General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newmans Chemists, 376 Barking Road, Plaistow, LONDON, E13 8HL

Pharmacy reference: 1040157

Type of pharmacy: Community

Date of inspection: 22/11/2022

Pharmacy context

The pharmacy is located on a busy high street in a largely residential area. It provides a range of services, including the New Medicine Service and flu vaccination service. The pharmacy also offers the COVID vaccination and travel vaccination services while the regular pharmacist is working. And it provides medicines as part of the Community Pharmacist Consultation Service. It also supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to some people.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It largely protects people's personal information. And people can provide feedback about the pharmacy's services. The pharmacy mostly keeps its records up to date and accurate. And team members know how to protect vulnerable people. The pharmacy doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) and most team members had signed to show that they had read, understood, and agreed to follow the SOPs. One team member was in the process of reading them. A near miss record was available to record dispensing mistakes which had been identified before the medicine had reached a person. But it had not been used for a few months and the trainee dispenser said that there had been some near misses during this time. He explained that near misses were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. He said that he would ensure that the near miss record was used in future and reviewed to help identify any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The trainee dispenser said that any dispensing errors where a dispensing mistakes had reached a person, were reported to the National Reporting and Learning System. He was not aware of any recent dispensing errors at the pharmacy.

Workspace in the dispensary was limited but it was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And 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.

One of the dispensers said that the pharmacy would open if the pharmacist had not turned up in the morning. She knew that she should not sell any medicines until the responsible pharmacist (RP) had signed in. and she knew that she should not sell any pharmacy-only medicines or hand out dispensed medicines if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The private prescription, emergency supply records and controlled drug (CD) registers examined were filled in correctly. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right RP notice was clearly displayed and the RP record was largely completed correctly. But there were several occasions where the pharmacist had not completed the record when they had finished their shift and a different pharmacist was working the following day. This was discussed with the locum pharmacist during the inspection.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged

items waiting collection could not be viewed by people using the pharmacy. But there were some bagged items kept on shelves where people passed to access the consultation room. And some people's personal information may be able to be read. The trainee pharmacist said that she would turn the bags round so that the information was not visible. And she said that a member of staff remained with people for the duration of their consultation.

The pharmacy's complaints procedure was available for team members to follow if needed. The trainee dispenser said that he would refer any complaints to the pharmacist. Team members were not aware of any recent complaints. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some training provided by the pharmacy. One of the dispensers described potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. Team members were not aware of any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. Team members are able to raise concerns to do with the pharmacy or other issues affecting people's safety. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one locum pharmacist, one trainee pharmacist, two trained dispensers, one trainee dispenser (NVQ level 3 student) and one trainee MCA working on the day of the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. They worked well together and communicated effectively during the inspection to ensure that tasks were prioritised, and the workload was well managed.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of medicines containing pseudoephedrine. And she could identify which medicines could be misused or may require additional care. She said that she would refer to the pharmacist if a person regularly requested to purchase an over-the-counter medicine. The trainee MCA asked people suitable questions to establish whether the medicines were suitable for them to take.

Team members had undertaken some recent training as part of the Pharmacy Quality Scheme, including cancer awareness and weight management. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. She had recently completed the face-to-face training for the flu and COVID vaccination services. And some training about electronic CD registers. The pharmacist felt able to take professional decisions. The COVID vaccination service had been put on hold while the regular pharmacist was on leave.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The trainee dispenser said that there were meetings held every two months to allow team members time to discuss any ongoing issues. He said that any issues were usually discussed at the time though and dealt with promptly. The trainee dispenser said that team members received ongoing informal reviews of their performance and yearly ones which were more formalised. Targets were not set for team members. The services were carried out for the benefit of the people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access and it was clean and tidy. 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. Pharmacy-only medicines were kept behind the counter. Air conditioning was available and the room temperature was suitable for storing medicines. There were three chairs with arms to aid standing in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The consultation room was to the rear of the dispensary. It was not accessible to wheelchair users from the shop area, but there was a door to the rear of the pharmacy and it could be accessed via that entrance. The trainee pharmacist said that a ramp was available to use if needed. The room was suitably equipped and well-screened. And conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. And overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use. And it dispenses medicines into multi-compartment compliance packs safely.

Inspector's evidence

There was a step up to the pharmacy through a wide entrance with an automatic door. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. A variety of health information leaflets was available and the pharmacy's services and opening times were clearly advertised.

The pharmacy was reusing dispensing bottles for some people who received supervised doses. And the bottled were not labelled with all the required information when the medicine was supplied. There were several dispensing bottles with residue in on the side in the dispensary and these were being reused. Each bottle was labelled with a person's details and was only used for that person. The dispenser said that this would not happen in future and people would be provided their medicines in clean and correctly labelled containers. Team members were observed preparing doses in new containers during the inspection.

Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. But the pharmacist said that she did not routinely check monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. The trainee 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 (PPP). The pharmacist said that she would check that a person was on a PPP if they needed to be on one and would refer them to their GP if they weren't. And she would record this on the person's medication record. The pharmacy had the relevant patient information leaflets, warning cards available and warning sticker available. Team members did not know that the warning card on the packaging could be removed to allow room to attach the dispensing label. But they would ensure that the warnings were not covered in future.

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 on the electronic register and destroyed with a witness. Previous paper records showed that some returned CDs had not been destroyed. The trainee dispenser said that these medicines had been destroyed, and he would ask the regular pharmacist to complete the record to reflect this. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next few months were marked. There were no date-expired items found in with

dispensing stock.

Part-dispensed prescriptions were checked frequently. ‘Owings’ notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. And prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The trainee pharmacist said that prescriptions with one or two items were not dispensed until the person came to collect their medicines. This was due to the lack of storage space in the pharmacy. The labels were printed and filed with the dispensing token to help minimise the waiting time when the person came to collect their items. Uncollected prescriptions were checked regularly and items remaining uncollected after around two months were returned to dispensing stock where possible. Any uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. And prescriptions for ‘when required’ medicines were not routinely requested. The trainee dispenser said that people ordered these if they needed them when their packs were due. 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 in these packs. The trainee dispenser said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people’s signatures to help minimise the spread of infection. The trainee dispenser said that failed deliveries were returned to the pharmacy before the end of the working day. And the driver left a note at the person’s address asking them 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. The trainee dispenser explained the action the pharmacy took in response to any alerts or recalls. 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.

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

Equipment for measuring liquids was available but not for volumes less than two millilitres. Some of the measures were made of plastic and one of the dispensers said that she would ensure that suitable measures were ordered and used in future. Separate liquid measures were used to measure marked for certain medicines only. 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 blood pressure monitor was replaced in line with the manufacturer's guidance. Other testing machines were calibrated at the required intervals. 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. The fridge was suitable for storing medicines and was not overstocked. Fridge temperatures were checked daily with maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range.

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.