General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Park Lane Pharmacy, 27-29 High Street, CARSHALTON, Surrey, SM5 3AX

Pharmacy reference: 1036463

Type of pharmacy: Community

Date of inspection: 12/03/2020

Pharmacy context

This is a Healthy Living Pharmacy (HLP) in the centre of Carshalton, Surrey. It dispenses NHS and private prescriptions. And also sells a range of over-the-counter medicines and provides health advice. The pharmacy offers flu vaccinations in the autumn and winter seasons. And home deliveries for those who cannot get to the pharmacy themselves. It supplies some medicines in multi-compartment compliance aids for those who may have difficulty managing their medicines.

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

The pharmacy provides its services in a safe and effective manner. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They work to professional standards and identify and manage risks appropriately. They understand their role in protecting vulnerable people, and they keep people's private information safe. They log the mistakes they make, and regularly review them together so that they can learn from them and act to avoid repeating problems. But the pharmacy is not keeping a satisfactory record of those reviews. Otherwise it generally keeps its records in a satisfactory manner. And it has appropriate insurance to protect people if things go wrong.

Inspector's evidence

There were standard operating procedures (SOPs) in place to underpin all professional standards, and all due for review at varying dates in 2020 and 2021. The responsible pharmacist (RP) explained that they were updating their SOPs across the whole company and he was setting up a numbered filing system in accordance with this. He had a checklist showing which folders had been updated and which were yet to be done, and by whom. Signature sheets had been signed by staff to indicate that they had read and understood them. The pharmacy also had a detailed business continuity plan in place to maintain its services in the event of a power failure or other major problem. The pharmacy had recently received an updated COVID-19 SOP detailing actions to be taken to minimise the risks associated with coronavirus. Posters had also been put on display in the window for people to see before entering the pharmacy.

Errors and near misses were recorded using a paper form displayed on the dispensary wall, showing what the error was, the members of staff involved and the action taken. The record sheet was current and indicated the near misses that had occurred, the possible reasons and evidence of reflection and learning. There were monthly patient safety reports which identified actions taken to reduce the risk of patient safety incidents, but the last documented report was dated June 2019. The RP explained that he had joined the pharmacy in September and had been holding monthly reviews but had not documented them. Upon reflection he agreed to start documenting them. Actions taken to minimise the risk of error included highlighting look alike soundalike medicines (LASAs) and labelling some of the shelves.

Roles and responsibilities of staff were not specifically documented in the SOPs. However, those questioned were able to clearly explain what they do, what they were responsible for and when they might seek help. They outlined their roles within the pharmacy and where responsibility lay for different activities.

Staff were able to describe what action they would take in the absence of the responsible pharmacist, and they explained what they could and could not do. The responsible pharmacist (RP) notice was clearly displayed for patients to see and the RP log held on the patient medication record (PMR) computer system was complete.

Results of the latest Community Pharmacy Patient Questionnaire (CPPQ) were displayed online at www.nhs.uk and at the pharmacy reception counter. The results were positive overall and areas for improvement highlighted by the CPPQ included the provision of stop smoking advice and improved

stock control to reduce owings. There was no visible pharmacy complaints procedure available for people to see or refer to. The RP agreed to print one and put it on display. A certificate of professional indemnity and public liability insurance from Numark valid until June 2020 was on display in the dispensary.

Private prescription records were maintained on the patient medication record (PMR) system and were complete with most details correctly recorded. But, some of the prescriber details were either incorrect or missing. The emergency supply records were completed on the PMR system, and most had been redeemed against valid prescriptions. Those outstanding were all recent and the pharmacist was expecting to receive prescriptions shortly. Valid reasons for these supplies had been recorded and the level of detail was generally satisfactory.

The CD registers were seen to be correctly maintained, with running balances checked at regular monthly (methadone was checked weekly) intervals in accordance with the SOP. The RP explained how he had set up a reminder on his phone to ensure he did not forget. Running balances of two randomly selected CDs were checked and both found to be correct. Alterations made in the CD register were asterisked with a note made at the bottom of the page, and they were initialled with the pharmacist's registration number and date. Records of CDs returned by patients were seen to be made upon receipt and subsequent destruction documented and witnessed. Records of unlicensed "specials" were all complete with the prescriber details, although some only recorded the surname.

All staff were able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. They were able to provide examples of how they protect patient confidentiality, for example not discussing patient's medication in front of other people or keeping prescriptions out of sight. The driver's delivery sheets were arranged in such a way as to avoid potential breaches of confidentiality. People signing for their delivery were not able to see other people's personal details. Completed prescriptions in the prescription retrieval system were out of sight of people waiting at the counter and were stored behind opaque roller blinds. Confidential waste was kept separate from general waste and shredded onsite. A privacy notice was on display opposite the prescription reception counter.

