General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: T T Pharmacy, 174 Croydon Road, LONDON, SE20 7YZ

Pharmacy reference: 1040920

Type of pharmacy: Community

Date of inspection: 13/08/2019

Pharmacy context

This is a community pharmacy in a largely residential area. People who use the pharmacy are mainly from the local area. The pharmacy supplies medications in multi-compartment compliance packs to people in a local care home. It provides Medicines Use Reviews and New Medicine Service checks to people.

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 generally manages the risks associated with its services. It mostly protects people's personal information well. And its team members know how to protect vulnerable people. The pharmacy largely keeps the records it needs to by law. But it could do more to make sure its records are up to date and contain all the required information. The pharmacy doesn't always record mistakes that happen during the dispensing process. And this could make it harder for it to identify any patterns and take preventative action to make the services safer.

Inspector's evidence

The pharmacy had processes to use to record mistakes that happened during the dispensing process. A book was available for recording near misses, but it was not regularly used. The last record found in the book dated from June 2018. The pharmacist gave an example of a near miss that had occurred between aspirin non-dispersible and aspirin dispersible tablets. He showed that the different tablets had been separated on the shelves as a result, but the near miss had not been recorded. He said that they discussed near misses in the team if they occurred. Dispensing errors had been recorded in the near miss log. The pharmacist gave an example of one where the wrong type of insulin had been supplied, although the person had spotted the mistake before they used it. The pharmacist explained that they had reviewed the dispensing standard operating procedure (SOP) to ensure that the type of insulin was double-checked. The record of the error in the near miss log did not contain much information (such as the person's name or if the GP had been contacted), and the pharmacist said that he would discuss with the superintendent how they would record errors in the future.

A range of SOPs was available, but the folder they were in was a little disorganised and it was hard to find specific procedures. The dispenser said that she had read the SOPs at the pharmacy she used to work at but was not certain if she had read the ones for this pharmacy. She could clearly describe her role and responsibilities, and what she could and couldn't do if the pharmacist was not present. Only the trainee dispenser had read and signed all the SOPs relevant to her role. The pharmacist said that he would discuss this with the superintendent and ensure the staff read through and signed the ones relevant to their role.

The pharmacist understood that the pharmacy surveyed people who used the pharmacy annually, but the results could not be found during the inspection or on the NHS website. The pharmacist believed that the superintendent may have the results. One review had been left on the NHS website for the pharmacy, and it had given the pharmacy a five-star rating. There was a complaint procedure but only the trainee dispenser had signed it. The dispenser said that she would refer any complaints to the pharmacist. There were no signs or leaflets found in the public area to inform people how they could provide feedback or make a complaint. This could make it harder for people to know how to do this.

The pharmacy's indemnity insurance provider confirmed to the inspector that the pharmacy had current indemnity insurance. The right responsible pharmacist (RP) notice was displayed. The pharmacist had some difficulty in showing the RP log, as he understood that the computer automatically made the entry in the log when he signed in. This was found not to be the case, and the superintendent pharmacist was still signed in as he had not signed out when he had left. This was resolved during the inspection, and the pharmacist said that he would complete the log correctly in the

future. There were previous records in the RP log from the regular (superintendent) pharmacist. Private prescription records and controlled drug (CD) registers examined complied with requirements. A small number of emergency supply records did not indicate the full reason as to the nature of the emergency. And this could make it harder for the pharmacy to show why a supply was made if there was a future query. Only one record for the supply of an unlicensed medicine was found, and it did not contain the required information. The pharmacist printed off the guidance on unlicensed medicines from the MHRA during the inspection and said that they would record the right information in the future.

People's private information was mostly away from public view. One large bag of dispensed medicines was behind the counter and the person's details on it could be read from the public area; the dispenser moved this immediately to a more secure location. A shredder was used to safely destroy confidential waste. The pharmacist and trainee dispenser had individual smartcards to access the NHS electronic systems. Computer terminal screens were turned away from people using the pharmacy and access to the terminals was password protected.

The pharmacist confirmed that he had completed level 2 safeguarding training. With some prompting, he could describe what he would do if he had any safeguarding concerns. The trainee dispenser said that she worked at a hospital one day a week and had completed safeguarding training there. There was no evidence that the dispenser had done any formal safeguarding training but she said that she would refer any safeguarding concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services safely. Team members have completed the required accredited training for their roles or are registered on a course. They receive some ongoing training, but this is not always structured or recorded. And this makes it harder for them to show what type of training they had done.

Inspector's evidence

At the time of the inspection there was one pharmacist (locum), a trained dispenser, and a trainee dispenser. The trained dispenser mainly worked on the medicines counter and also prepared the multi-compartment compliance packs. The trainee dispenser was registered on an accredited training course. The pharmacy also employed a part-time medicines counter assistant (MCA); the pharmacist confirmed that the MCA had completed the accredited training course. Dispensing was up to date and team members were managing the workload well.

Team members did not receive structured ongoing training, but they said that they read information about new products and other training materials from manufacturers and suppliers on an irregular basis. This training was not recorded, so this made it harder for them to show what type of training they had done. They sometimes received time set aside to do the training at work, but they said that this was difficult when the pharmacy was busy. The trainee dispenser said that she got some time set aside in work to do her course, but this was not always possible. The team did not have regular meetings, but the pharmacist explained that they discussed any issues as they arose.

