General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kristal Pharmacy, 127/129 Evelina Road, Nunhead, LONDON, SE15 3HB

Pharmacy reference: 1040867

Type of pharmacy: Community

Date of inspection: 18/08/2020

Pharmacy context

A community pharmacy located on a local high street in South-East London. It includes a post office and large retail area. It dispenses large volume of NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them organise 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 adequately manages the risks associated with its services. It records mistakes that occur during the dispensing process so that it can help improve its processes. The pharmacy keeps the records it needs to by law. And it protects people's personal information. Team members know how to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place. It had introduced a new SOP in response to the COVID-19 pandemic, however the regular pharmacist was still discussing this with some members of the team. Some members of the team had not signed to confirm they had read and understood the relevant procedures.

Names and job titles of team members were displayed in the dispensary. This helped identify who was responsible for which task.

Several services had been suspended since the start of the pandemic in order to help minimise the risk of infection, for example, those requiring the use of the consultation room. Staff risk assessments had been carried out. Hand sanitizers were available for the team, as well as personal protective equipment (PPE), including face masks, visors, gloves and aprons. Staff regularly washed their hands.

Dispensing mistakes which had been identified before reaching people were recorded in a 'near miss' book. Members of the team said they discussed any mistakes to help reduce the likelihood of them reoccurring. The pharmacists reviewed these near misses and signed the relevant page in the book to confirm this. Dispensing mistakes which reached people were documented on a specific form; there had not been any recently.

The pharmacy regularly asked people visiting the pharmacy to complete patient satisfaction surveys. There were several positive, five-star reviews on a search engine and the NHS website. Team members had good rapport with people visiting the pharmacy. The complaints procedure was displayed for people and a suggestions box was available on the front counter should people wish to add any comments.

The pharmacy had current indemnity and public liability insurance. The responsible pharmacist's name and registration number was displayed on a notice on the medicines counter. Records about the responsible pharmacist were kept. Other necessary records, including private prescription and emergency supply records, were kept and maintained adequately.

Samples of controlled drug (CD) registers examined were in order. CD balance audits were conducted at regular intervals and entered in the register. The physical stock of two CDs was checked and matched the recorded balance. Patient returned CDs were entered in a separate register and destroyed promptly, in the presence of a witness. Records were updated to include all relevant details. Date-expired CDs were kept separate and clearly marked to minimise the risk of dispensing them by mistake. The pharmacy had emailed the CD Accountable Officer to arrange for their destruction.

Procedures were in place to help manage information and maintain confidentiality. Personal information was not kept near the front counters and confidential waste was shredded. Computers were password protected and access to the pharmacy system was via individual electronic smartcards. A small consultation room was available for private conversations.

There were procedures in place for dealing with any safeguarding issues. Members of the team said they would escalate any concerns to the pharmacist. The contact details of the local safeguarding team were available. There had not been any previous concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to manage the workload and they communicate effectively with each other. Team members are kept up-to-date with changes and given feedback. And they are provided with some ongoing training resources. But this is not very structured, which may make it harder for them to keep their knowledge and skills up to date. Not all team members complete the relevant accredited training modules for their role or complete their courses in a timely manner. This means that they may not have the background knowledge and skills required for the tasks they are completing.

Inspector's evidence

During the inspection, there was the superintendent pharmacist (SI), a regular locum pharmacist, two medicine counter assistants (MCAs), a trainee MCA and a trainee dispenser. Another member of staff worked in the dispensary and was responsible for reordering repeat prescriptions and printing labels for multi-compartment compliance packs. Although she had been enrolled onto a dispensing course in 2017, she had not completed it and was no longer enrolled on it. Following the inspection, the SI provided evidence of her enrolment onto a dispensing course.

The pharmacy also employed another two MCAs, a trainee technician and a trainee dispenser. A member of staff had been employed in March 2020 and was involved in delivering medicines and checking expiry dates of stock. She had not been enrolled onto the relevant course in order to carry out expiry date checks, however, the SI assured the inspector that she would not be involved in conducting these checks in the future.

The pharmacy was busy, but team members dealt with queries efficiently and took their time to ensure people's requests were fulfilled. Team members were observed providing detailed information to people, for example, if a product was not available, people were told when it would arrive and reminded of the pharmacy’s opening hours. Members of the team worked well together. A dispensary communication log was displayed and filled out by team members who wanted to share important information with their colleagues. The log was checked at the start of their shifts to ensure any tasks were actioned appropriately and in a timely manner.

The MCAs asked several questions before selling over-the-counter medicines. They also advised people to read the information available within the medicine packs, after providing additional advice on how to take the medicine. There was little evidence of structured training at the pharmacy, but team members said they regularly read booklets and pharmacy magazines. The trainee dispenser said she felt supported at work, by both pharmacists and other colleagues. The pharmacists reviewed her progress every week and provided her with training time during working hours whenever she needed. One MCA said he was rereading the course material with his colleague who was currently enrolled onto the MCA course. He said this helped keep his own knowledge up to date.

Members of the team said that the pharmacists observed their conversations with people and gave feedback. The pharmacists also informed them of any changes or updates, for example, information received from NHS England. Formal team meetings were held every three months and informal ones every two to three weeks. The team had a meeting at the start of the pandemic, where they were provided with additional information on how the pharmacy would manage risks. For example, they

discussed cleaning procedures and the availability of PPE for the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, and the pharmacy provides a safe and secure environment for people to receive the pharmacy's services.

