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: 24/08/2020

Pharmacy context

This pharmacy is located on a busy main road in East London. It is surrounded by residential premises and there is a large mosque and a doctor's surgery nearby. The pharmacy mainly serves older people and receives most of its prescriptions electronically. It provides a range of services including Medicines Use Reviews, the New Medicine Service and the influenza vaccine (seasonal). It provides medication in multi-compartment compliance packs to people who live in their own homes and need help managing their medicines. This inspection was undertaken during the Covid-19 pandemic.

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 appropriately identifies and manages the risks associated with providing its services. It generally keeps the records it needs to by law, to show that medicines are supplied safely and legally. People who use the pharmacy can provide feedback and raise concerns and the pharmacy team have received some basic training to help protect the welfare of vulnerable people. The pharmacy does not always records mistakes that occur during the dispensing process. This may mean that staff are less able to spot patterns in mistakes and take action to prevent similar mistakes in the future.

Inspector's evidence

Standard operating procedures (SOPs) were available at the pharmacy, including those required by law. Not all current members of the team had signed the relevant procedures. This may make it difficult for the pharmacy to show that members of the team have read and understood the procedures. Team members' roles and responsibilities were clearly outlined within the SOPs. The trainee dispenser described tasks which she could not undertake in the absence of the pharmacist.

Team meetings were held regularly to discuss any changes due to the pandemic, including procedures for the team to follow and cleaning processes. Personal protective equipment was available for team members.

Mistakes which had been identified before they reached people (near misses) were highlighted to the team member involved and corrected. Some near misses were recorded but there had not been any entries since February 2020. This may indicate that some mistakes were not always captured. Shelf-edge labels had been placed to highlight some medicines which sounded alike or looked alike, for example, allopurinol/amlodipine/amitriptyline, prednisolone/propranolol and zopiclone/zolpidem. The pharmacist explained that the pharmacy avoided ordering medicines from the same manufacturer so that the packs looked different. Dispensing mistakes which had reached people were documented in a book and on the person's electronic record, but not in detail. For example, contributing factors, prescriber details and action taken by the team in response to the mistake were not always recorded. The pharmacist said that he would use the Community Pharmacy Incident Report Form as a template to ensure enough information was recorded in the future.

The dispensary workbenches were kept clean and clutter-free. There was an organised workflow and baskets were used to minimise the risk of mixing people's prescriptions and medicines. Team members signed the dispensing label when they dispensed and checked a medicine to show who had completed these tasks.

The pharmacy carried out yearly patient satisfaction surveys, but the results were not available to view. The pharmacy had complaint record forms available. The medicine counter assistant (MCA) said she would deal with minor complaints or refer people to the pharmacist if necessary. She explained that the pharmacy had introduced additional services, such as blood pressure measuring, pregnancy testing and diabetes checks in response to local demand. She was involved in conducting some services, such as weight checks, and described providing healthy living advice to people.

The pharmacy had current professional indemnity and public liability insurance. Records required for

the safe provision of pharmacy services were generally completed in line with legal requirements, including those for unlicensed medicines and private prescriptions. The pharmacist said that emergency supplies were recorded on the pharmacy's electronic records, but he was not able to access the report. He said that he would ensure that a hand-written record would be kept in the future. A sample of controlled drug (CD) registers was inspected and these were filled in correctly. The physical stock of two CDs was checked but one did not match the recorded balance. The pharmacist explained that an incorrect entry had been made; this was corrected at the time of inspection.

There were three different responsible pharmacist (RP) notices displayed behind the medicines counter. An arrow labelled with 'responsible pharmacist' pointed to the pharmacist responsible at the time. Records about the responsible pharmacist were kept and were in order.

Patient confidentiality was protected using a range of measures. Confidential waste was shredded, computers were password protected and smartcards were used to access the pharmacy's electronic records. Confidential information was not visible to people visiting the pharmacy, including bagged items awaiting collection. Pharmacy team members had completed General Data Protection Regulation training.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had received some training on the subject verbally. The trainee dispenser said she would refer any concerns to the pharmacist but could not locate the contact details of the local safeguarding team; she said that she would ask the pharmacist or another colleague for these.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services, and they work effectively together. They have the appropriate skills, qualifications and training to deliver services safely and effectively. Team members are given some ongoing training but this is not very structured. This could make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

There was a pharmacist, a provisionally registered pharmacist, a trainee dispenser and an MCA during the inspection. The pharmacy also employed another dispenser and two trainee dispensers. The trainee dispensers were currently enrolled onto a dispensing course. The dispenser and MCA had completed their courses several years ago.

Members of staff were responsible for various tasks, for example, the trainee dispenser oversaw the ordering of prescriptions and the assembly of multi-compartment compliance packs.

The trainee dispenser said she completed her course modules as and when she could at home. She said it had been a struggle completing the training modules during the pandemic as the pharmacy was busy and the modules were time consuming. She felt supported by her colleagues and said she could ask for help when needed. She did not have access to other training material but said the pharmacists briefed the team regularly, for example, about discontinued medicines and items which were out of stock from the manufacturers.

