General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Sherrys Chemist, 48 South Road, SOUTHALL, Middlesex, UB1 1RR

**Pharmacy reference:** 1035125

**Type of pharmacy:** Community

**Date of inspection:** 17/06/2019

## Pharmacy context

An independently owned pharmacy situated in the centre of Southall. As well as essential NHS services, the pharmacy provides medicines in multi-compartment compliance packs (MDS trays) for over 140 people. Other services include: Medicines Use Reviews (MURs), New Medicines Service (NMS), seasonal influenza vaccinations, emergency hormonal contraception (EHC), medicines for erectile dysfunction and travel vaccinations for meningitis and Hepatitis B. The pharmacy also provides medication for period delay and has a prescription delivery service.

## 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 understand their roles and responsibilities and respond well to people's feedback. The pharmacy's team members log any mistakes they make during the dispensing process. They learn from these and take action to avoid the same mistakes being repeated. But, they could do more to reflect on what had gone wrong so that they could improve their procedures overall. The pharmacy could also improve procedures for ensuring that people's information is always protected when they have their medicines delivered.

### Inspector's evidence

Staff worked under the supervision of the responsible pharmacist (RP), whose sign was displayed for the public to see and there was a set of standard operating procedures (SOPs) for staff to follow. The pharmacy had a procedure for managing risks in the dispensing process. All incidents, including near misses, were discussed at the time and recorded. These records were reviewed periodically by the superintendent and discussed in team meetings, to raise awareness and to help the team to learn from its mistakes. But, near miss records did not show what the learning points were, or details of what could be done differently to help prevent a reoccurrence. This made it more difficult for the review process to monitor whether mistakes had led to an understanding of what had gone wrong and an improvement in the team's day to day practice. One of the dispensers said that during reviews the pharmacist/ superintendent had advised staff to concentrate on dispensing one item at a time and to always cross check the item with the prescription. So while the team, including the trainee, were encouraged to check the medicines they were dispensing, they were missing opportunities to monitor whether this was happening day to day.

The pharmacy team had a positive approach to customer feedback. Comments from customers regarding shingles vaccinations and travel vaccinations had prompted the pharmacist to investigate the provision of these services, and training was underway. The dispenser described how the team responded to customers' requests for the same brands of medicines. Many customers were very particular about the brands they used. Individual preferences included the Teva brand of amlodipine 5mg, amitriptyline 10mg and 25mg and the Pfizer brand of all strengths of atorvastatin. Although these brands were often more expensive to supply than the generic form for which the pharmacy was reimbursed, the team chose to supply them to help with patient compliance.

The pharmacy staff could not locate a documented complaints procedure but said that concerns were generally dealt with at the time. They also said that complaints were rare. Formal complaints would be recorded and referred to the superintendent. Details of the local NHS complaints advocacy service and PALs could be provided if necessary. 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 30th June 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 and emergency supplies. Records for the responsible pharmacist (RP)were generally in order with only one incomplete entry in the last two months. The pharmacy kept records for patient returned CDs but had not had any for over a year. Records of returned CDs were kept for audit trail and to account for all the non-stock CDs which RPs had under their control. Several records for unlicensed 'Specials' were missing the patient's details and a copy of the dispensing label as

required by the MHRA.

Staff understood the importance of safeguarding people’s private information. They had been briefed by the regular pharmacist but had not had any formal training. Discarded labels and tokens were set aside in a box and shredded daily. But, delivery records showed the names and addresses of several people on each page. This meant that when people signed the delivery sheet they could see everyone else’s details. The regular pharmacist had completed level 2 CPPE safeguarding training. Staff had been briefed but not had any concerns to report. There was a SOP for staff to follow and details of the local safeguarding authorities could be found online.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy team manages the workload safely and effectively. Team members work well together. They are comfortable about providing feedback to pharmacists and managers and play an active role in improving the pharmacy's services.

