General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ropharm Chemist, 169 Rye Lane, Peckham, LONDON, SE15 4TL

Pharmacy reference: 1040874

Type of pharmacy: Community

Date of inspection: 03/04/2019

Pharmacy context

This is a large community pharmacy situated on a busy main road in South East London. It serves a diverse local population. It mainly dispenses NHS prescriptions. It also supplies medicines in multi-compartment compliance aids and offers other services including a delivery service, minor ailments, medicine use reviews and needle exchange.

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 manages the risks associated with its services. The pharmacist logs any mistakes they make during the dispensing process and tries to learn from these. Some written procedures have not been reviewed for some time so they may not reflect current practices. The pharmacy keeps the records it needs to by law. Running balances are not regularly checked. It generally manages and protects confidential information well. Members of the team have had training on safeguarding vulnerable groups. But this was some time ago. So, their knowledge might not be up to date.

Inspector's evidence

A set of standard operating procedures (SOPs) from 'the Informacist' were in place but these had not been reviewed since 2015. Some were not updated following changes in legislation, e.g. the SOP covering controlled drug (CD) requisitions. Current members of staff had signed the relevant SOPs to confirm they had read and understood them.

Prescriptions were mainly received electronically and this enabled the superintendent (SI) pharmacist to manage and prioritise his workload. Prescriptions were prepared in advance of the person presenting at the pharmacy. People who had not collected their medication were contacted where possible.

The SI pharmacist self-checked; he described dispensing from prescriptions rather than labels to help reduce picking errors. He took a short mental break between dispensing and checking each prescription.

The SI pharmacist recorded any near-misses on a log and said this was to help him reduce errors in the future. Part-dispensed packs were clearly marked and rubber-banded to help reduce quantity errors. Some medication had also been separated, e.g. metformin 500mg and 1000mg slow release tablets. A formalised review of the near-miss log was not conducted. This could make it harder for the pharmacy to identify any patterns or trends.

The SI pharmacist said there had not been any dispensing incidents for several years. A form was available to document incidents should they arise and the SI would also report these on the national reporting and learning system (NRLS).

In date indemnity and public liability insurance was in place. The correct responsible pharmacist (RP) sign was displayed in the retail area and the RP register was in order. The medicine counter assistants (MCAs) were aware of the tasks that could and couldn't be carried out in the absence of the RP.

All necessary records, including private prescription and emergency supply records, were kept. They were mostly in order but the date on which a private prescription was written was not recorded for some entries in the private book. The pharmacy had not dispensed unlicensed medicines for a long period of time.

Records for CDs were in place and entries in the CD registers were complete. Quantity audits for

schedule 2 CDs were not conducted at regular or frequent intervals. A random stock check of a controlled drug agreed with the recorded balance; the pack had expired in August 2018 but was mixed with other stock. Other expired CDs were found in a clear plastic bag, segregated from stock. A returns and destruction register was available to record any CDs returned by people.

A privacy policy was displayed on a notice board in the retail area. The MCAs had received some inhouse training on protecting patient confidentiality but had not completed any training on the General Data Protection Regulation. Computers were password protected and were not visible to people. Verbal consent was gained from people when accessing their Summary Care Records. Confidential waste was shredded at the pharmacy. Repeat slips attached to bags of medicines awaiting collection were visible to people accessing the consultation room; the SI pharmacist said he would turn the bags so that information was not visible.

The complaints procedure was displayed for people accessing the pharmacy's services. Feedback was sought from people verbally or via annual community pharmacy patient questionnaires (CPPQ). An additional chair had been placed and one gondola was removed to create more space in the retail area in response to feedback.

The MCAs and SI pharmacist had attended a training workshop on safeguarding which had been arranged by the local pharmaceutical committee, but this was several years ago. One MCA said she would refer any concerns to the pharmacist but she could not describe signs of neglect.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff for the services it provides.

The team members do ongoing training to keep their knowledge and skills up to date, but this is not always recorded. This could make it harder for the pharmacy to show which training packages the team members have done.

Inspector's evidence

At the time of inspection there was the SI pharmacist and two MCAs. The pharmacy also employed another part-time MCA. A regular locum pharmacist was used to cover pharmacist leave. This was a quiet pharmacy and the SI and MCAs managed their workload well throughout the inspection.

One MCA described her responsibilities and these included checking deliveries, sorting the retail delivery out, serving people, selling pharmacy only (P) medicines and handing out dispensed medicines. The MCAs confirmed peoples' names and addresses before handing out dispensing medicines. They asked the WWHAM questions before selling P medicines and checked for allergies or any other conditions. They were able to name products which were open to abuse, such as codeine and pseudoephedrine containing medicines and some cough syrups. They said they would refer multiple requests of these to the pharmacist.

