General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Health First Pharmacy, 95 Wembley Park Drive, WEMBLEY, Middlesex, HA9 8HF

Pharmacy reference: 1035216

Type of pharmacy: Community

Date of inspection: 12/06/2019

Pharmacy context

This is a community pharmacy located along a parade of shops in Wembley, Middlesex. The pharmacy dispenses NHS and private prescriptions. It provides Medicines Use reviews (MURs) and the Emergency Hormonal Contraception (EHC). And it supplies some people with their medicines inside multi-compartment compliance aids, if they find it difficult to take their medicines on time.

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 manages most risks appropriately. Pharmacy team members deal with their mistakes responsibly. But, they are not always recording all the details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening. The team in general, understands how to protect the welfare of vulnerable people. And, the pharmacy protects people's private information well. But the pharmacy does not always maintain all of its records, in accordance with the law. This could mean that team members may not have all the information they need if problems or queries arise.

Inspector's evidence

The pharmacy was clear of clutter, organised and held enough space for prescriptions to be dispensed safely. There were segregated areas for staff to assemble Monitored Dosage Systems (MDS), for storing medicines that required delivery, for prescriptions to be dispensed and processed as well as a separate area for the responsible pharmacist (RP) to conduct the final accuracy-check. This helped prevent errors from interruptions and distractions.

Staff routinely recorded their near misses, the superintendent pharmacist (SI) and the manager explained that they were in the process of introducing several changes. The team identified look-alike and sound-alike (LASA) medicines, there were caution notes placed in front of stock to highlight these medicines, this included Epilim (see Principle 4) and staff described separating medicines that were involved in errors. This included moving different strengths of sertraline away from one another.

Details about near misses were collectively reviewed every month and a discussion with the team occurred to inform them about trends or patterns seen. However, information was only seen documented from January to April 2019. There were also some gaps within the near miss log where some details about the action taken in response to the error or the learning points were missing.

The manager and the SI were designated as managing complaints for the pharmacy or handling incidents. The process involved checking details, rectifying the situation, apologising, informing the person’s GP if anything had been taken incorrectly, documenting details and reporting this to the National Reporting and Learning System (NRLS). There was information on display about the pharmacy’s complaints procedure and the team had set up a ‘comments, complaints and suggestions’ box to further capture information or feedback from people.

A range of documented standard operating procedures (SOPs) were present to support the services being provided. They were implemented in February 2019, staff had read and signed the SOPs, and some were still in the process of being reviewed. Members of the pharmacy team were clear about their roles and responsibilities and they knew the activities that were permissible in the absence of the RP. An incorrect RP notice was initially on display, the inspection occurred early morning, this was discussed at the time and it was changed when highlighted.

Staff ensured no confidential material was left within areas that the public could access. Dispensed prescriptions awaiting collection were stored in a location where sensitive information could not be seen from the retail area. Staff were trained on the EU General Data Protection Regulation (GDPR) and there was information on display to inform people about how their privacy was maintained. Summary

Care Records were accessed for emergency supplies and people were asked verbally for their consent to access this.

Apart from one member of the team, remaining staff were trained and could identify signs of concern to safeguard vulnerable people. They were trained as dementia friends and informed the RP in the event of a concern. The RP was trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE). There were local contact details for the safeguarding agencies as well as a policy available for the team to use as guidance.

A complete audit trail for the receipt and destruction of returned CDs was maintained. The team checked the minimum and maximum temperature of the fridge to ensure medicines were appropriately stored here. Daily records were kept verifying this.

A sample of registers checked for Controlled Drugs (CDs) were maintained in line with the Regulations. Balances for CDs were checked and documented every month, this included routine overage checks for methadone. On randomly selecting CDs held in the cabinet (MST, Shortec), their quantities matched the balance entries in the corresponding registers.

