General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kingsway Chemists, 290 Barking Road, East Ham, LONDON, E6 3BA

Pharmacy reference: 1040050

Type of pharmacy: Community

Date of inspection: 16/08/2019

Pharmacy context

The pharmacy is located on a busy main road in a town centre surrounded by residential premises. It is near to a large mosque and a large surgery. The people who use the pharmacy are mainly older people. The pharmacy receives around 90% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, travel vaccines and the influenza vaccine (seasonal). It provides medication in multi-compartment compliance packs to around many people who live in their own homes to help them manage their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	The pharmacy does not always ensure that team members are registered on the required accredited training courses in a timely manner.
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 largely identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And it regularly seeks feedback from people who use the pharmacy. Team members understand their role in protecting vulnerable people. But the pharmacy does not always keep its records up to date and accurate. And this could make it harder to show what had happened if there was a query.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. All standard operating procedures (SOPs) required by law were not available at the pharmacy. The missing ones included 'the arrangements which are to apply during the absence of the responsible pharmacist from the premises'. The missing SOPs may make it harder for the pharmacy team to know what the right procedures are. Team members had read and signed the available SOPs. The pharmacist said that she would ensure that all SOPs required by law were available. The trainee dispenser explained that near misses were highlighted with the team member involved at the time of the incident and that they identified and rectified their own mistakes. A book had been used to record some near misses, but there had been no entries made since December 2018, and only around 25 entries in the last 11 years. The pharmacist printed out a near miss log during the inspection. The layout of this would prompt team members to record more detail about the near miss and help the pharmacy to review them for patterns. The pharmacist said that she would ensure that team members kept a record of their own near misses in the future. The second pharmacist said that dispensing incidents would be recorded on a designated form and a root cause analysis would be undertaken. He said that he was not aware of any recent dispensing incidents. Interventions were recorded and kept at the pharmacy for future reference.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The trainee dispenser said that the pharmacy would open if the pharmacist had not turned up. She confirmed that she would not sell any medicines or hand out dispensed items until the pharmacist had arrived. She thought that she was allowed to carry out dispensing tasks. The inspector reminded her what she could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. There were some records for supplies of unlicensed specials medicines, but these were from 2016. They had been completed correctly. The second pharmacist was not sure where the recent records were kept. He said that he would ensure that these were made available and completed correctly. The patient's and prescriber's full address was not always recorded in the private prescription record. The pharmacist said that records of emergency supplies were made on the pharmacy's patient medication record, but he was not able to access the report. He said that he would ensure that a hand-

written record was kept and that he would include the nature of the emergency. Signed in-date patient group directions were available for the services offered. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not recorded. The CD running balances were routinely checked. The recorded quantity of one item checked at random was the same as the physical amount of stock available. There were three different responsible pharmacist (RP) notices displayed. An arrow labelled as 'responsible pharmacist' pointed to the person who was responsible at that time. The RP had not completed the RP log for two days and she had completed the log on the day of the inspection before she had finished her shift. The inspector explained that the log should be completed contemporaneously and for all days that the pharmacy was open. She agreed to ensure that this was completed correctly in future.

Patient confidentiality was protected using a range of measures. Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smart cards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed General Data Protection Regulation training.

The pharmacy carried out yearly satisfaction surveys; results from the 2017 to 2018 survey were displayed in the shop area and were available on the NHS website. Results showed that 100% of people who responded were satisfied with the service received from the pharmacist and other pharmacy staff. The complaints procedure was available for team members to follow if needed and details about it were displayed in the shop area. The pharmacy had complaint record forms available. The pharmacist said that he was not aware of any complaints at the pharmacy since he started working there around one year ago.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members could not recall having completed any safeguarding training. The pharmacist said that she would ensure that all team members had some training so that they knew what to do if they had any concerns about a vulnerable person. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough team members to provide its services safely. But it does not always ensure that team members are enrolled on the required accredited pharmacy courses within the required time frame. And this could mean that they do not have all the skills and knowledge they need to undertake their tasks safely. They are not always provided with regular ongoing training. This could make it harder for them to keep their skills and knowledge up-to-date. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. They can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There were two pharmacists and four other team members working during the inspection. One member of the team had been enrolled on an accredited counter assistant course. Another team member working on the medicines counter said that she had qualified as a pharmacist in Pakistan. She confirmed that she had been working on the medicines counter at the pharmacy for around one year but she was not yet enrolled on an accredited pharmacy course. One team member had been enrolled on an accredited counter assistant course, but she was carrying out dispensing tasks during the inspection and was not enrolled on a course for this. Another said that they had been enrolled on an accredited dispenser course. The pharmacist said that he would speak with the superintendent (SI) pharmacist to ensure that all team members were enrolled on accredited courses appropriate for the work they were carrying out. One member of the team was responsible for ordering stock, but he did not carry out any tasks in the dispensary.