Team members felt able to raise any concerns about patient safety. The superintendent pharmacist often worked at the pharmacy and so was accessible to staff if they wanted to discuss something. Team members were not set any numerical targets. The pharmacist felt able to take professional decisions to ensure that people were kept safe.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are mostly clean and tidy. People can have a conversation with a team member in a private area. But this area has restricted space, which limits the range of services that the pharmacy can provide.

Inspector's evidence

The pharmacy was generally clean and tidy. Storage space was limited but it had mostly been used well. There were some bags of dispensed medicines on the floor near the medicines counter but they were kept out of the reach of the public. The pharmacist said that the bags contained medicines which people were due to collect, and they had dispensed a few large prescriptions recently. He said that he would contact the people to let them know their medicines were ready. There was an adequate amount of clear work space in the dispensary and there was good lighting throughout.

There was limited space in the consultation room, and only room for one chair. The pharmacist said that this had limited the range of services they could provide, and Medicines Use Reviews were rarely done. The room did allow a conversation to take place inside which would not be overheard, but there was not enough space for people to sit down.

The room temperature in the pharmacy was suitable for the storage of medicines and regulated with air conditioning. The pharmacy was kept secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services in a safe and effective manner. It gets its medicines from reputable sources and mostly stores them properly. It takes the right action in response to safety alerts, to make sure that people get medicines and devices that are safe to use. But the pharmacy doesn't always include all the required information when it dispenses multi-compartment compliance packs. So, people may not have all the information they need to take their medicines safely.

Inspector's evidence

There was a step at the front of the pharmacy. Team members had a clear view of outside from the counter and said that they went out to people who needed assistance. The doorbell was not working and the dispenser said that they would change the battery. A list of the opening times was displayed in the window along with several posters. Some of the posters were old and faded, which detracted somewhat from the outside appearance of the pharmacy.

Baskets were used during the dispensing process to help prevent people's medicines becoming mixed up. There was a clear workflow through the pharmacy.

Dispensed multi-compartment compliance packs were mostly labelled appropriately. But they were not labelled with a description of the medication, which could make it harder for people or their carers to identify the medicines. Required safety warnings for certain medicines were not included on the labels; the pharmacist said that they were able to rectify this to include them in the future. He said that this could be done by changing a setting in the computer software. The packs were of a disposable type, which meant that people always got a fresh pack with their medicines. Patient information leaflets were not routinely supplied, and this could mean that people don't get all the information they need to take their medicines safely. The dispenser said that she would make sure they were supplied in the future. She explained that any changes in medicines or communication with prescribers was put on to the person's electronic record but was unable to find any recent examples. The backing sheets for the packs were loosely placed inside them, which may increase the chance that they could become misplaced. The dispenser said that they would start attaching them to the packs.

The pharmacist was aware of the guidance about pregnancy prevention that some people taking valproate needed to be given. He was not aware of any people the pharmacy had who were in the at-risk group. Team members were unable to locate the additional safety material for valproate and said that they would order some more in. The pharmacist explained that he wrote 'see pharmacist' on any dispensed bags containing higher-risk medicines such as methotrexate or lithium. No bags containing these medicines were found on the shelves, so this could not be confirmed during the inspection. A bag of dispensed medicines containing a Schedule 3 CD was found, and it had not been highlighted. This could increase the chance that the medicine is supplied after the prescription was no longer valid. Prescriptions were not routinely kept for dispensed medicines, and this could make it harder for the team members to refer to the original prescription if there was a query. The pharmacist said that they would retain the prescriptions in future.

The pharmacist described how they obtained signatures from recipients when delivering medicines. But the record of this was with the driver and was unable to be examined during the inspection. The

inspector discussed with him the importance of protecting other people's personal information when collecting signatures.

The pharmacist was not aware of the requirements around the Falsified Medicines Directive (FMD). The superintendent was not due back into the pharmacy until the end of the month. Following the inspection, the pharmacist confirmed that he had spoken with the superintendent who was in the process of enquiring about the equipment and systems he needed and that he would pursue it further when he returned to the pharmacy.

Medicines were obtained from licenced wholesalers and specials suppliers. The medicines were stored tidily, but one box found in stock contained mixed brands, and another two contained mixed batches. This could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The dispenser said that they date-checked the stock regularly and was able to show stickers placed on items which were approaching their expiry date. But the date checks were not recorded. And three date-expired medicines were found in with stock. The dispenser said that they would record the date checking in the future and date-check all the stock again. Medicines for destruction were separated from stock and placed into designated bins and sacks for secure offsite disposal.

CDs were largely kept securely. Medicines which required cold storage were kept in a medical fridge, but the minimum and maximum temperatures were not routinely monitored or recorded. On the day of inspection, the minimum and maximum temperatures were 3 and 14 degrees Celsius respectively. The current temperature showed as 4 degrees Celsius, which was within the acceptable range. The lack of records meant that the pharmacy was unable to show that the medicines inside had been stored appropriately and were safe to use. The pharmacist was advised to contact their indemnity insurance provider to seek advice. Following the inspection, the pharmacist said that he had discussed the issue with the superintendent. He provided evidence that the stock inside the fridge had been removed for destruction and that the fridge temperatures were now being recorded daily.

The pharmacy received information about drug alerts and recalls via email, and the pharmacist described the action they had taken for a recent recall. A record of the action taken was not always made, and this made it harder for the pharmacy to show what action they had taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Calibrated glass measures were clean, and a separate marked one was used to measure CDs to help avoid cross-contamination. Equipment used to count tablets was clean, and empty bottles used for dispensing were capped to prevent contamination. The pharmacy had access to up-to-date reference sources. The fax machine was away from the public area, and the phone could be moved somewhere more private 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.