Inspector's evidence

The pharmacy was spacious, clean and tidy. Additional measures had been implemented in response to the COVID-19 pandemic, including sanitizing the work benches daily. There were signs and floor markings to help remind people to maintain a safe social distance. A cleaning rota was displayed to help remind team members to complete cleaning tasks, including an additional rota put in place at the start of the pandemic. Workbenches were kept clutter free so that tasks could be completed safely.

A small consultation room was available for private conversations and services. The room was generally tidy. A clean sink, with hot and cold running water, was used for the preparation of medicines. An electric hand dryer was fitted in the staff toilets. The room temperature and lighting were suitable for the provision of pharmacy services. The premises were secure.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services in an organised manner. It has robust audit trails in place to help team members provide the services safely and effectively. People taking higher risk medicines are provided with appropriate advice and information about their medicines. The pharmacy makes sure its medicines are safe to use and it stores them properly.

Inspector's evidence

There was step-free access at the pharmacy which made it easier for people with wheelchairs or those with pushchairs to use the pharmacy. A practice leaflet was not displayed to inform people of the services that were available at the pharmacy. The superintendent pharmacist said he had ordered a new batch but wanted to check their accuracy before displaying them for people.

There was a robust process in place to keep track of prescriptions which had been ordered by the pharmacy. Clear audit trails were kept on the pharmacy's electronic system which allowed all team members to identify which stage the prescription was at. Once repeat prescriptions were ordered, the system was updated with the date on which the order was made and the method (for example, by email). Prescriptions which were not received back on time were followed up and the person was informed over the telephone of any delays to their prescription. The system was updated again when the GP and person were contacted. Team members would annotate the electronic system if a person did not answer the telephone call.

Baskets were used to keep medicines and prescriptions together and help prevent mixing of people's medicines. The pharmacy's electronic system highlighted any interactions, and these were printed out for the pharmacist to review.

Stickers were used to highlight medicines requiring additional counselling. The pharmacy had conducted several Medicines Use Reviews with people who were in the 'at-risk' group and taking sodium valproate. This was to help ensure they understood the potential risks associated with this medicine. The pharmacy had the relevant information cards, booklets and stickers to provide to people taking this medicine. The pharmacy team kept clear notes on people's electronic records of any counselling points or interventions. Team members initialled any notes so that it was clear who had added them, should any queries arise.

A delivery service was available at the pharmacy. Clear audit trails were maintained on the pharmacy's electronic system so that team members could identify when medicines had been delivered to a person, or if they had been collected, and by whom. People were asked to sign additional sheets to confirm they had received CDs.

The pharmacy's electronic system was annotated if a fax was received for a person. Faxes were stored in a designated area and members of the team were able to easily find these once they checked the system. These were dispensed when the person visited the pharmacy.

Any important information about a person's medicine was logged onto the system in a way that

members of the team could see this information first, before accessing the list of medicines. This meant they could only dispense after checking the additional notes. The system was also annotated clearly if a person was hospitalised. This helped ensure that medicines were only dispensed once a hospital discharge note was received, in case there had been any changes to a person's medicines.

People whose medicines were not available from wholesalers were kept up to date with any information, for example, when their medicine was due back in stock. The pharmacy offered to contact doctors and provide suggestions for alternatives, with the person's permission. The pharmacy's electronic record system was updated with any communication between the pharmacy, the person and the prescriber.

People needing help to take their medicines were supplied with multi-compartment compliance packs to organise their medicines. Detailed electronic records of people receiving these packs were kept up to date. Any changes were clearly annotated, including medicines which had been stopped. This helped reduce errors, stockpiling and wastage. Members of the team involved in picking and checking the medicines signed a bag label, and those involved in assembling the packs initialled the packs. This helped identify who was involved in all the steps. Descriptions of the medicines dispensed in the packs were provided to help people identify the medicine. Information leaflets were seen to be provided with dispensed packs. This meant people had access to up-to-date information about their medicines.

Licensed wholesalers were used to order medicines; invoices were retained at the pharmacy. The pharmacy checked its stock's expiry dates every month and kept records of these checks. Medicines approaching their expiry dates were clearly marked with a coloured sticker annotated with their expiry date. Several medicines were checked at random and were seen to be in date. Expired medicines and those returned by patients were stored in waste medicine bins. These bins were stored appropriately and kept away from other medicines. Separate bins were available for cytotoxic and hazardous medicines.

The pharmacy did not have the software needed to comply with the Falsified Medicines Directive but had registered with the appropriate organisation. The SI pharmacist was looking into this. Medicine recalls were received, actioned and stored for reference.

A large medicinal fridge was used to store medicines requiring cold storage. Fridge temperatures were checked and recorded daily. A sample of record sheets was checked, and the fridge was seen to be maintained at the appropriate temperatures.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. Team members maintain equipment appropriately and they make sure that people's confidential information is kept secure.

Inspector's evidence

Clean glass measures were available. The fridge was clean and suitable for the storage of medicines. Clean counting triangles were also available, including a separate one for cytotoxic medicine. This helped avoid cross-contamination. 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.

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.