General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Baum Pharmacy, 10-11 Manor Park Parade, Lee High Road, Lewisham, LONDON, SE13 5PB

Pharmacy reference: 1040852

Type of pharmacy: Community

Date of inspection: 09/04/2019

Pharmacy context

This is a relatively large community pharmacy on a busy main road. It has an automatic door and sells a range of mobility aids. Most of the staff have worked there for a long time and the pharmacy has many regular patients. It dispenses NHS prescriptions. In addition, it offers a wide range of services, including travel vaccinations and on-site anticoagulant monitoring.

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	2.2	Good practice	Team members are well supported when training, and get time set aside to do it. This helps them keep their knowledge and skills up to date.
		2.4	Good practice	Team members are encouraged to discuss and learn from incidents to help improve the safety of the pharmacy's services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy is good at making the services accessible to people by helping address the needs of the local community.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally manages risk well, and learns from any mistakes. Team members are clear about their role and responsibilities. And they know how to safeguard vulnerable people. The pharmacy generally keeps the records it needs to by law. This helps the pharmacy have an accurate record of what happened if there was a query. It largely protects people's private information.

Inspector's evidence

Near misses were recorded on an ongoing basis using a book in the dispensary. The responsible pharmacist (RP) explained that they reviewed them as they occurred and discussed them with the rest of the staff. There was a small team in the pharmacy, and they had meetings most mornings. The superintendent pharmacist visited the pharmacy on Fridays to talk with the staff. They discussed any incidents or other issues at the meetings. The RP said that following some near misses, they had discussed taking more time when dispensing and not rushing. She said that this had helped reduce the number of near misses. She gave an example of a near miss which had occurred between different strengths of bisoprolol, and they had discussed this in the team.

Dispensing errors were recorded electronically and reported to the National Reporting and Learning System. The team members gave an example of an error where atorvastatin had been dispensed instead of bisoprolol. They showed that the medicines had been segregated on the shelves. And said that they had discussed it to make other team members aware. They said that there was a low incidence of errors. The team had a list of medicines which looked or sounded alike, and had put warning stickers on the shelves.

The pharmacy used an audit trail for deliveries to people. A communal page was used for most deliveries, where other people's information was potentially visible. The pharmacist showed that she had set up a system where they used separate pages for each person. But the driver was not using it. She said that she would discuss this with the driver and ensure the correct system was used. For controlled drug (CD) deliveries, people signed individual sheets.

A range of standard operating procedures (SOPs) was in place. Staff had signed ones relevant to their role to indicate that they had read and understood them. But the review dates on the SOPs were not always clear. The dispenser was clear about her role and responsibilities. She could explain what she could and couldn't do when the RP was not present. Team members were seen referring queries to the pharmacist as appropriate.

The pharmacy did an annual survey to get feedback from people using the pharmacy. The results from the previous one were positive, with 96% of respondents rating the pharmacy as very good or excellent overall. Team members were familiar with the complaints procedure. They were not aware of any recent complaints.

Current indemnity insurance was in place. The wrong RP notice was displayed, but this was immediately rectified. The RP log, private prescription records, emergency supply records, and specials records examined complied with requirements. CD registers largely complied but there was the occasional header missing. The pharmacist said that she would fill them in. CD running balance checks were done

monthly.

A shredder was used to destroy confidential waste, and staff had signed confidentiality agreements. Computer terminal screens were turned away from people, and were password protected. Staff used individual Smart cards to access the NHS electronic systems. At the start of the inspection, some confidential patient information was in the consultation room. The room was not locked. This was immediately removed, and the staff said that they would keep the room locked in the future.

The staff had read through the safeguarding policy, and could explain what they would do if they had any concerns. They had access to the contact details of local safeguarding agencies. They had not had any recent concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained staff for its services. They are well supported when training, and get time set aside to do it. This helps them keep their knowledge and skills up to date. They are encouraged to discuss and learn from incidents to help improve the safety of the pharmacy's services.

Inspector's evidence

At the time of the inspection there was one pharmacist (RP), one medicines counter assistant (MCA), and one dispenser. They could explain what accredited training they had done. The pharmacy also had a pre-registration student and a part-time MCA.

The MCA described circumstances in which she would speak with the pharmacy, for example if a person was pregnant or taking other medicines. She was clear about what she would do when selling medicines which could be abused. And she could talk about her questioning technique. She felt comfortable in using the NHS website to help signpost people to further information.

The pharmacist felt able to comply with her own professional and legal obligations. She gave an example of a time when she had contacted a prescriber when there had been a stock problem. And had discussed alternative products with a prescriber when a particular brand was unavailable.