### Inspector's evidence

Pharmacy services were managed by the regular responsible pharmacist (RP)/superintendent, and a team of regular locums, dispensing and counter staff. On the day of the inspection the pharmacy was run by a regular locum, two NVQ3 qualified dispensers, a trainee dispenser and a medicines counter assistant (MCA). Staff were observed to work well together, each attending to their own tasks and assisting one another when required. The daily workload of prescriptions was in hand and customers were attended to promptly. The pharmacist wasn't set targets other than to manage the daily workload and complete MURs when she felt it was appropriate. So, she felt able to make decisions in people's best interests.

The dispenser described being able to raise concerns. She described having regular informal discussions with the regular pharmacist/ superintendent. She could also raise concerns with the company directors who attended the pharmacy regularly. During their visits they asked the team about any problems, worries or concerns they may have. She said she had suggested that they move the dispensing of MDS trays from the consultation room to a room at the rear of the dispensary where the staff kitchen had been. Subsequently the kitchen was moved to the back-shop area and the old kitchen made into an MDS room. The new MDS area provided a more spacious working environment with more dispensing surface and was in a better location for staff to access stock from the dispensary.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The premises are generally clean, secure and suitable for the services the pharmacy provides. But, the team could use facilities to better protect people’s private information.

### Inspector's evidence

The pharmacy had been refitted and modernised approximately two years ago and it had a bright modern appearance. It had a double front with full height windows and a glass door, providing natural light. Items stocked included a range of baby care, healthcare, beauty and personal care items. The shop floor was kept clear of obstructions and was wide enough for wheelchair users, as was the consultation room.

The counter and dispensary occupied a side wall. There was a small seating area and a consultation room. The consultation room was at the back of the pharmacy shop floor area, with access from the shop floor for customers. But the door into the room was left unopened during the inspection and customers were observed standing outside it. At the time, there were no staff members in the room. The computer screen had been left on, showing the names of several patients. Completed prescriptions were stored behind the counter and on shelves in the back-shop area. These could potentially be viewed by customers going to and from the consultation room.

The dispensary and counter were on a side wall. The dispensary occupied approximately two thirds of the length of the wall alongside the counter. The dispensary had a three-metre run of dispensing bench and a sink on a separate wall. The area of dispensing bench nearest the counter was where most of the dispensing and checking took place. An additional small table had been put in place to provide more space for checking. Although work surfaces were well used, there was a clear work flow.

There was a counter height gate next to the counter to prevent unauthorised access to the area behind the counter and dispensary. The back-shop area had several rooms, including the room for dispensing MDS trays, staff facilities and a stock room. All these areas were clean. The staff toilet had hand washing facilities and a hand dryer.The MDS room had dispensing benches on either side providing four to five metres of work surface as well as storage facilities for MDS documents, equipment and stock. The pharmacy fridge was also located in this room, freeing up space in the main dispensary.

The pharmacy was equipped with shutters to the front and a shuttered loading bay to the rear. The pharmacy was clean tidy and organised and had a professional appearance. Shelves, worksurfaces, floors and sinks were clean.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy generally provides services safely and tries to make its services available to everyone. But, it could do more to provide the most up to date information about its services. Team members generally give people the advice and support they need to help them use their medicines safely and properly but could provide more information to patients who have their medicines supplied in multi-compartment compliance packs. In general, the pharmacy team manages medicines safely and effectively. It carries out checks to help make sure that the pharmacy's medicines are fit for purpose. But, it does not always properly label medicines which have been removed from their original packaging. And, it was not scanning products with a unique barcode, as required in law. The pharmacy's team members do not always respond promptly to drug recalls. This could mean that the team is not able to identify all stock affected by drug recalls or safety alerts.

### Inspector's evidence

The pharmacy's services were not advertised at the front window, and the information cards on the counter were not up to date. There was a small range of information leaflets available for customer selection but a wheelchair for sale had been placed in front of the leaflet stand, making it difficult for staff and customers to access them. The range of leaflets available had not been updated for some time.