The MCAs were observed referring some people to the pharmacist, for example, one woman who was showing signs of a skin infection. The MCAs had access to books and leaflets, for example, Counter Intelligence booklets. One MCA said she also read another colleague's training workbooks whilst she was training to be a MCA, to refresh her knowledge. Training records were not maintained.

Performance was discussed informally. Staff meetings were also held at times to discuss workload, customer service and any problems or issues. The MCAs were happy to openly raise concerns to the SI pharmacist and said they regularly made suggestions, e.g. on stock holding and arrangement. Targets were not set for the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is maintained and secured properly, and provides an environment that is suitable for its services.

Inspector's evidence

This was a spacious pharmacy with ample work and storage space. Workbenches were clean and tidy. The retail area was well laid out though fittings had not been updated for some time. There were two cushioned chairs available for people wanting to wait for a service.

The cleaning was shared by members of the team and done on a daily basis. A clean sink, with hot and cold running water, was used for the preparation of medicines. The room temperature and lighting were suitable for the provision of pharmacy services.

A small consultation room was available for private conversations and services but it was cluttered with boxes. This detracted a little from the overall appearance. The room was located behind the medicines counter; the pharmacist said he escorted people into the room. Staff facilities included a clean kitchenette and WC. The premises were secure.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy services. The pharmacy has some systems in place for making sure that services are organised. But people taking some higher risk medicines might not get all the information they need to take their medicines safely. The pharmacy generally manages medicines well. But there are long intervals between expiry date checks. This could increase the risk that people get medicines that are out of date. It does not always keep records of what it had done about drug alerts and recalls. This may make it harder for the pharmacy to show that the stock is safe and fit for purpose.

Inspector's evidence

Access into the pharmacy was step free and via a wide automatic door. There was ample space for people with wheelchairs in the retail area. The SI described speaking clearly to people with hearing difficulties and said he personally delivered medication to housebound people.

Members of the team were multilingual and were observed translating for some people who did not speak English well. The SI said he also asked staff at local shops to translate if necessary, with consent from people accessing the services.

Services were advertised on the NHS website. Some services, e.g. needle exchange, were also advertised in store.

Amber medicine bottles were at times reused for methadone instalments. One bottle was found with several labels placed over each other. This was unhygienic and could increase the risk of contamination.

Dispensing audit trails were maintained to help identify the pharmacist involved in dispensing and checking prescriptions.

Prescriptions were retained with dispensed medicines. Some bags of medicine awaiting collection were stored on a low shelf, under some P medicines. the bags were kept open and there was therefore a risk of P medicines falling inside the bags.

The pharmacist said he checked if people taking higher risk medicines were being monitored but did not routinely provide advice, for example on signs of toxicity and diet. INR levels of people taking warfarin were not recorded for reference.

People receiving multi-compartment compliance trays were asked to contact the pharmacy before finishing their final tray. The pharmacy sent repeat requests to GP surgeries and kept a record of requests to help keep track. The GP was contacted if the prescription was not received in a timely manner. Prescriptions were cross-checked with the patient medication record (PMR) and any changes would be documented in the ‘notes’ section. But these were not always detailed. For example, one

person was not supplied Depakote due to stock supply issues. The pharmacist said he had contacted the GP and found that the person had sufficient amounts at home. But this information was not noted on the PMR. The pharmacist had not checked if Depakote could be safely supplied in compliance aid trays. Drug descriptions were provided and patient information leaflets were routinely supplied. The pharmacist said he verbally reviewed people's needs and compliance with trays though this was not formalised.

The pharmacist had read the valproate guidance. He said he would check if there was a risk of pregnancy in women prescribed valproate. But he did not know about the pregnancy prevention programme (PPP) and was not entirely sure of the information to provide them. Information cards were available at the pharmacy. The SI could not describe how he would label valproate removed from its original pack and supplied to women taking the medicine.

The pharmacy was still in the process of ordering equipment and updating the system to meet the requirements of the Falsified Medicines Directive. Stock was obtained from reputable wholesalers. It was stored tidily on the shelves.

Dispensary date checks were done at irregular intervals and at times by the MCAs. Intervals of nine to twelve months were seen between some checks. Medicines with short expiry dates were flagged up using elastic bands. No expired medicines were found at the time of inspection.

The date of opening was not written on methadone liquid which had a limited shelf life after the seal was broken. This made it harder for team members to know if the methadone was still safe to dispense.

Medicines that needed cold storage were kept inside a fridge. Fridge temperatures were checked and recorded daily. These were kept within the recommended range of two to eight degrees Celsius.

Waste medicine was disposed of in waste medicine bins which were stored in the dispensary. These bins were collected every three months by an approved contractor; invoices were retained at the pharmacy.

The pharmacy received drug alerts and recalls via email. But audit trails of any action taken in response to these were not always maintained. Some alerts received in 2018 were seen to have been printed out and filed for reference.

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

The CD cabinet was kept secure. There were several clean glass measures available. A clean counting triangle and capsule counter were available.

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 reference sources.

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.