Team members were registered with an online training provider, although some were having initial difficulties in using it. They described how they had recently done a package on children’s oral health. And they had then discussed what they had learnt in the team. They had time set aside for training and were able to do it in work. They explained how they discussed any dispensing incidents and any other issues in the team. And they were encouraged to raise any concerns or make suggestions. The MCA described how she had helped the new MCA to navigate her workbooks, and gone through several over-the-counter products with her. The staff were keen to learn about new products and described how they opened packages and went through the leaflets. They then spoke with the other team members to help increase their product knowledge.

The superintendent was easily contactable, and the pharmacist felt fully able to discuss any issues with them. Staff did not have targets in place, and they said that they provided the services for the benefit of people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are secure and suitable for the pharmacy's services. People can talk with a pharmacist in a private area.

Inspector's evidence

The premises were clean and tidy, with laminate flooring in the shop area. There was good lighting, and ample clear workspace in the dispensary. The pharmacy had two consultation rooms. One was on the shop floor and although a little small, it allowed a conversation to take place inside which would not be overheard. There was a larger room off the shop floor which could be used for vaccinations and other services. This was well fitted out and had a professional appearance.

The room temperature was suitable for the storage of medicines and this was maintained with air conditioning. Handwashing facilities and cleaning products were available. The premises were secure from unauthorised access

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is good at making the services accessible to people by helping address the needs of the local community. Team members generally provide the services safely. And they take the right action when safety alerts are received. The pharmacy mostly manages medicines well. But some packs of medicines contain mixed batches. This could make it harder for team members to do date checking or deal with safety alerts.

Inspector's evidence

The pharmacy had step free access via an automatic door, and a list of services in the window. The pharmacist described how they had considered the needs of the local community and obtained a selection of mobility aids. She said that take-up so far had been good, and they had removed a range of other items to fit them in. Staff described how they signposted people to other services, and they had a good local knowledge.

Dispensed multi-compartment compliance aids were not routinely labelled with a description of the medicines. This could make it harder for the person or their carer to identify the medicines. Patient information leaflets (PILs) were regularly supplied so that people had the information they needed to take their medicines safely. Clinically significant changes, such as when a medicine was stopped or a dose altered, were not always recorded with the full details. For example, dates were not routinely recorded. This could make it harder to know when a change had happened or identify an issue. The dispenser said that they would review the system to make the records more complete.

Dispensed medicines were stored in an alphabetical retrieval system. The prescriptions were retained, in case there was a query on handout. Higher risk dispensed medicines were identified with a sticker. So that the person handing out could refer them to the pharmacist if needed. The team was aware of the additional advice to be given with valproate medicines, and had the relevant cards, leaflets, and stickers. The pharmacist had done an audit, and found no patients who may become pregnant who were taking the medicine.

A range of patient group directions (PGDs) was present, but some had expired in March 2019. The pharmacist said that they were renewed on a rolling basis and she would obtain copies from the superintendent. She described the training she had done to administer medicines (such as vaccinations) under the PGDs.

The pharmacist gave an example of a person who had been prescribed metformin 500mg which had suddenly changed to 1000mg. The person was not getting on well with the new strength, and experienced some side effects. The pharmacist spoke with them during a Medicines Use Review, and then spoke with the prescriber. The dose was changed back to 500mg and the person felt a lot better.

The pharmacy had the equipment to comply with the Falsified Medicines Directive and was regularly using it. The SOPs had been updated to reflect this. The team members said that many packs of medicines did not yet work with the system. But they were using it when they could.

Medicines were obtained from licensed wholesale dealers and specials suppliers. They were organised

and stored very tidily on the shelves. Stock was regularly date checked and this was supported with records. Two boxes of stock were found to contain mixed brands; these were immediately removed. Medicines for destruction were segregated from stock and placed into designated bins and sacks. They were then disposed of via a specialist waste company.

CDs were kept securely. The pharmacy kept medicines that needed cold storage in suitable fridges. The temperatures were monitored daily. Records seen were within the required range.

The pharmacy received drug alerts and products recalls via email from NHS London. It had received a recent one for atropine, and a record had been made of the action taken. A recent recall for amoxicillin had not been received, and the pharmacist signed up to the MHRA email alert system during the inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the right equipment it needs for its services.

Inspector's evidence

A range of calibrated glass measures was available. The electronic tablet counter was clean, and staff confirmed that the electronic equipment had been safety tested. The blood pressure meter did not have a record of when it had been recalibrated or replaced. This could make it harder for the pharmacy to show that it could give accurate readings. The pharmacist said that she would discuss this with the superintendent.

Up-to-date reference sources were available. The anaphylaxis kits in the consultation rooms had expired. The pharmacist immediately replaced one kit, and she said that she would order another replacement in. The fax machine was in the dispensary, and the phone could be moved somewhere more private to help protect people's private 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.