They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The person working on the medicines counter appeared confident when speaking with people. She was unsure of the restrictions on sales of pseudoephedrine containing products. But said that she would refer to the pharmacist if someone asked to buy more than one box of any over-the-counter medicine. And she explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist said that she completed continuing professional development for the professional revalidation process. She said that team members were not provided with ongoing training on a regular basis. She confirmed that she had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The pharmacist said that the pharmacy had a meeting every few months to discuss any issues. Records of the minutes to the meetings were kept for future reference and included a list of team members who were present during the meeting. It was noted that team members were reminded to keep the noise in the pharmacy to a minimum, especially when there were people in the shop area. The pharmacist said that team members had ongoing informal performance reviews, but these were not yet documented. She explained that the superintendent pharmacist would deal with any performance related issues. The trainee dispenser said that she felt confident to discuss any issues with the pharmacists during the working day. The pharmacist said that he had a good working relationship with

the SI.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that the pharmacy met the targets and the services were carried out for the benefit of the people using the pharmacy. She said that the targets did not affect her professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. The pharmacist said that the pharmacy underwent a refit around one year ago. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air-conditioning was available; the room temperature was suitable for storing medicines.

There were four chairs in the shop area. These were positioned close to the dispensary counter. The pharmacy was open plan and conversations in the dispensary could be clearly heard from the shop area. The pharmacist said that she was aware of this and ensured that private conversations were held in another area of the pharmacy when needed.

The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened and low-level conversations in the room could not be heard from the shop area. It was not kept secure when not in use and there were some medicines kept under the sink. These were moved into the dispensary during the inspection. The pharmacist said that she would ensure that these were kept in the dispensary until needed.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages its services well and provides them safely. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. The pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There were two entrances to the pharmacy, one had a small step and the other was step free. Team members had a clear view of the doors from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available. And team members could speak several languages. This helped people in the local community access the services.

The pharmacist said that the local surgeries would not usually issue a prescription for someone taking a higher-risk medicine if they had not had a recent blood test. The pharmacy did not keep a record of any checks made at the pharmacy. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 and 4 CDs were not highlighted. The pharmacist said that all prescriptions were handed out by a member of the dispensary team who were aware of the validity of these. Most items were dispensed when the person came to collect them. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. It did not have the patient information leaflets or warning cards available. The second pharmacist said that he would order these from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every two months and this activity was recorded. Stock due to expire within the next three months was marked. There were boxes containing several mixed batches found with dispensing stock. This could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately.

The pharmacist said that the part-dispensed prescriptions were checked daily. 'Owings' labels were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed, but not until the items were collected. This could increase the chance of items being handed out after the prescription was no longer valid. The pharmacist said that uncollected prescriptions were checked monthly and were kept until the prescription had expired. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

There were a few members of the team who could manage the process for ordering prescriptions for people who received their medicines in multi-compartment compliance packs. Prescriptions were

ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that people contacted the pharmacy when they needed them. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed into these packs.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not obtain people's signatures for deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. The pharmacist said that she would ensure that signatures were obtained while ensuring that other people's personal information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The pharmacist said that the team had undertaken some training on how the system worked. And there were written instructions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Suitable equipment for measuring medicines was available but not for volumes less than ten millilitres. The pharmacist said that she would order a suitable measure. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The weighing scales and the shredder were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

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.