General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Richmond Pharmacy, 82-86 Sheen Road, RICHMOND, Surrey, TW9 1UF

Pharmacy reference: 1036718

Type of pharmacy: Community

Date of inspection: 08/11/2019

Pharmacy context

The pharmacy belongs to a small group of independently owned community pharmacies and is on a main road in a residential area of Richmond. As well as NHS essential services the pharmacy provides medicines in multi-compartment compliance packs for people in the community and in a local care home. Other services include: Medicines Use Reviews (MURs), New Medicines Service (NMS) and seasonal flu vaccinations. The pharmacy also offers a supervised consumption service and needle exchange.

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

In general, the pharmacy's working practices are safe and effective. Its team members 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 yet do enough in the way that they gather information and use it to learn and improve.

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 them to follow. SOPs were last reviewed approximately two years previously, so were due for review. The pharmacy had recently recruited an EU qualified pharmacist, who was gaining experience and improving her language skills by working as an assistant in the dispensary and on the counter. She had been coached on procedures but had yet to read and sign SOPs.

The RP was a locum who had taken up regular employment at the pharmacy approximately two weeks earlier and was in the process of familiarising himself with the pharmacy's procedures. There had not been any near misses recorded in the previous seven months. The RP said that he had been aware of the lack of records and intended to re-introduce a procedure for recording, monitoring and reviewing any incidents as soon as possible. He said that, currently, mistakes were rare. He described his dispensing and checking procedure, whereby he checked each item and label against the prescription when dispensing. He then performed a second check and left a break before doing a final accuracy check. If another member of the team made a mistake he would discuss it with them at the time so that they could learn from it and find ways of preventing a reoccurrence. But, without accurate records of what had gone wrong it may be more difficult for the team to conduct a thorough review of their mistakes so that they could reflect on their dispensing procedures and identify what should be done differently next time. But, it was evident that the RP managed risks in other ways. He had placed brightly coloured notices in front of products at risk of error such as 'look-like-sound-alike' drugs (LASAs) including amlodipine and amitriptyline and also in front of high-risk drugs such as methotrexate.

The RP described how they ordered the same brands of medicines for certain people to help them take their medicines properly and to avoid supplying people with brands they may be sensitive to. Customers' preferences included the Teva brands of cetirizine and amlodipine tablets. The pharmacy had a procedure for handling complaints. A documented SOP for the full procedure was available for reference. Customer concerns were generally dealt with at the time by the RP where possible and the owner informed. Most recently, customer concerns were to do with medicines shortages. The RP said he worked with local GPs by suggesting alternative brands and also with other pharmacy's nearby to try to get what people needed. Staff said that formal complaints were rare but if they were to get a complaint it would be recorded. Details of the local NHS complaints advocacy and PALs could be provided on request. 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 31st August 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

private prescriptions and the responsible pharmacist. Records of returned CDs were also kept for audit trail and to account for all the non-stock controlled drugs (CDs) which pharmacists had under their control. But several records for unlicensed 'Specials' did not provide patient labelling and prescriber details. And, records for emergency supplies did not all have a clear reason for supply.

The assistant (EU pharmacist) had been briefed and understood the importance of confidentiality although had yet to read a confidentiality agreement. Discarded patient labels and prescription tokens were shredded on a regular basis. Completed prescriptions were stored in the dispensary in a way that patient details couldn't be viewed from the counter and customer areas. Discarded waste, containing confidential information, was shredded. Staff said that any confidential information, in customer accessed areas of the dispensary and consultation room, would be removed or hidden prior to a consultation. 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 one another which will help the pharmacy maintain the quality of its services.

Inspector's evidence

The pharmacy was run by the regular RP who had been in post for two weeks. The superintendent worked a regular Saturday morning. Pharmacists were supported by a trained dispenser on a Saturday morning and the new assistant (EU pharmacist) who worked on both the counter and dispensary. At the time of the inspection the pharmacy was run by the regular RP and the assistant. There appeared to be an adequate level of appropriately skilled staff. The RP felt supported in his role although staff shortages from time to time could still be a problem. The pharmacy had been run by locums for almost a year prior to the RP taking up his post and his main priority was to steady the service and to organise and tidy the dispensary, whilst reviewing procedures.

Staff were observed to work well together. The RP was observed coaching the assistant, and they were seen to assist another when required. The team was up to date with the daily workload of prescriptions, and customers were attended to promptly. The assistant described being able to ask for help and support. Although she had worked only for a short time at the pharmacy she said she had regular informal discussions with RPs on a day to day basis. The RP was not set targets for services such as MURs and Flu vaccinations and was able to make autonomous professional decisions. He felt he could prioritise his tasks in accordance with people’s needs.

Principle 3 - Premises ✔ Standards met

Summary findings

In general, the pharmacy's premises are clean, tidy and organised. They provide a safe, secure and professional environment for people to receive healthcare services. But, in some areas, the pharmacy's floors and general decor does not look as clean as it could and needs to be refreshed.

