General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: PC Pharmacies, 12 Back Lane, RICHMOND, Surrey, TW10 7LF

Pharmacy reference: 1036709

Type of pharmacy: Community

Date of inspection: 24/10/2019

Pharmacy context

An independent community pharmacy. One of two belonging to the same company. The pharmacy is on a small parade of four locally run shops and businesses, in a residential area of Richmond. As well as NHS Essential Services, the pharmacy provides Medicines Use Reviews (MURs), New Medicines Service (NMS) and a delivery service for urgent prescriptions and the housebound. The pharmacy also provides medicines in multi-compartment compliance packs for many people in the community. It also provides a substance misuse prescription service. EHC, ED, Travel vaccinations, anti-malarials and a seasonal flu vaccination 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. They 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 do not always keep the pharmacy's records in the way the law requires.

Inspector's evidence

Staff worked in accordance with a set of standard operating procedures (SOPs), under the supervision of the responsible pharmacist. The responsible pharmacist notice was displayed for the public to see. Staff said they had read the SOPs relevant to their roles, but they had not signed them. SOPs were last reviewed in 2017 and were therefore due for review. The pharmacy had a procedure for managing risks in the dispensing process, but it wasn't always followed. According to procedure, all incidents, including near misses were to be recorded and discussed, but the last recorded near miss was three months earlier. Records that had been made did not provide details of what had led to the mistake and what would be done differently in future. Without accurate records of what had gone wrong it may be difficult for the pharmacists and staff to conduct a thorough review of their mistakes so that they could continue to learn from them. This could be particularly relevant for staff in training such as the pre-registration pharmacist (pre-reg.) Staff reported that the superintendent (SI) recorded learnings on the quality payments recording system, but these were not available at the time of the inspection.

However, it was clear that the team discussed any incidents and were aware of the risk of error. The pre-reg. described how the pharmacist would discuss mistakes with her, coaching her to note all the details for the drug prescribed, including drug form and strength to prevent her from automatically selecting the most commonly prescribed variety of drug. But she did not routinely record her mistakes or what she had learned. The pharmacy team met every two weeks. During meetings they would discuss anything that had gone wrong including any near misses or errors. The dispenser said they had recently discussed ways of making sure that patients were ordering everything they required, so that they didn't run out.

The pharmacy team had a positive approach to customer feedback. The most recent survey had produced a 100% satisfaction rating. The dispenser described how they ordered the same brands of medicines for certain people to help them to take their medicines properly. Customer preferences included the Actavis brand of amlodipine 5mg and the Teva brand of furosemide 40mg, amongst others. All preferred brands had been stored separately to make sure they were kept for the people who needed them.

The pharmacy had a documented complaints procedure. A documented SOP for the full procedure was available for reference. Customer concerns were generally dealt with at the time by the responsible pharmacist (RP) where possible and the owner informed. Staff said that complaints were rare but if they were to get a formal complaint it would be recorded. Details of the local NHS complaints advocacy and PALs were available on a leaflet on the counter. The most common source of concern from customers recently had been about medicines shortages. The dispenser described how they liaised with

surgeries to try to find alternatives for people after checking what was available from their wholesalers. The pharmacy had managed to source hormone replacement therapy (HRT) products which people had been unable to obtain elsewhere. 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 April 2020 when they would be renewed for the following year.

All the necessary records were kept and were generally in order including CD registers and records for unlicensed 'Specials'. Records of CDs which had been returned by patients, for destruction, were kept for audit trail and to account for all the non-stock Controlled Drugs (CDs) which pharmacists had under their control. The RP records were generally in order but had several omissions at the time when the RP's responsibilities ceased, and emergency supply records did not give a clear reason for supply. Records for private prescriptions were generally in order although did not show a date of dispensing.

Staff were aware of the need to protect confidentiality and had been briefed on their responsibilities regarding GDPR. Discarded patient labels and prescription tokens were shredded daily. Completed prescriptions were stored in the dispensary in a way that patient details couldn't be viewed from the counter and customer areas. But, customers were observed leaning over the dispensing bench at the prescription reception area, near to where dispensed prescriptions were awaiting a check. The pharmacist on duty had completed level 2 CPPE training for safeguarding children and vulnerable adults. Support staff had been briefed on their responsibilities. 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 employers and are involved in improving the pharmacy's services.

Inspector's evidence

The pharmacy was run by two regular responsible pharmacists (RPs). The superintendent worked the equivalent of three days per week (one full day and three half days) and a regular locum covered the remaining shifts. Pharmacists were supported by an overseas pharmacist dispenser and a pre-reg. On the day of the inspection the locum RP was supported by the dispenser and pre-reg. There appeared to be an adequate number of appropriately skilled staff. Staff were up to date with the daily workload of prescriptions, and customers were attended to promptly. Staff were observed to work well together, each attending to their own tasks and assisting one another when required. The dispenser was observed coaching the pre-reg. He said that he encouraged her to talk to people and listen attentively to them. And to always clarify what they wanted and what their expectations were. He felt it was important to engage with people and also to keep them up to date with what was happening with their prescriptions, particularly where there were problems.

The dispenser had worked at the pharmacy for over five years. He said that the pharmacy team had regular meetings in which he and his colleagues could raise concerns and make suggestions about how to improve the quality of services. He also had regular informal discussions with pharmacists on a day to day basis. He described how he had suggested printing out records of daily sales to analyse what was selling and what wasn't. This helped him to reorder items which they had sold so that they could be reordered easily for the next time. The pharmacist was not set targets for services such as MURs and was able to make autonomous professional decisions. He felt that he could prioritise his tasks in accordance with people's needs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean and professional looking. They provide a safe, secure environment for people to receive healthcare services. But storage arrangements meant that it did not look as tidy and organised as it could.