The pharmacy had been busier than usual during the pandemic. Staff shifts had been rearranged so that fewer members of the team worked at the same time to help minimise the risk of infection. The pharmacy's opening hours had been reduced slightly in order to help the team cope with the additional workload.

Team members worked well together. The MCA was observed serving people effectively and translating for people who did not speak English well. She asked a number of questions before selling Pharmacy-only medicines and provided additional advice. Informal performance reviews were conducted but these were not documented. Team members were happy to raise any concerns to the pharmacist or the superintendent pharmacist. Targets were not set for the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy underwent a full refit approximately two years ago. It was bright, clean and tidy throughout. Pharmacy-only medicines were stored behind a medicines counter and were not accessible to people. There was a clear view of the medicines counter from the dispensary to allow the pharmacist to hear conversations and intervene if necessary. The room temperature was suitable for storing medicines; air conditioning was available. The premises were secure from unauthorised access.

There were several chairs in the retail area. A spacious consultation room was available for services and it was suitable for private conversations. The room was kept clean and tidy and was not used to store any confidential information.

A plastic screen had been fitted at the medicines counter in response to the Covid-19 pandemic. Members of the team cleaned the pharmacy twice a day, in the morning and evening, to help prevent cross-infection. They described washing their hand frequently and using hand sanitizers. Signs were displayed reminding people to wear face masks and to maintain a safe distance.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are generally delivered in a safe and effective manner. And people with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and manages them appropriately to make sure that they are safe to use. And it takes the right action in response to safety alerts. But people taking some higher-risk medicines might not always get all the information they need to take their medicines safely.

Inspector's evidence

There were two entrances to the pharmacy, one was step free and another had a small step. Services and opening hours were clearly advertised so that people knew what they could access at the pharmacy. Team members could speak several languages and were observed translating for some people who did not speak English well. There were several leaflets and booklets displayed in the retail area.

There was no process in place to highlight prescriptions for 'higher-risk' medicines so that team members could identify the presence of these medicines when handing out bagged items. This could make it harder for the pharmacy to check if the person was having the relevant tests done. Checks or advice provided to people were not always recorded on the person's electronic record for reference. The trainee dispenser could not describe what checks to carry out when dispensing sodium valproate to people in the 'at risk' group. The pharmacy did not have the information leaflets and warning cards available. The pharmacist said he would order these from the manufacturer and retrain members of the team on the appropriate steps to take when dispensing valproate. Prescriptions for Schedule 3 and 4 CDs were highlighted to help ensure they were not handed out past the valid date on the prescription.

Part-dispensed prescriptions were checked daily. People were kept updated about any supply issues. The pharmacy offered to contact their prescriber for alternative items if there were long-term delays in obtaining the medicine. Uncollected prescriptions were returned to the NHS spine.

The pharmacy provided multi-compartment compliance packs to people who needed help managing their medicines. Prescriptions were ordered in advance by the pharmacy team. The pharmacy kept a record of all medicines taken by people receiving these packs and these records were kept up to date. Some assembled packs were checked; they were labelled appropriately and included the descriptions of the medicines. This helped people identify their medicines. Clear dispensing audit trails were maintained to help identify the team members involved in dispensing and checking the packs. People were not always provided with patient information leaflets. This may mean that they do not always have up to date information about their medicines.

A delivery service was available for people. Deliveries were made from a safe distance and signatures were not obtained to help reduce the risk of cross-infection. Medicines were returned to the pharmacy if a person was not at home. A card was left at the address informing the person about the missed delivery and asking then to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Stock was stored in an organised manner. Expiry dates of medicines were checked every one to two months and

documented to help keep track of these checks. Medicines with short expiry dates were clearly marked with coloured stickers though they were not always removed from the shelves in a timely manner. There were boxes containing several mixed batches of medicines, with varying expiry dates. This could make it difficult for the pharmacy to date-check the stock properly or respond to drug safety alerts. Opening dates were not always written on liquids with a short shelf-life after opening. This could make it harder for staff to know if the liquid was still suitable to use. Drug alerts and recalls were received from the NHS and MHRA. Records were kept of any action taken by the team in response to these. CDs were stored in accordance with legal requirements. Denaturing kits were available for the safe destruction of CDs.

The pharmacy had the equipment it needed to comply with the EU Falsified Medicines Directive. The team had undertaken training on the system and SOPs were in place. The system was used by the pharmacy, though not often.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Clean glass measures were available. Clean counting triangles were also available, including a separate one for cytotoxic medicines. This helped avoid cross-contamination. The fridges were clean and suitable for the storage of medicines. Fridge temperatures were checked and recorded daily. Records indicated that the temperatures were maintained within the recommended range. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Members of the team had access to the internet and several up-to-date reference sources. Confidential information was stored securely and was not visible to people visiting the pharmacy. The shredder was in good working order. The telephone in the dispensary was portable so it could be taken to a more private area if needed.

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.