General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Frith Bros. Ltd., 11 The Broadway, Cheam, SUTTON, Surrey, SM3 8BH

Pharmacy reference: 1036753

Type of pharmacy: Community

Date of inspection: 19/02/2020

Pharmacy context

This Healthy Living Pharmacy (HLP) is in the centre of Cheam, Surrey. It dispenses NHS and private prescriptions, sells a range of over-the-counter medicines and provides health advice. The pharmacy dispenses some medicines in multicompartment compliance aids for those who may have difficulty managing their medicines. It also offers a home delivery service for people who can't get to the pharmacy themselves.

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

The pharmacy's team members work to professional standards, identifying and generally managing risks effectively. The pharmacy manages and protects confidential information reasonably well and tells people how their private information will be used. Team members understand their role in helping to protect the welfare of vulnerable people. The pharmacy has adequate insurance in place to help protect people if things do go wrong. But the pharmacy does not keep its written procedures sufficiently up to date. And it doesn't put enough detail in its records which may make it difficult to show what had been done if a query should arise in the future.

Inspector's evidence

There were standard operating procedures (SOPs) in place to underpin all professional standards, but they appeared to have been due for a review on or before 1 January 2013. There was no evidence to show that they had been reviewed since that date, despite this having been identified during the previous inspection in 2016. The responsible pharmacist (RP) explained that the superintendent pharmacist (SI) had been working in the pharmacy the previous day and had taken some paperwork away in order to update the SOPs. There were signature sheets for each SOP which had been signed by all staff to indicate that they had read and understood them. But the most recent signature seen was dated September 2016. The RP SOPs were undated but appeared to date back to 2009. This was subsequently discussed with the SI who confirmed that she was in the process of updating them. She agreed to prioritise the RP SOPs and complete them as soon as possible. The pharmacy had a business continuity plan in place which involved contacting the SI for guidance in the event of a power failure or other major problem.

Errors and near misses were recorded using a paper form, showing what the error was, the members of staff involved, and the reason for the error. The near miss register was kept on a clip in the dispensary for easy access by all staff. The possible causes were recorded for some of the near misses, but for most of them the entry was blank. The form did not identify any action taken to minimise the risk of the error being repeated. There was no evidence of reflection and learning on the record sheet itself, but the quarterly near miss analysis did show this. The RP explained that she would brief all staff once she had completed that analysis. Although the most recent document seen was for the period September to December 2018. There was a section within the PQS folder for errors, which were also recorded on the NHS National Reporting and Learning Service (NRLS) website. The RP had also completed an annual patient safety report for submission to the NHS. She had identified some items that were prone to error, such as the ‘look alike sound alike’ (LASAs) medicines amitriptyline and amlodipine which had subsequently been separated on the shelves. They had also added pop-up reminders on their patient medication record (PMR) system to alert staff to some of the LASA products which had been erroneously selected in the past.

There was a staff roles and responsibilities matrix in the RP folder, but it had not been filled in or signed by any staff. Each individual SOP referred to those who had the delegated authority to carry out specific tasks, and 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 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 the results were positive overall. There were several thank you cards pinned to the dispensary wall from people who were pleased with the service they had received. The pharmacy complaints procedure was set out in the SOP file, but there was no visible notice on display for people to see.

A certificate of professional indemnity and public liability insurance from the National Pharmacy Association (NPA) valid until 30 June 2020 was on display in the dispensary. Private prescription records were maintained electronically on the PMR system and were generally complete with most details correctly recorded. The incorrect, or no prescriber had been recorded in several instances. This was discussed and upon reflection the RP agreed to ensure that the correct details would be recorded in future. The emergency supply records were complete with all the necessary details.

The CD register was seen to be correctly maintained, with supplier addresses written in full as required. Running balances were checked at each dispensing supply and confirmed by initials alongside the running balance figure. In addition to the regular individual checks, the RP also carried out a full balance check at least once a year. Corrections were made by using an asterisk and footnote but with no name or registration number to indicate who had made the amendment. Running balances of two randomly selected CDs were checked and both found to be correct. 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 required patient and prescriber details.