Inspector's evidence

The pharmacy was on a small parade of shops which was on a quiet road running through a residential area. The pharmacy's premises had a traditional appearance. They had a double front with full height windows, and a glass door, which provided natural light. There were steps and a grab bar at the pharmacy entrance. The shop floor was to the front with the dispensary in the corner. The counter was at right angles to the dispensary on a side wall. The shop floor was small but kept clear of obstructions and there was a seat for waiting customers. Items stocked included a range of baby care, healthcare, beauty and personal care items. The pharmacy was tidy and organised and had a professional appearance. Shelves, worksurfaces, floors and sinks were clean.

The dispensary was compact. Completed prescriptions were stored on shelves in the dispensary but, a lack of storage space meant that bulky prescriptions were stored on the dispensary floor. The dispensary had approximately six metres of dispensing bench to the front and a further three to four metres of dispensing bench, to the back. And a sink. The front dispensing bench was where most of the dispensing and checking took place. The dispensary had a small reception area at the front dispensing bench. The reception area was at the furthest point away from the counter. And so, provided a greater degree of privacy for patients handing in or collecting prescriptions. However, prescriptions in baskets on the bench could potentially be viewed by people standing here.

There was a consultation room, accessible from the shop floor. The door to the consultation room was closed but not locked. The room was used to store a small number of folders which contained patient confidential information. While it was unlikely that a member of the public would enter the room unnoticed, the information could be kept more securely if the room was locked. The pharmacy had a second consultation room which was used as a general store room. The pharmacy had a small cupboard storage area to the rear of the dispensary for storing files and folders and some dispensing stock. The back-shop area also had a stock room and a staff toilet. All these areas were clean and tidy. Access to the dispensary and consultation area was authorised by the Pharmacist.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes them 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 store all of its medicines appropriately, once they have been removed from their original packs. While team members generally give people the advice they need, they do not always give people enough information to help them take their medicines safely and properly.

Inspector's evidence

A selection of pharmacy's services were advertised at the front window and there was a poster advertising the flu vaccination service. There was a small range of information leaflets available for customer selection. The pharmacy had three steps up at the entrance and so wheelchair users could not enter the premises. Staff would help people over the threshold when required and would also serve people at the door if that was more appropriate. The pharmacy offered a prescription collection service although the need was rare. It also offered a prescription ordering service for those who had difficulty managing their own prescriptions. The pharmacy also had a smart phone 'app' through which people could order their repeat prescriptions. The pharmacy also dispensed private prescriptions issued by the on-line prescribing service Medic spot.

There was a set of SOPs in place. In general, staff appeared to be following the SOPs. A CD stock balance was carried out on a regular basis as per the SOP, and the quantity of stock checked (Oxycontin 10mg tablets) matched the running balance total in the CD register. Multi-compartment compliance packs were provided for people who needed them. Patient information leaflets (PILs) were offered to patients with new medicines but not on a regular basis thereafter. While labels on compliance packs had the required BNF advisory information, to help people take their medicines properly, the packs were supplied without a description of colour and shape, so it would have been difficult for people to identify which medicine was which.

The pharmacy had procedures for targeting and counselling all patients in the at-risk group taking sodium valproate. Staff couldn't locate warning cards, or the MHRA guidance sheet but the RP said he had read the safety alert information issued by the MHRA and offered counselling as appropriate. Packs of sodium valproate in stock bore the updated warning label. The pharmacy had up to date PGDs in place 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 the equipment and software for scanning products in accordance with the European Falsified Medicines Directive (FMD) but were not yet scanning all packs with a unique barcode. Medicines and Medical equipment were obtained from: Alliance Healthcare, Sigma, DE Pharmaceuticals, Colorama and AAH. Unlicensed 'specials' were obtained from Thame laboratories. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. However, there was a pack of fexofenadine 120mg tablets (Chanelle brand) on the shelf which contained several strips of loose tablets from different manufacturers. Strips also had their expiry dates missing. A pack of fluoxetine was found to contain two different brands and a pack of Ibuprofen contained five different brands. Staff were unsure as to why the tablets had been stored this way or for

how long.

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. General stock was regularly date checked and records kept. Short-dated stock was highlighted with a sticker. Waste medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. But the staff did not have a list of hazardous waste to refer to, which would help ensure that they were disposing all medicines appropriately. Drug recalls and safety alerts were generally responded to by the pharmacist and records kept. None of the affected stock was found in any recent recalls, including the recall for ranitidine tablets.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And, it uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had a CD cabinet for the safe storage of CDs. The cabinet was secured into place in accordance with regulatory requirements. 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 generally clean. The pharmacy had a separate measure for measuring methadone, but it contained a watery residue of methadone from when it was last used. But, staff said they would always clean equipment before use, if it did not look clean. Tablet triangles were clean. And amber dispensing bottles were stored with their caps on. Bottles were capped to prevent contamination with dust and debris.

There were up to date information sources available in the form of paper copies of the BNF, BNF for children and the drug tariff. Pharmacists also used the NPA advice line service and used the interaction checker on the computer. They also had access to a range of reputable online information sources such as EMC. There was one computer terminal available for use in the dispensary. The computer had a PMR facility. It was password protected and out of view of patients and the public. A separate computer was available for general admin and management tasks. Patient sensitive documentation was generally stored out of public view in the pharmacy and confidential waste was collected for shredding. The pharmacist used his own smart card when working on PMRs. Staff generally used their own smart cards although the dispenser’s smart card had been used by staff all day, even when he was on a break. 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.