fill this vacancy.

The pharmacy team discussed mistakes as they happened to share learning. And team meetings were held to update staff and encourage them to do their jobs well. Members of the pharmacy team felt comfortable in providing feedback about the pharmacy amongst themselves and to the superintendent pharmacist. Staff were unaware if the company had a whistle-blowing policy. But they knew how to raise a concern if they had one. And their feedback led to changes in the pharmacy's repeat prescription ordering process. Whilst the pharmacy team was encouraged to promote the pharmacy's services, the

company did not set targets or incentives for its staff.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and the pharmacy provides a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The pharmacy was bright, clean, appropriately presented and air-conditioned. The pharmacy team was responsible for keeping the premises clean and tidy. The pharmacy had sufficient storage space and workbench available for its current workload. But occasionally some bulky items were stored in boxes on its floor. The pharmacy's automated dispensing robot has been removed since the last inspection as it frequently malfunctioned. And its removal has provided more workspace in the dispensary.

A consultation room was available if people needed to speak to a team member in private. And its contents were kept secure when it wasn't in use. The pharmacy's sinks were clean. There was a supply of hot and cold water within the premises. Antibacterial hand wash and alcoholic hand gel were available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of services and makes it easy for people to access them. Its working practices are safe and effective. The pharmacy gets its medicines from reputable sources and stores them appropriately and securely. Members of the pharmacy team check stocks of medicines regularly to make sure they are in-date and fit for purpose. The pharmacy generally disposes of people's waste medicines safely. But its staff don't always correctly dispose of medicines that require special handling.

Inspector's evidence

The pharmacy had an automated door and its entrance was level with the outside pavement. It had an induction loop for people who wore hearing aids. The pharmacy's services were advertised in-store and online on its website. The pharmacy team knew where to signpost people to if a service was not provided. The pharmacy offered a delivery service to people who couldn't attend its premises in person. An audit trail was maintained for each delivery.

The pharmacy provided about 10 MURs and up to 15 NMS consultations a month and people were required to provide their written consent when recruited for these. The pharmacy had about 100 people whose medicines were dispensed into multi-compartment compliance packs. And it used a disposable and tamper-evident system for this service. A dispensing audit trail was maintained for the packs seen and a brief description of each medicine contained within them was routinely provided. But sometimes the same description, such as white round tablet, was used to describe different medicines within the same pack. Patient information leaflets were provided with the first pack supplied or when a new medicine was prescribed.

The pharmacy offered a seasonal flu vaccination service. Its pharmacists administered about 140 vaccinations last winter. Some people chose to use the vaccination service at the pharmacy rather than their doctor's surgery for convenience or because they were not eligible for the NHS service.

People were signposted to the pharmacy's private travel clinic by other healthcare providers. And the service was advertised online and in a local magazine. The pharmacy was a registered Yellow Fever vaccination centre. People wanting to access the pharmacy's travel clinic needed to make appointments when a suitably trained pharmacist was on duty. Between five and ten travel consultations were undertaken at the pharmacy most weeks. Valid and up-to-date patient group directions were in place for the service.

The pharmacists were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. Although valproate educational materials were not available at the time of the inspection, they had been ordered.

The pharmacy used recognised wholesalers, such as AAH, Alliance Healthcare DE South and Waymade, to obtain medicines and medical devices. CDs, which were not exempt from safe custody requirements, were stored within the CD cabinet. A record of the destruction of patient-returned CDs was maintained. Out-of-date and patient-returned CDs were kept separate from in-date stock. But these had been allowed to accumulate and the pharmacy team needed to notify the local CD

Accountable Officer that the pharmacy had some out-of-date CDs that needed to be destroyed.

Pharmaceutical stock requiring refrigeration was appropriately stored between 2 and 8 degrees Celsius. Most medicines and medical devices were stored within their original manufacturer's packaging. A few split medication packs were found to contain stock from different manufacturers. But these were promptly disposed of when they were brought to the attention of the pharmacy team. Pharmaceutical stock was subject to date checks and short dated products were marked.

The pharmacists were aware of the Falsified Medicines Directive (FMD). The pharmacy's procedures hadn't been amended to reflect the changes FMD would bring to its processes. It didn't have a scanning device. But it had entered into an arrangement for the appropriate FMD software to be added to its patient medication record (PMR) system. Staff could check the anti-tampering device on each medicine was intact during the dispensing process. But they weren't verifying or decommissioning medicines at the time of the inspection.

Procedures were in place for the handling of patient-returned medicines and medical devices. Patient-returned waste was checked for CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. Although pharmaceutical waste receptacles were available and in use, the pharmacy didn't have a receptacle to dispose of people's hazardous waste, such as, cytostatic and cytotoxic products. And some hazardous waste was found in a waste receptacle intended for non-hazardous waste. A process was in place for dealing with MHRA recalls and concerns about medicines or medical devices. MHRA alerts were retained and annotated with the actions taken following their receipt.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and the facilities it needs to provide services safely.

Inspector's evidence

The pharmacy had up-to-date reference sources available and it had access to the NPA's information department. The pharmacy had a range of clean glass measures including marked measures for its substance misuse treatment service. It also had equipment for counting loose tablets and capsules including a counting triangle for cytotoxic products. The pharmacy used three medical refrigerators to store pharmaceutical stock requiring refrigeration. Whilst their maximum and minimum temperatures were checked regularly, these weren't always recorded.

A private online doctor consultation service was recently introduced at the pharmacy. The provider of this service was responsible for maintaining the diagnostic equipment connected to the dedicated computer terminal within the pharmacy's consultation room. The pharmacy team used sanitising wipes to clean the diagnostic equipment after each use.

The pharmacy provided blood pressure (BP) checks on request. And its BP monitor was recently replaced. The breath carbon monoxide monitor used in the pharmacy's smoking cessation service was replaced last year. The pharmacy was looking to re-introduce its NHS health check service soon. And its team needed to check that the equipment it would use for this service was safe, fit for purpose and appropriately maintained.

Access to the pharmacy computers and the PMR system was restricted to authorised personnel and password protected. The computer screens were out of view of the public. A cordless telephone system was installed at the pharmacy to allow staff to have confidential conversations when necessary.

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.