The pharmacy's other records were largely compliant with statutory requirements. This included most of the RP record, records of unlicensed medicines and emergency supplies. There were occasional missing entries in the former where pharmacists had failed to record the time that their responsibility ceased, on occasion, prescriber details were missing from records of unlicensed medicines and some records for the latter only included "Rx to follow" instead of the nature of the emergency.

There was only one date seen recorded for records of private prescriptions, some private prescriptions were present, that were dated from 12 May 2019, whose details had not been entered in the register, in line with legal requirements and a prescription from a hospital outpatient's department, that was dispensed at the pharmacy but instructed the person to "take to the pharmacy in the hospital". This was discussed at the time.

The pharmacy's professional indemnity insurance was through the National Pharmacy Association (NPA), the certificate to verify this was seen and it was due for renewal after 3 December 2019.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. In general, pharmacy team members understand their roles and responsibilities. They are provided with resources to complete ongoing training. This helps to ensure that their skills and knowledge are kept up to date.

Inspector's evidence

The pharmacy dispensed between 4,500 to 5,000 prescription items every month with 50-70 people receiving their medicines inside MDS trays and two people with instalment prescriptions.

The staffing profile included the superintendent pharmacist, three trained dispensing assistants, one of whom was the pharmacy manager, a regular pharmacist, a pre-registration pharmacist and a trained medicines counter assistant (MCA). The latter three were not present during the inspection. All staff were trained through accredited routes and their certificates of qualifications obtained were seen to verify this.

Staff used a range of questions to obtain relevant information before they sold over-the-counter (OTC) medicines and if they were unsure, details were brought to the attention of the RP. The team held sufficient knowledge of OTC medicines to sell these safely.

Staff completed regular and ongoing training, this was through completing online modules from CPPE, reading trade magazines, using resources from other pharmacy websites (such as the Pharmaceutical Services Negotiating Committee) and they received literature/instruction from the pharmacists as well as from the manager. Their progress was checked annually through formal appraisals. As they were a small team, they communicated verbally, regularly discussed details between them and used a diary.

The superintendent pharmacist described a target to complete 40 MURs every month, she stated that this was not routinely achieved, nor strictly enforced and no pressure was applied to achieve this.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are secure and provide an appropriate environment for the delivery of its services.

Inspector's evidence

The premises consisted of a medium sized retail area and dispensary at the rear. The pharmacy was bright and appropriately ventilated. The retail area was professional in appearance and most areas were clean. A signposted consultation room was available, where services and private conversations could be held, and the space was of a suitable size for this purpose. Pharmacy (P) medicines were stored behind the front counter and staff were always present to help prevent the self-selection of these medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team is helpful and tries to ensure people with different needs can easily access the pharmacy's services. The pharmacy sources, stores and manages most of its medicines appropriately. Members of the pharmacy team try to ensure their services are provided safely. They highlight prescriptions that require extra advice and they take extra care with most people receiving high-risk medicines. This helps ensure that people can take their medicines safely. But, team members fill compliance aids, then leave them unsealed while they wait for them to be checked. This means the medicines are not very well protected if left overnight and may also increase the risk of mistakes happening.

Inspector's evidence

There was a slight ramp, from the street at the pharmacy's entrance. This, along with the wide, front door and clear, open space inside the premises meant that people requiring wheelchair access could easily use the pharmacy's services. There were three seats available for people waiting for prescriptions and a range of leaflets on display about other services. Staff physically assisted people who were visually impaired, they provided written information for people who were partially deaf, and could explain details in Arabic, Dutch, Farsi, French, Urdu, Nepalese and Hindi for those whose first language was not English. Team members explained that because they were multilingual, they also provided written information in these languages to help explain and aid understanding if required.

One of the dispensing assistants delivered medicines in the evening or if urgent, CDs or fridge items were required, this occurred during the day. The team kept audit trails to demonstrate when and where medicines were delivered, and this included identifying CDs and fridge items. People were contacted before an attempt to deliver occurred, staff obtained people's signatures when medicines were delivered and brought back failed deliveries. They left notes to inform people about the attempt made and did not leave medicines unattended.