Wheelchair users could enter the pharmacy at the front entrance. Aisles were wide and were kept clear and wide enough for wheelchair users to move around. Wheelchair users could also access the consultation room and so had access to services such as MURs. There was a repeat prescription collection service. A prescription ordering service was offered to a small number of patients who needed help to manage their own prescriptions.

There was a set of SOPs in place. SOPs had been reviewed the previous year and were up to date. According to the CD SOP, the team were required to carry out a stock balance every week, but only two CD stock audits had been carried out in the last 6 months. The last audit before that had been 15 months previously. However, a random sample of CD stock was checked and the quantity in stock matched the total quantity given in the register. Only a small amount of schedule 2 CDs was stocked.

Mult-icompartment compliance packs (MDS trays) were provided for people who needed them. Patient Information Leaflets (PILs) were offered with new medicines but not on a regular basis thereafter. The medication in MDS trays was given a description including colour and shape to help people identify the medicines. The labelling directions on trays gave the required BNF advisory information to help people take their medicines properly.

The pharmacy had procedures for counselling all female patients in the at-risk group, who were taking sodium valproate. The pharmacist could locate warning cards and the MHRA guidance sheet. She gave assurances that they had no female patients in the at-risk group, receiving the drug at the time. Packs of sodium valproate in stock bore the updated warning label, except for one. But, the pharmacist had additional updated warning labels to apply to packs if needed.

Medicines and Medical equipment were obtained from: AAH, Alliance Healthcare, Sigma, and Colorama. Unlicensed 'specials' were obtained from Unichem and BCM specials. All suppliers held the

appropriate licenses. Stock was generally stored in a tidy, organised fashion. A fridge was available for storing medicines requiring cold chain storage. Staff said that fridge temperatures were read and recorded, but records could not be retrieved during the inspection. The pharmacy staff were unaware of the European Falsified Medicines Directive (FMD) and did not have the equipment for scanning products with a unique barcode.

Stock was generally stored in an organised manner. But there were two amber dispensing bottles in the MDS area which contained tablets which had been removed from their blister packs for MDS trays. The bottles had hand written labels showing the name strength and form of the contents, but no details of P/L number, batch number or expiry date. The contents had also been placed in the bottles and labelled without a pharmacist's check.

Stock was date checked infrequently, but short dated stock was highlighted with a sticker so that it could be identified and removed more easily. Records were kept. Waste medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. But the team did not have a list of Hazardous waste to refer to. The list would help ensure that they were disposing of the medicines in the most appropriate way. Drug recalls and safety alerts were responded to promptly and records were kept. Showing that recalls had been responded to up until 26th April 2019. But there was no record of staff responding to the May recall for Co-amoxiclav 125mg/ 32.5mg/5ml and Co-amoxiclav 250mg/62.5mg/5ml. Staff could not recall it.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the right equipment and facilities for the services it provides. In general, the pharmacy uses its facilities and equipment to keep people's information safe. But, it could do more to ensure that there is an accurate record of who has had access to patient records.

### Inspector's evidence

There was a CD cabinet for the safe storage of CDs. The CD cabinet was appropriately secured into place. CD denaturing kits were used for the safe disposal of CDs.

The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures were of the appropriate BS standard and clean although heavily lime scaled.

Precautions were taken to help prevent cross contamination by using a separate triangle for counting loose cytotoxic tablets, although the Methotrexate stocked was in foil strips. 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, and the drug tariff. The pharmacist said she also used the NPA advice line. Pharmacists also had access to a range of reputable online information sources such as patient.co.uk, EMC and Medicines complete.

There were two computer terminals available for use. One in the dispensary and one in the consultation room. All computers had PMR facility, 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.

It was noted that staff were all using one of the dispensers' smart cards when working on the main pharmacy computer. Staff should 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. |