There were safeguarding procedures in place and contact details of local referring agencies were seen on display near the labelling workstation in the dispensary. The pharmacist had completed level 2 safeguarding training, and the rest of the team had been trained to recognise the signs to look out for. One of the dispensing assistants explained how she would immediately draw any concerns to the attention of the pharmacist. All staff were dementia friends.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload safely. And they work well together. Pharmacy team members are well trained and have a good understanding of their roles and responsibilities. They can make suggestions to improve safety and workflows where appropriate.

Inspector's evidence

There was one member of staff present whose role combined the duties of both medicines counter assistant (MCA) and dispensing assistant. There was also one dispensing assistant, one beauty counter assistant and the RP on duty during the inspection. This appeared to be appropriate for the workload and everyone was working well together. In the event of staff shortages, the pharmacist could call upon other local branches to help where possible. He could also call upon the SI for assistance if necessary.

Training records were seen confirming that all staff had completed, or were completing, the required training. Both of the dispensers were currently completing the NVQ2 combined dispensing and counter assistant course from ‘Buttercups’. The records for each were seen, together with a pathway leading to accredited qualifications. The beauty assistant was not registered on any accredited pharmacy training as her role did not involve any pharmacy work. Staff were able to demonstrate an awareness of potential medicines abuse and could identify patients making repeat purchases. They described how they would refer to the pharmacist if necessary. The dispensers and pharmacist were seen to serve customers, and all were asking appropriate questions when responding to requests or selling medicines. Team members said that they could raise concerns and there was a whistleblowing policy in place. There were targets in place, but they were applied reasonably and did not impact upon the professional judgement of the pharmacist. He confirmed that he was comfortable with making decisions and did not feel pressurised to compromise his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a secure and professional environment for people to receive its services. The pharmacy keeps its premises satisfactorily maintained. It has a consultation room which it uses regularly for some of its services and for sensitive conversations.

Inspector's evidence

The pharmacy premises were large and in a reasonable state of repair, although the dispensary floor was looking worn in places. There was step-free access through single doors, and sufficient space to allow wheelchair access. There was a spacious dispensary, providing sufficient space to work safely and effectively, and the layout was suitable for the activities undertaken. There was a clear workflow in the dispensary. The dispensary sink only had cold running water, and handwash was available. Hot running water was available in the staff area beside the dispensary.

The pharmacy's consultation room was used for confidential conversations, consultations and the provision of pharmacy services. Access to this was through the entrance to the dispensary and past the area used for prescription retrieval. Patient details on prescriptions awaiting collection had been obscured by opaque roller blinds which were kept closed. The door to the consultation room was kept closed when the room was not in use and people could not access this without passing a member of staff. There was a sink with cold running water and a password-protected PMR terminal in the room.

There was also a separate room which was rented to a local chiropodist who provided his services on two days per week. The pharmacy staff's only involvement in this service was to take bookings and maintain the appointments diary on his behalf.

The toilet areas were clean and well maintained. Room temperatures were appropriately maintained by a fans and heaters (depending upon the season) keeping staff comfortable and suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, and people with a range of needs can access them. The pharmacy sources, stores and manages its medicines safely, and so makes sure that all the medicines it supplies are fit for purpose. It responds well to drug alerts or product recalls so that people only get medicines or devices which are safe for them to take. It identifies people supplied with high-risk medicines and carries out most of the checks it should. But it is not doing enough to record all of those checks.

Inspector's evidence

A list of pharmacy services was displayed in the shop window and there was a health zone inside the pharmacy with health information on display. The pharmacy provided a limited range of services including seasonal flu vaccinations during the autumn and winter.

Controls were seen to be in place to reduce the risk of picking errors, such as highlighting those medicines considered to be vulnerable to errors. They used colour-coded baskets to keep individual prescriptions separate, and to highlight those waiting for collection and those calling back later. Prescription labels were initialled to show who had dispensed and checked them. Owings tickets were in use when medicines could not be supplied in their entirety. The dispensing assistant explained how they would try to obtain the missing item(s) from other local branches, and if that was not possible then they would email the GP with a suggested alternative that they could obtain.

There was one prescription for a schedule 3 CD found in retrieval which had recently passed its expiry date. The RP explained how uncollected prescriptions for CDs were usually annotated with their expiry date so that staff would know whether they could hand them out or not. The RP explained that they cleared the retrieval shelves every four weeks. Any CDs approaching expiry and still awaiting collection were removed. Fridge lines in retrieval awaiting collection were highlighted so that staff would know that there were items to be collected from the fridge.

