General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Grove Street Pharmacy Limited, 2 Golden Hind Place, Grove Street, Deptford, LONDON, SE8 3QG

Pharmacy reference: 1040800

Type of pharmacy: Community

Date of inspection: 25/02/2020

Pharmacy context

This is a community pharmacy in a parade of shops in a largely residential area. It has recently changed its name and owner. It mainly dispenses NHS prescriptions and also offers Medicines Use Reviews and New Medicine Service checks. Some people use its substance misuse service. The pharmacy supplies medications in multi-compartment compliance packs to some people to help them take their medicines safely. And it provides a minor ailments service.

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 identifies and manages the risks associated with its services to help provide them safely. People using the pharmacy can provide feedback and raise concerns. The pharmacy largely keeps the records it needs to by law to show that medicines are supplied safely and legally. Team members know how to safeguard vulnerable people. And they generally protect people's personal information well. When a mistake happens, the pharmacy team responds well. But team members do not always record mistakes that happen during the dispensing process. And this may mean that they miss out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

A range of standard operating procedures (SOPs) was available and included SOPs on safeguarding and dealing with complaints. The pharmacist confirmed that team members had been through the SOPs, with the exception of the new member of staff. A record of this was maintained at the front of the SOPs. The pharmacist was unsure if the new member of staff had signed a confidentiality agreement yet but said that he would check.

Sheet were available to record near misses, where a dispensing mistake was picked up before the medicines were handed out. But the sheets for 2020 were blank. The pharmacist said that some near misses may have occurred and not been recorded. He gave assurances that they would be recorded in the future. Prior to this, the pharmacy had been keeping near miss records and reviewing them monthly for any patterns. A previous pattern had been identified where there had been near misses between amlodipine and amitriptyline. As a result, the medicines had been separated on the shelves to help prevent a recurrence.

Dispensing errors, where a mistake was given out to a person, were recorded on designated forms. The pharmacist was aware of one recent error where the person had been supplied the wrong medicine. The person had ended up taking the medicine for three days. Once the incident was highlighted to the team members, they discussed it between them so that they were reminded to take extra care with those particular medicines.

The medicines counter assistant (MCA) was clear about her own role and responsibilities and she could explain what she could and couldn't do if the pharmacist had not turned up.

The pharmacy undertook an annual patient survey, and the pharmacist said that the results were displayed on the NHS website. The results could not be found on the website, which could be due to the pharmacy recently changing ownership and its trading name. The complaints procedure was available for staff to refer to. The pharmacist was not aware of any recent complaints which were specifically about the pharmacy. A sign was displayed in the public area to explain to people how they could make a complaint or provide feedback.

The pharmacy had recently changes ownership from a sole trading pharmacist to a company, and on the day of inspection the indemnity insurance was still in the name of the sole trader. The previous owner telephoned the indemnity insurer during the inspection to rectify this. Following the inspection, the indemnity insurer confirmed that the pharmacy had current and unbroken indemnity insurance

cover.

The right responsible pharmacist (RP) notice was displayed, and the RP record had been filled in correctly. The pharmacy only dealt with a small number of private prescriptions, but not all the records for these contained all the required information. One record seen had no prescriber name recorded; this could make it harder for the pharmacy to find out these details if there was a query. The pharmacy did not dispense any unlicensed medicines that needed ordering from a specials manufacturer. Or many emergency supplies, as the pharmacist said that the local surgery was willing to prescribe medicines in an emergency. The pharmacist showed a record of one emergency supply that had been made but was unable to access all the information. He said that he was intending to change the provider of the electronic record system so that this information would be accessible in the future. Controlled drug (CD) registers examined largely complied with requirements but some headings had not been filled in. CD running balances were checked regularly. A random check on a CD balance matched the amount of physical stock present.

People's personal information was generally protected well. Team members used individual smartcards to access the NHS electronic systems. Computer terminal screens were turned away from people using the pharmacy and were password protected. Some people's personal details were initially visible on bags on the way to the consultation room, but this was addressed during the inspection. There were some items containing people's personal information in the room itself, and the pharmacist gave assurances that these would be moved before the room was used again. The MCA remembered signing a confidentiality agreement as part of her employment contract. A window cleaner was observed to walk through the dispensary to fill his bucket. This was discussed with the pharmacist, who said that he would get the window cleaner to sign a confidentiality agreement or look for another way for him to fill his bucket. Confidential waste was disposed of with a shredder. One label found in the shredder bin had not been shredded properly; the pharmacist said that he would review this and if necessary, obtain a new shredder.

Team members had read the pharmacy's safeguarding SOP. The pharmacist and pharmacy technician had completed the level 2 safeguarding course and could explain what they would do if they had any concerns. They said that the dispenser who worked at the pharmacy had also completed the level 2 course. The pharmacist was aware of how to access contact details of local safeguarding agencies.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. And they do the right training for their roles. They are comfortable about raising any concerns or making suggestions. And they can take professional decisions. They do some ongoing training to help them keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection, there was one pharmacist, one pharmacy technician, one MCA, a trainee dispenser, and a new member of staff who was mainly working as a cleaner. The new member of staff was not involved in the sale of medicines or dispensing. The pharmacy technician was undertaking an accuracy checking course and did most of the training for this at home. The previous owner (who had been a sole-trader pharmacist) came in part-way through the inspection. The team was up-do-date with dispensing and the pharmacy's workload.