MDS trays were supplied initially through the person's GP. The team ordered prescriptions on behalf of people with trays, when these were received, details on prescriptions were cross-referenced against individual records to help identify changes or missing items. Queries were checked with the prescriber and audit trails were maintained to demonstrate this. A communication book was also used. Descriptions of medicines within trays were provided and Patient Information Leaflets (PILs) were routinely supplied. All medicines included in trays were de-blistered and removed from their outer packaging. Mid-cycle changes involved trays being retrieved, amended, re-checked and re-supplied.

Trays were routinely left unsealed overnight. There were several trays present that were prepared, in some instances, the week before the inspection and left unsealed before they were checked for accuracy by the RP. There were also trays present for some females at risk, who were receiving Epilim inside the trays, some of them were dispensed four weeks at a time. There had been no checks made with the person, if this was necessary, in line with guidance released from the Medicines and Healthcare products Regulatory Agency (MHRA) and the team appeared to be unaware about stability concerns and suitability for its inclusion inside trays. The RP was instructed to re-assess the pharmacy's processes here, consult reference sources, check with representatives and the persons' prescriber as well as to re-train and educate the team. Evidence was received that the pharmacy's process was subsequently amended.

The pharmacy team used baskets to hold each prescription and associated medicines. This prevented any inadvertent transfer. Staff used a dispensing audit trail to verify their involvement in processes and this was through a facility on generated labels.

Staff were aware of risks associated with valproate, there was literature present to provide to people, caution notes on the shelf where this medicine was stored, as an additional highlight and the team described informing the RP if prescriptions for females at risk were seen. Prescriptions for higher-risk medicines were identified to enable counselling and for relevant parameters to be checked. Staff explained that they called people who received these medicines inside MDS trays to obtain this information, this included routinely asking people prescribed warfarin about their International Normalised Ratio (INR) level and blood test results for people prescribed lithium. There were details seen documented to confirm this.

Stickers were used on dispensed prescriptions requiring collection to identify higher-risk medicines, fridge items and CDs (Schedules 2-4). Uncollected medicines were checked and removed every three months. The pharmacy used licensed wholesalers to obtain medicines and medical devices, this included AAH, Alliance Healthcare, Sigma and Colorama. Unlicensed medicines were obtained through Colorama. The team was complying with the European Falsified Medicines Directive (FMD). The pharmacy was registered with SecurMed, the pharmacy system had been updated and relevant equipment was present. Staff were provided with information about the process.

In general, medicines were stored in an organised manner. Staff described checking expiry dates on medicines whilst they unpacked orders, they also routinely date-checked medicines every three months and used a schedule to demonstrate the process. Short-dated medicines were identified using stickers and there were no date-expired medicines seen. Medicines were stored in clear bags in the fridge and CDs were stored under safe custody, the keys to the cabinets were maintained in a manner that prevented unauthorised access during the day as well as overnight. Drug alerts were received by email. The process involved checking for stock, acting as necessary and an audit trail was available to verify this.

On occasion, the team stored some medicines as loose blisters and in poorly labelled containers. Ensuring medicines were appropriately stored, including recording full details for those medicines stored outside of their original containers was discussed during the inspection. The team managed this on the day.

Once accepted, the team stored returned medicines requiring disposal within appropriate receptacles. People bringing back sharps for disposal were referred to the local council or GP surgery. Returned CDs were brought to the attention of the RP, segregated in the CD cabinet before destruction and relevant details entered into a CD returns register.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

There were current versions of reference sources, a range of clean, crown stamped conical measures present for liquid medicines, pill cutters and counting triangles available. This included a separate triangle for cytotoxic medicines.

Computer terminals were positioned in a way that prevented unauthorised access. Staff used their own NHS smart cards to access electronic prescriptions and took them home overnight. The dispensary sink used to reconstitute medicines was clean, there was hot and cold running water available as well as hand wash present. The fridge was appropriate for the storage of medicines and the CD cabinets were secured in line with legal requirements.

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.