General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Vale Pharmacy, 104 Grove Vale, East Dulwich, LONDON, SE22 8DR

Pharmacy reference: 1040930

Type of pharmacy: Community

Date of inspection: 06/03/2020

Pharmacy context

The pharmacy is located on a busy high street in a town centre in a largely residential area. The pharmacy receives around 80% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews and the New Medicine Service. It 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 to a small number of 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It largely protects people's personal information and people can provide feedback about the pharmacy. It largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people. But the pharmacy doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included; documented, up-to-date standard operating procedures (SOPs). Team members had not signed all of the SOPs relating to their role to show that they had understood them. The superintendent (SI) pharmacist said that he would ensure that team members understood the SOPs and he would request that they sign them. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. The trainee dispenser said that she did not record her near misses. A near miss book was available, but it had not been used for a couple of years. The SI said that he would encourage team members to record their own mistakes and he would review them regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The SI said that he was not aware of any dispensing incidents where the wrong product had been supplied to a person. He confirmed that any incidents would be recorded on the pharmacy's computer and a root cause analysis would be undertaken.

The second pharmacist dispensed most of the medicines during the inspection and he took a mental break between dispensing and checking. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The trainee dispenser said that the pharmacy would open if the pharmacist had not turned up. She thought that she could sell general sales list medicines and carry out dispensing tasks if there was no responsible pharmacist. She knew that she should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. A notice was displayed showing what tasks could be carried out if the responsible pharmacist was absent from the premises. The inspector informed the trainee dispenser what she could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. The responsible pharmacist (RP) log was completed correctly and the right RP notice was clearly displayed. All necessary information was recorded when a supply of an unlicensed medicine was made. And the emergency supply record was completed correctly. Controlled drug (CD) registers examined were filled in correctly. The CD running balances were checked at regular intervals and any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were largely completed correctly, but the

full prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2017 to 2018 survey were available on the NHS website. Results were positive with 99% of respondents satisfied with the service they received from the staff. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The SI said that there had not been any recent complaints.

The SI had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The trainee dispenser had not undertaken any safeguarding training yet. But she could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The SI said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe. But the pharmacy does not always ensure that team members are enrolled on approved pharmacy courses within the required time frame. This could mean that they do not have all the skills and knowledge they need to undertake their tasks safely.

Inspector's evidence

The superintendent (SI) pharmacist was working on the day of the inspection, alongside a second pharmacist and a trainee dispenser who had worked at the pharmacy for around six months. The trainee dispenser said that she had not been enrolled on an accredited course yet, but this had recently been discussed with the SI. She had been working on the medicines counter and carrying out dispensing tasks. The SI said that he would ensure that the trainee dispenser was enrolled on a suitable accredited course for her role. Following the inspection, the inspector received confirmation that the trainee dispenser had been enrolled on an accredited course. The second pharmacist said that he worked at the pharmacy when it was short staffed. The team members worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee dispenser appeared confident when speaking with people. She was not aware of the restrictions on sales of pseudoephedrine containing products. But the till prompted her to seek assistance from the pharmacist before allowing her to sell it. She said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacists were aware of the continuing professional development requirement for the professional revalidation process. The second pharmacist said that he had recently attended a seminar about type II diabetes. He said that he regularly read pharmacy related magazines and articles online to keep his knowledge up to date.

The pharmacists said that they felt able to take professional decisions. The trainee dispenser said that she felt comfortable about discussing any issues with the SI or making any suggestions. She said that any information was passed on informally throughout the day. The SI said that he carried out ongoing informal performance reviews with team members and he planned to carry out more formalised appraisals in the future. Targets were not set for team members. The SI said that services were provided for the benefit of the people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area. But the pharmacy could do more to keep some areas tidy and free from clutter.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and generally tidy. Workspace in the dispensary was limited and it was cluttered at the start of the inspection with little clear space for dispensing and checking medicines. Some bagged items waiting collection were taking up much of the worktop area. These were moved and there was clear space for dispensing and checking.

Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacists could hear conversations at the counter and could intervene when needed. Air conditioning was not available; the room temperature was suitable for storing medicines on the day of the inspection. The SI said that the room temperature was suitable during the warmer months and heaters were available when it was colder.

There were two chairs in the shop area. These were positioned close to the medicines counter which meant that conversations at the counter may be overheard. The trainee dispenser said that she would offer the use of the consultation room if a person asked to speak with someone in a more private setting.

The consultation room was located in the shop area. It was small but it was accessible to wheelchair users. Low-level conversations in the consultation room could not be heard from the shop area. The room was suitably equipped and well-screened, but it was not kept secure when not in use. And there were some unsecured items in the room. This was discussed with the SI and the items were moved into the dispensary during the inspection. The Si said that he would remind team members to ensure that the consultation room was not used to store these types of items in the future.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. It responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines. The pharmacy does not regularly remove uncollected medicines from its shelves. And this could increase the chance of these being handed out when the prescription was no longer valid.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available.

The SI said that prescriptions for Schedule 3 and 4 CDs were kept separate from other prescriptions and these were managed by the pharmacist to help minimise the chance of these medicines being handed out when the prescription was no longer valid. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The SI said that the pharmacy did not keep a record of any blood test results for people taking higher-risk medicines. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The SI said team members checked CDs and fridge items with people when handing them out. He said that the pharmacy did not currently supply valproate medicines to any people in the at-risk group. The pharmacy had not yet received the updated version of the relevant patient information leaflets or warning cards. The SI said that he would order these from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. There were no date-expired items found in with dispensing stock, but there was a box found which contained loose capsules. The SI said that he would remind team members to ensure that any medicines which were removed from the foil strips in error were disposed of appropriately.

The second pharmacist said that part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions had not been checked for around a year. Most of the prescriptions for the items waiting collection were no longer valid and some of the medicines were out-of-date. Some of the prescriptions were dated over one year ago. The SI said that he would remove uncollected items after around three months in the future to help minimise the chance of them being handed out when the prescription was no longer valid. The trainee dispenser said that she would check a person's name and address before handing out any dispensed medicines. She would not check the date on the prescription or on the bag label.

The SI said that people's GPs carried out assessments to show that they needed their medicines in multi-compartment compliance packs. The pharmacy did not routinely order prescriptions on behalf of people who received their medicines in multi-compartment compliance packs. The SI said that most people were responsible for ordering their own prescriptions for their medicines. But the pharmacy did manage this for a few people who were not able to do this themselves. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled, but there was no audit trail to show who had dispensed and checked each tray. This could make it harder for the pharmacy to identify who had done these tasks and limit the opportunities to learn from any mistakes. Medication descriptions were put on the packs to help people and their carers identify the medicines, but patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The SI said that he would ensure that team members signed the packs in the future and that patient information leaflets were supplied. The trainee dispenser wore disposable gloves when handling medicines that were placed in these packs.

CDs were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. The SI was not able to locate the register where returned CDs were recorded. He said that there was a register available and that the returned CDs were destroyed with a witness.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The SI explained the action the pharmacy took in response to any alerts or recalls. And the emails were kept for future reference. The pharmacy did not have the equipment to be able to comply with the EU Falsified Medicines Directive. The SI said that the pharmacy would have the equipment in the near future and the current software could be used with the equipment.

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

Suitable equipment for measuring liquids was available and separate liquid measures were marked for methadone use only. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. An electronic tablet counter was available and this was clean.

Up-to-date reference sources were available in the pharmacy and online. The SI said that the blood pressure monitor had been in use for around one year and this would be replaced in line with the manufacturer's guidance. The shredder was in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

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.