Staff had monthly meetings, and team members said that they felt comfortable about raising any concerns or making suggestions. The pharmacist said that he had spoken with the team recently about sepsis, and this was confirmed by a team member. The dispenser had recently undertaken training on the local NHS vitamin D service, with a view to providing this in the future. Team members received occasional leaflets about new products and said that they discussed any issues as they arose in the team meetings. They did not receive regular structured training but were informed about new topics as they came up. They did not have any numerical targets in place and the pharmacist felt able to take any professional decisions as they arose.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy’s services and they are kept secure. People can have a conversation with a pharmacist in a private area.

Inspector's evidence

The pharmacy had not received a refit for some time, and this was reflected in the state of some of the fixtures and fittings. However, they were generally in a good state of repair. Lighting was good throughout. The workspace in the dispensary was kept clear from unnecessary clutter and there was sufficient space to dispense safely. The room temperature was suitable for the storage of medicines and was maintained with air conditioning. As a whole, the pharmacy was generally clean and tidy.

Staff had access to handwashing facilities. The consultation room was a little cluttered with unnecessary items, but the pharmacist moved some of these out during the inspection and said that the remaining ones would be moved. The room was set away from the shop floor and allowed conversations to take place inside which would not be overheard. The room was accessed by going past the back of the pharmacy counter; some bags of dispensed medicines with people’s personal information could be seen on the way through. During the inspection the dispenser moved these so that personal information was no longer visible. The premises were secured from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. People with a range of needs can access its services. It gets its stock from reputable sources and largely stores it properly. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. It dispenses medicines into multi-compartment compliance packs safely. But it doesn't always supply patient information leaflets which come with the medicines. And this could mean that people don't have all the information they need to take their medicines safely.

Inspector's evidence

The pharmacy had step-free access from outside and wide spaces in the shops area to help people with wheelchairs and pushchairs manoeuvre. A list of the opening times was displayed in the door. The pharmacist said that the pharmacy had a good working relationship with the local surgery, and they had regular meetings together. A seating area was available for people to wait while their prescriptions were dispensed.

Baskets were used during the dispensing process to isolate individual people's medicines. There was enough clear workspace to dispense safely, and there was a clear workflow through the pharmacy.

The pharmacist described how he asked people for their recent blood test results when they presented a prescription for a higher-risk medicine such as warfarin or methotrexate. But he said that people often did not have their results with them. He explained that if they had their yellow book for warfarin, he sent a copy of the readings in the book to the surgery when ordering people's repeat prescription. He described how they highlighted prescriptions for higher-risk medicines on the shelves. No dispensed bags containing higher-risk medicines were found on the shelves. Prescriptions for CDs were highlighted to help reduce the chance of the medicines being handed out when the prescription was no longer valid. Team members were aware of the additional guidance around pregnancy prevention to be given to some people taking valproate. The pharmacy did not have any people in the at-risk group. It did not have the associated information literature such as cards or stickers and the pharmacist said that he would order some in from the manufacturer. The pharmacist said that he was in the process of investigating which equipment the pharmacy would get to comply with the Falsified Medicines Directive (FMD). He showed the additional SOPs the pharmacy had which included the FMD procedures.

People were assessed by the local medicines optimisation service (LIMOS) before they started using the multi-compartment compliance packs. LIMOS also undertook some degree of ongoing monitoring to see how people were managing their medicines. The compliance packs were labelled with a description of the medicines inside, to help people and their carers identify them. And there was an audit trail to show who had dispensed and checked the packs. Any changes in people's medicines were recorded on the person's individual sheet, and hospital discharge notes were retained. Patient information leaflets were not routinely supplied with the packs, which could mean that people do not have all the information they need to take their medicines safely.

Medicines were ordered from licensed wholesale dealers and stored in an orderly manner in the dispensary. Date-checking was done regularly, and this was supported with records. But three date-

expired medicines were found on the shelves sampled; two had been highlighted as approaching their expiry date. The medicines were removed for destruction. Three packets of medicines found contained mixed batches inside, and this could make safety recalls or date checks less effective. Bulk liquids were marked with the date of opening to help staff know if they were still suitable to use. Medicines for destruction were separated from stock and placed into designated bins and sacks.

CDs were kept securely. Medicines which needed cold storage were kept in a suitable fridge and the temperatures were monitored and recorded daily. Records seen showed that the fridges had remained within the appropriate temperature range. Drug alerts and recalls were received by the pharmacy and the pharmacist explained what they did in response. A record of the action that had been taken was maintained.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for its services and generally maintains it well. It uses its equipment to help protect people's personal information.

Inspector's evidence

There were suitable glass measures for use with liquids. Tablet counting triangles were clean, and a separate marked one was used for methotrexate to help avoid cross-contamination. There was a blood pressure meter, but the pharmacist said that they were not using it until it had been replaced. Staff had access to up-to-date reference sources including the internet.

The pharmacy computers were password protected. The phone was cordless and could easily be moved to a more private area to help protect people's personal information.

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.