Inspector's evidence

The pharmacy was on a parade of shops on a busy main road. The pharmacy's premises had a dated appearance. They had a double front with full height windows, and a glass door, which provided natural light. The pharmacy had a ramp outside giving step-free access. It had a gradual slope from the entrance into the main customer area where there had once been steps? The flooring had recently been renewed but the area around the entrance had yet to be finished. The floor here was covered with several mats which might present a trip hazard. The shop floor was kept clear of obstructions. There was enough room for wheelchair users. There was a seat for waiting customers. Items stocked included a range of baby care, healthcare, footwear, beauty and personal care items.

The pharmacy had an elongated layout. The dispensary occupied two distinct areas, connected through a doorway. It had a medicines counter alongside it on one side and a small fold down counter on the other. This small counter was quieter and offered more privacy for people. This part of the dispensary was used mainly for dispensing multi-compartment compliance packs and methadone. Pharmacists could dispense methadone here and hand it to methadone clients in relative privacy. The consultation room was also an office. It was at the back of the dispensary and customers would have to walk through this area of the dispensary to access it. The pharmacist said that they would ensure that all patient sensitive information was hidden from view when the room was used. In general, dispensed prescriptions were stored so that patients' details could not be viewed by the public. The area of dispensary nearest the counter was compact but was where most of the dispensing and checking took place. It had a short dispensing and checking bench, a central island providing extra dispensing surface and a run of shelves on two sides for storing stock. Access to the dispensary and consultation area was authorised by the RP.

The pharmacy was tidy and organised. In the dispensary, shelves, worksurfaces, floors and sinks were generally clean, but the age and fabric of the floor tiles, fixtures and fittings made them appear less so. The pharmacy also had a basement area which had a stock room and a staff toilet. All these areas were clean and tidy although in general they were in need of refreshing and upgrading.

Principle 4 - Services ✔ Standards met

Summary findings

In general, the pharmacy provides its services safely and effectively and tries to make its services 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 properly.

Inspector's evidence

The pharmacy's services were advertised at the front window and there was a small range of information leaflets available for customer selection. The pharmacy had step-free access at the entrance which made it suitable for wheelchair users. And. the shop floor was wide enough for wheelchair users to move around. However, the pharmacy had a step up into the dispensary where customers entered for the consultation room and had a further step up into the consultation room. This meant that wheelchair users would be unable to access the consultation room. But, the RP would use the small dispensary counter to conduct more private consultations with people when necessary. The pharmacy offered a prescription ordering service for those who had difficulty managing their own prescriptions.

In general, staff appeared to be providing services in accordance with standardised procedures. CDs were audited regularly, as per procedure. And a random check of CD stock (Zomorph 10mg capsules) indicated that the running balance quantity in the register, was correct. Dispensing labels were initialled by the person dispensing and the person checking, to provide a dispensing audit trail. This was as per the SOP.

Multi-compartment compliance aids were provided for people who needed them. Product Information Leaflets (PILs) were offered to patients with new medicines but not provided regularly with repeat medicines. The medication in compliance aids was given a basic description, including colour and shape, to help people to identify the medicines from the descriptions. But the labelling directions did not have the required BNF advisory information to help people take their medicines properly. The RP had read the valproate safety alert, issued by the MHRA and understood the risks for people taking sodium valproate, who were in the at-risk group. The pharmacy did not currently have any at-risk patients taking valproate but would provide counselling if that were to change. The RP had placed a sticker on the shelf edge in front of valproate products to act as a reminder. Packs of sodium valproate in stock bore the updated warning label.

Medicines and Medical equipment were obtained from: Alliance Healthcare, Sigma, Colorama and AAH. Unlicensed 'specials' were obtained from Alliance Healthcare. All suppliers held the appropriate licenses. In general, stock was stored in a tidy, organised fashion. But, the pharmacy had a pack of metformin tablets 500mg on the shelf, which was found to contain three different batches of tablets. One of the strips had no expiry date. There was also a quantity of loose strips of prednisolone 5mg tablets which had been removed from their original packaging and therefore did not have all the required manufacturer's details. Products stored in this way could be missed when checking product recalls or expiry dates. 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 but more recent checks had not been recorded. The pharmacy also had an open botte of methadone 1mg/ml sugar free liquid which had not been marked to show the date of opening. The pharmacy did not yet have equipment and software for scanning products in accordance with the European Falsified Medicines Directive (FMD). And so, it was not scanning all packs with a unique barcode.

Waste medicines were disposed of in the appropriate containers, for collection by a licensed waste contractor. But staff did not have a list of hazardous waste to refer to or a separate container, so they could ensure that they were disposing of all medicines appropriately. Drug recalls and safety alerts were generally responded to promptly. The RP had received a recall for Sigma paracetamol products, two days ago, and had not had any of the affected stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities for the services it provides. It uses its facilities and equipment to keep people's 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 clean. Tablet and capsule counting equipment was also clean. There was a separate methadone measure which was washed at the end of the day. Precautions were taken to help prevent cross contamination by using a separate triangle for counting loose cytotoxic tablets. 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. The pharmacist also accessed BNF on line. 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. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was collected for safe disposal. The pharmacist used his own smart card when working on PMRs. He used his own smart card to maintain an accurate audit trail and to ensure that access to patient records was 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.