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 checking people's identity before discussing their medication, or inviting them into the consulting room when discussing sensitive information. Completed prescriptions in the prescription retrieval system were in the dispensary so that people waiting at the counter couldn't read other people's details. Confidential waste was kept separate from general waste and taken away by the superintendent to be shredded offsite. A privacy notice was on display.

There were safeguarding procedures in place and contact details of local referring agencies were seen in an address book, together with other useful contact details for all staff to access. There was also a clip with information on safeguarding provided by NHS London. The pharmacist had completed level 2 safeguarding training, and the rest of the team had been briefed so that they could recognise potential safeguarding risks. They would refer to the pharmacist if they were unsure. All staff were dementia friends.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. 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 medicines counter assistant (MCA), one dispensing assistant and two pharmacists (including the RP) on duty during the inspection. There was also a registered technician present at the beginning of the inspection, but he finished his shift shortly afterwards. This appeared to be appropriate for the workload and everyone was working well together. In the event of staff shortages, part-time staff could adjust their working hours to provide additional cover or staff could come over from their other pharmacy if needed.

Training records were seen confirming that all staff had completed the required training. There were some certificates to be seen in the Pharmacy Quality Scheme (PQS) folder, and others on display in the pharmacy for people to see. 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.

All staff were seen to serve customers when the MCA was busy, and all asking appropriate questions when responding to requests or selling medicines. There was no pressure to achieve specific targets. They appeared to have open discussions about all aspects of the pharmacy, and team members were involved in discussions about their mistakes and learning from them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises appear very old and traditional from the outside. But inside, they are modern and professional looking. They provide a safe environment for people to receive the pharmacy's services. The premises include a private room which the team uses for some of its services and for private conversations.

Inspector's evidence

The pharmacy premises had a traditional appearance which was in keeping with other buildings in the surrounding area. The interior was more modern looking, bright and clean. There was step-free access from the street via a single manual door. There was a central gondola and the aisles on either side were wide enough to allow wheelchair users to easily access all areas of the pharmacy. There was a large, well laid out dispensary with a small central island providing sufficient space to work safely and effectively. There was a clear workflow in the dispensary and the layout was suitable for the activities undertaken. There were stains and screw holes left in the dispensary ceiling from when old light fittings had been replaced with more modern energy-efficient lighting. There was a separate room just off the dispensary for the assembly of multicompartment compliance aids. The dispensary sink had hot and cold running water. There was handwash available at the sink in the staff area and also at the sink in the consultation room. Room temperatures were appropriately maintained by a combined air-conditioning and heating unit, keeping staff comfortable and suitable for the storage of medicines.

There was a spacious consultation room available for confidential conversations, consultations and the provision of services. The door to the consultation room was open when not in use, but there was no confidential information visible. There was a password protected PMR computer present. There was also a sink with hot and cold running water.

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. Team members identify people supplied with high-risk medicines and give them any extra information they may need to take their medicines safely. But they only record some of those checks which may make it difficult for them to show what they had done if a query were to arise in the future.

Inspector's evidence

A list of pharmacy services was displayed in the front window and there was also a range of health information leaflets in the consultation room. The pharmacy also had leaflets and posters highlighting local health related events as part of its HLP activity. They were currently promoting a local diabetes event. The MCA explained how they liked to promote local health-related events whenever possible. The pharmacy provided a limited range of additional 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 the use of baskets to keep individual prescriptions separate. Prescription labels were initialled to show who had dispensed and checked them. Owings tickets were used if the pharmacy was unable to supply the entire prescription. The prescription was kept in the owings box until the stock arrived. In the event of being unable to obtain any items before the patient might run out, they contacted the GP for an alternative.

Completed prescriptions for schedule 2 CDs were highlighted with a note of the expiry date in red ink so that staff would know that they needed to ask the pharmacist to get it from the CD cupboard. There was also a reminder to obtain a patient signature and to return it to the pharmacist so they could make the necessary entry in the CD register. Schedules 3 and 4 CDs were also highlighted with their expiry date (on both the EPS token and on the bag) to help ensure that they weren't handed out after they had expired. The RP explained that the retrieval shelves were checked every month and that any prescriptions that had remained uncollected for more than three months, or CDs for more than 28 days, were removed. Any expired EPS tokens were returned to the NHS spine. Fridge lines in retrieval awaiting collection were stickered so that staff would know that there were items to be collected from the fridge.