Compliance aids were dispensed in a separate room beside the dispensary, away from distractions. They were managed by one of the dispensing assistants, who ensured that prescriptions were ordered in sufficient time. The prescriptions and the medication times were checked, and any discrepancies were followed up before dispensing. The compliance aids were always sealed as soon as she had assembled them ready for the pharmacist to complete the final check. They were placed in a designated checking area before being checked by the pharmacist. Compliance aids were seen to include product descriptions on the backing sheet and patient information leaflets (PILs) were always supplied. Warfarin, epilim and alendronic acid were supplied separately.

Staff were aware of the risks involved in dispensing valproates to people who could become pregnant, and all such patients would be counselled and provided with leaflets and cards highlighting the importance of having effective contraception. Patients on warfarin were asked if they knew their current dosage, and whether their INR levels had been recently checked as part of the PQS audit. These interventions were not recorded on patient’s individual PMR and the figures themselves were not routinely asked for. Patients taking methotrexate and lithium were also asked about blood tests. The pharmacy had completed the recent Pharmacy Quality Scheme (PQS) audit on these high-risk

medicines, and upon reflection the RP agreed to continue recording these interventions on the PMR system. There were yellow warfarin books, lithium record cards and methotrexate record cards available to offer patients who needed them.

There were valid signed PGDs for both private and NHS seasonal influenza vaccination services, both expiring in March 2020. The private PGD was from 'Pharmadoctor' and it could only be accessed online by the pharmacists authorised to carry out the vaccinations. In order to obtain a login, they had to submit evidence of training and their declaration of competence. Records were seen of consent and of vaccinations provided, for both the private and the NHS services.

The pharmacy participated in the locally commissioned minor ailments scheme, although the RP explained that this service was due to finish at the end of March 2020. There was a notice on display advising people of this. There was a file containing the formulary for the service, and the associated administration was completed and submitted online via the 'service pact' website. Records were all kept online and shared with the relevant GP practice. The RP explained that this had now been superseded by the recently introduced Community Pharmacist Consultation Service (CPCS). There had been very little uptake of the new service to date.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance, Sigma. Unlicensed 'specials' were obtained from Quantum. Appliances were obtained from North West Ostomy Supplies (NWOS). The RP explained how they used the agency scheme from NWOS for some appliance prescriptions. They didn't currently have a notice or a procedure for letting people know that their prescriptions may be processed elsewhere. Upon reflection the RP agreed to contact NWOS for a suitable notice and for some guidance. The pharmacy had the scanners necessary to comply with the Falsified Medicines Directive (FMD) but they were waiting for their software to be registered before starting to decommission products.

Routine date checks were seen to be in place, and record sheets were seen to have been completed. Stock with a shelf life of less than three months was highlighted and then disposed of one month prior to expiry. The RP explained how he would use his professional judgement to determine whether to dispose of some items earlier depending upon their usage and typical duration of supply. Opened bottles of liquid medicine were annotated with the date of opening, and there were no plain cartons of stock seen on the shelves. No boxes were found to contain mixed batches of tablets or capsules.

Fridge temperatures were recorded daily and all seen to be within the 2 to 8 Celsius range. Staff explained how they would note any variation from this and check the temperature again until it was back within the required range. Pharmacy medicines were displayed behind the medicines counter, preventing unauthorised access or self-selection of those medicines.

Patient-returned medicines were screened to ensure that any CDs were appropriately recorded, and to see whether there were any sharps present. People returning sharps were signposted to the local council. There was no separate purple-lidded hazardous waste container present, and the RP thought that it had been collected by the waste contractor and not replaced. The RP subsequently agreed to obtain one and to print a copy of the list of hazardous medicines from their SOP. Denaturing kits for the safe disposal of CDs were available for use. The pharmacy received drug alerts and recalls from the MHRA, copies of which were seen to be kept in a file. Each alert was annotated with any actions taken, the date and initials of those involved. The RP explained how he also completed an update on google docs for the SI so that he could check that all alerts had been acted upon. The team knew what to do if they received damaged or faulty stock and they explained how they would return them to the wholesalers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for the range of services it provides. It takes reasonable steps to ensure that people’s private information is kept safe and secure.

Inspector's evidence

The pharmacy has the necessary resources required for the services provided, including a range of crown stamped measuring equipment, counting triangles (including a separate one for cytotoxics), reference sources including the BNF and BNF for children. The pharmacy also had internet access and used this as an additional reference source.

The blood pressure meter was thought to have been replaced every year, but the current one was dated November 2017. The RP immediately put it aside and made arrangements to obtain a new one. Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Computer screens are positioned so they are not visible to the public except when accessing the consultation room.

Staff were seen to take precautions such as moving to the rear of the dispensary when making telephone calls so as not to be overheard. NHS smartcards were seen to be used appropriately and with no sharing of passwords. They were not left on the premises overnight. Confidential information was kept secure and items awaiting collection were not visible from retail area

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.