General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hills Pharmacy, 99 Kennington Lane, LONDON, SE11 4HQ

Pharmacy reference: 1040830

Type of pharmacy: Community

Date of inspection: 17/10/2022

Pharmacy context

The pharmacy is located within a parade of shops and opposite a GP surgery. And it serves a mixed local population. The pharmacy provides a range of services, including the New Medicine Service and Covid-19 and flu vaccinations. It also supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications.

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 generally identifies and manages the risks associated with its services to help provide them safely. It mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And it protects people's personal information. People who use the pharmacy can provide feedback about its services. When a dispensing mistake occurs, team members generally react appropriately. But they do not always make a record of dispensing mistakes. So, they might be missing opportunities to learn and make the services safer.

Inspector's evidence

Up-to-date standard operating procedures (SOPs) were in place but not all team members had signed to show that they had read and understood them. The superintendent pharmacist (SI), who was also the responsible pharmacist (RP) on the day said that he would ask the newer members of the team to read and sign the SOPs.

The SI said that near misses (where a dispensing mistake was identified before the medicine had reached a person) had not been documented for some time but he did discuss them with the team member involved. He added that near misses had reduced significantly since a dispensing robot was fitted at the pharmacy. The SI said he would encourage team members to record them in the future. The inspector discussed the benefits of recording and reviewing the near miss records, for example, to help the pharmacy to identify patterns and minimise the chance of mistakes. The SI described some changes that had been made to minimise near misses, such as retraining team members on how to correctly register medicines before inserting them into the robot. Baskets were used to minimise the risk of medicines being transferred to a different prescription, but some workbenches were cluttered, with limited space to dispense and check on. The inspector discussed the risks of this with the SI. There was a designated form to document dispensing errors, where a dispensing mistake had reached a person. There had not been any recent errors. Some dispensed medicines were stored on the dispensary floor and bags of confidential waste were stored directly in front of the fire exit. These were removed during the inspection.

A business continuity plan was in place. The SI said that local GP surgeries would be informed in case of an emergency pharmacy closure. Local pharmacies would also be informed. A regular locum pharmacist helped cover some shifts and the SI's business partner was also a pharmacist and could help as and when needed. A list of useful contacts, such as wholesalers, alarm system provider, PMR system provider, indemnity insurer and local police station, was displayed in the dispensary.

The pharmacy had current professional indemnity and public liability insurance. The correct RP notice was displayed. Samples of the RP record was in order. Other records required for the safe provision of pharmacy services were generally completed in line with legal requirements. A sample of the electronic controlled drug (CD) registers was inspected, and these were filled in correctly. The physical stock of a CD was checked and matched the recorded balance.

The pharmacy previously carried out yearly patient satisfaction surveys, but because of the pandemic it had not done one. People were able to provide feedback verbally or online. The SI said that during the height of the pandemic, and following some customer feedback, a barrier had been placed to separate

people queuing for pharmacy and Covid-19 vaccine services. A shed had also been erected at front of the pharmacy to house people waiting for the Covid-19 vaccine service.

An information governance policy was in place and members of the team had received some training on protecting people's confidentiality. Confidential waste was either collected by an approved contractor or shredded on site. Computers were password protected but usernames and passwords were displayed on the dispensary wall. These were removed during the inspection. The SI described ways in which the team tried to keep patient-sensitive information secure, for example, confirming people's details before handing out medicines and speaking discreetly.

The SI had completed Level 3 safeguarding training. The medicine counter assistant (MCA) had completed Level 1 training, but other support staff had not received training on the subject. The SI said he would provide the team with some training. He described reporting two concerns during the pandemic and following up on them.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely and they can raise any concerns or make suggestions. Team members do the right training for their roles, but they do not always get time to do their training during their working hours. This may make it harder for them to complete the relevant training in a timely manner and to keep their knowledge and skills up to date.

Inspector's evidence

There was the SI, a MCA, a dispenser and an assistant during the inspection. They worked well together and communicated effectively. The dispenser had completed the relevant training and was involved in providing the Covid-19 vaccine under the National Protocol. The MCA was involved in dispensing tasks and has been enrolled onto the dispensing course twice but had not completed it on time on both occasions. The SI confirmed that she had been enrolled onto the course for the third time following the inspection. The assistant completed administrative tasks and was not involved in dispensing or selling Pharmacy-only medicines (P-medicines).

This was a relatively busy pharmacy. The telephone rang constantly throughout the inspection with the calls mainly handled by SI, who was also dispensing. The dispenser was managing the vaccine service and the MCA was covering the medicines counter. The SI explained that two members of the team were off sick on the day of the inspection. One was a trained dispenser and the other would be enrolled onto a suitable course following the probation period. He said that the pharmacy usually had enough staff for the services provided but he had been advertising for a second dispenser vacancy for some time now. He said he was finding it increasingly difficult to find permanent staff and several new employees had left after working for a short period of time. This made it difficult to keep on top of the pharmacy's workload as he had to constantly train new members. The pharmacy was up to date with its dispensing service and did not have a back log of work.

The MCA described her responsibilities which included serving at the medicines counter, dispensing, putting stock away and expiry date checking. She said that she would not hand out dispensed medicines or sell P-medicines in the absence of the RP. She was observed referring to the pharmacist at times, for example, when selling a medicine for a child. She said that she did not always have time to complete her dispenser training modules at work. The SI said that he previously provided team members with two hours study time per week, however, this was not always used effectively by some previous members. He was looking at introducing set study time again.