Compliance aids were dispensed in a separate designated area to the side of the dispensary. The pharmacy had a four-week cycle to help ensure that prescriptions were ordered and assembled at the appropriate time. Any known allergies were recorded on the patient's PMR and any hospital discharge summaries were stored in the individual patient's basket. Changes were recorded on the individual PMR. Medication times were checked against the patient's records, and any discrepancies were followed up before labelling. The completed compliance aids would then be checked by the RP before being bagged up ready for either collection or delivery. Compliance aids were seen to include product descriptions on the backing sheet and patient information leaflets (PILs) were always supplied. There were a number of compliance aids ready for supply to individual patients which were also seen to have product descriptions and to contain PILs. Warfarin and alendronic acid were supplied separately. Mid-

cycle medication changes were collected by the delivery driver and re-dispensed before delivering back out to the patient, unless the prescriber had indicated that they were happy for the change to wait until the start of the next compliance aid.

The delivery driver's signature sheet listed the number of items to be delivered to each address. But the way it was laid out meant that people were able to see other people's personal details when signing for their delivery. This was discussed and upon reflection the pharmacist agreed to find a way of protecting patient confidentiality whilst obtaining signatures. The driver explained that in the event of a failed delivery he would either bring the item back to the pharmacy or would put it through the letter box if he had patient consent to do so. The pharmacist added that she phoned each person before delivering to ensure that they would be in, or to take any special instructions if they would be out.

Staff were aware of the risks involved in dispensing valproates to women in the at-risk group, and all such patients were counselled regarding the importance of having effective contraception. The PMR had been checked and there were some patients in the at-risk group. Patients taking warfarin were asked if they knew their current dosage, and whether their INR levels had been recently checked. Some of these interventions were recorded on the PMR, but the INR results themselves were not always asked for. Patients taking methotrexate and lithium had been checked recently as part of the audit for the pharmacy quality scheme (PQS). Upon reflection, the RP agreed to start recording all of this information in future, using the counselling notes function on the PMR system. This would make it much easier to audit them in future. There were good records of a variety of other interventions seen on the PMR system. There were steroid cards, lithium record cards and methotrexate record cards available to offer patients who needed them.

There were valid Patient Group Directions (PGDs) in place for both the NHS and the private flu vaccination services. Appropriate informed consent was documented, and records of each vaccination kept in a file within the consultation room. There were adrenaline autoinjectors available for use in emergencies when providing a vaccination service.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance and Colorama. Unlicensed 'specials' were obtained from Colorama. The pharmacy had the software but not the scanners necessary to comply with the Falsified Medicines Directive (FMD). So they were not yet decommissioning any products.

Routine date checks were seen to be in place, record sheets were seen to have been completed, and no out-of-date stock was found. The RP explained that they always checked with the patient if they were supplying a short-dated product to ensure that it would be used before going out of date and that the patient was happy to accept it. Opened bottles of liquid medicine were annotated with the date of opening. There were no plain cartons of stock seen on the shelves and 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. The RP explained how she 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.

The RP described how patient-returned medicines were screened to ensure that any CDs were appropriately recorded, and that there were no sharps present. Patients with sharps were signposted to the local council for disposal. There was a separate purple-lidded container designated for the disposal of hazardous waste medicines, but no list of those medicines for reference. The pharmacist arranged to

obtain one straight away. 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 designated section within the PQS folder. Each alert was annotated with any actions taken, the date and initials of those involved. 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, and it makes sure that it is properly maintained. The pharmacy takes reasonable steps to ensure that people's private information is kept safe and secure.

Inspector's evidence

The pharmacy had the necessary resources required for the services provided, including the consultation room itself, 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.

Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Computer screens were positioned so they were not visible to the public. 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 left in a secure location within 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.