The SI had done a leadership course and described how that had helped him change some of his working ways, for example, effective delegation of tasks and asking for feedback from the team. He felt that he had good core staff who he encouraged to share ideas and to simplify processes. For example, the dispenser and assistant had digitalised the paperwork for the multi-compartment compliance pack service. The SI completed ongoing training to help keep his knowledge up to date, for example, he had attended online webinars by the Royal Pharmaceutical Society, and had completed a minor surgery course with a primary care training provider.

Team members said they felt comfortable about discussing any issues with the SI or making any suggestions. Performance was discussed informally and targets were not set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had a small retail area which had several chairs for people wanting to wait for a service. The dispensary was spacious and there was sufficient work and storage space, but some workbenches were cluttered. The emergency exit at the back of the dispensary was blocked by bags of confidential waste but these were removed during the inspection.

Multi-compartment compliance packs were assembled on a designated workbench which was located in a room beside the main dispensary. This area was well organised. A spacious consultation room was available for service and a hatch was fitted between the room and the dispensary. This allowed the RP to observe other team members providing services. The dispensing robot was fitted towards the back of the dispensary. A staff toilet and kitchenette were available.

The pharmacy was generally clean though the retail floor was not clean in some areas. Cleaning was shared by team members and generally done once a week. The ambient temperature and lighting were adequate for the provision of pharmacy services. The pharmacy was secured from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

People can access the pharmacy's services. Overall, the pharmacy provides its services safely. And it orders its medicines from reputable sources and largely stores them properly. But it does not highlight prescriptions for higher-risk medicines. So it may be missing out on opportunities to provide people taking these medicines with the information they need to take them safely.

Inspector's evidence

There was step-free access to the pharmacy. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. A list of local practices was displayed in the dispensary and used by team members to signpost people when needed. Some members of the team were observed translating for people who did not speak English.

Dispensing audit trails to identify who dispensed and checked medicines were not always completed. This may make it difficult to identify who was involved in these processes, for example, if a dispensing mistake occurred. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. A prescription for zopiclone, dated 5th September 2022, and was therefore no longer valid, was found still in the retrieval. The SI said he would implement some changes to highlight these prescriptions.

The Covid-19 and flu vaccine services were mainly managed by the dispenser. People could either book or walk in for the service. The Covid-19 vaccine was reconstituted either in the consultation room or back of the dispensary on a designated workbench. The dispenser confirmed the person's details, asked the screening questions and went through the criteria before administering the vaccine. To minimise vaccine wastage, the pharmacy visited a local hospitality business to inform people of any spare doses available on the day.

Prescriptions for higher-risk medicines, such as methotrexate and lithium, were not highlighted in any way. The MCA said she would hand out prescriptions for lithium without necessarily referring to the pharmacist or making any additional checks. She was involved in dispensing but could not remember reading the valproate guidance. She could not accurately describe the 'at-risk' group and said she would read the guidance. The SI was familiar with the guidance. And said he had carried out an audit to find if the pharmacy supplied valproate to anyone in the at-risk group and found only one person who was now taking another medicine.

Prescriptions were filed in alphabetical order and placed in plastic sleeve annotated with the location of the dispensed medicine. The SI said he had briefed the team to double check names and underline the first letter of the surname before filing the prescription. The labels had also been set to generate the surname in brackets so it was clear for team members. Prescriptions were scanned and the computer system was updated when a person collected their medicine.

One of dispensers managed the multi-compartment compliance pack service. Trays were assembled in a designated area which was kept clean and tidy. Prescriptions were printed out and clinically checked by the pharmacist. Backing sheets were generated and packs were assembled against these instead of the prescriptions. The risks of this practice were discussed with the SI who agreed to review the

process. A log was displayed in the dispensary and was updated when a change was made to an assembled pack. The log included details of the change and who had actioned it. Prepared packs observed were labelled with product descriptions and mandatory warnings, but patient information leaflets (PILs) were not always supplied. The SI said that PILs would be supplied with every prescription in the future. Assembled multi-compartment compliance packs were stored on designated shelves at the back of the dispensary. The shelves were annotated with day of collection or delivery and people's names. Red warning cards were placed on some packs to alert team members of any special instructions, for example, if a person collected weekly rather than monthly.

All team members were trained to use the dispensing robot and could deal with most issues in-house. The manufacturer was generally only contacted if the issue was parts related. When stock was received, the 2D barcode on the medicine pack was scanned. The robot generated an arbitrary one-year expiry for medicines inserted as new stock. Stock medicine that had been returned to the robot was given a three-month expiry. Team members included the brand or manufacturer name when registering medicines and this helped them action drug alerts and recalls more efficiently. Drug alerts and recalls were received electronically and filed for reference. Recent alerts were seen to have been actioned.

Manual expiry date checks were conducted every two to three months for stock kept inside the robot and on the shelves, however, records were not maintained. The SI said that expiry date checks would be documented in the future to help keep track. Medicines removed from their original packaging were not always labelled with their batch number and expiry dates. Several amber bottles were removed from the shelves and disposed of during the inspection. The fridge temperature was monitored daily, and records indicated that the temperatures were maintained within the recommended range. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier.

Some empty amber medicine bottles were seen to have been washed and dried in the sink area. SI said these were reused for substance misuse treatment. They were disposed of during the inspection and the SI said that bottles would no longer be reused in the future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

Suitable equipment for measuring liquids was available. A separate plastic measure was used to measure certain liquids only. This was disposed of during the inspection. The SI said he would use approved measuring equipment to measure liquids. Triangle tablet counters were available including a separate counter which 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 phone in the dispensary was portable so it could be taken to a more private area where needed. The SI said that the blood pressure monitor was replaced regularly. The dispensing robot was serviced twice a year.

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.