General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Touchwood Pharmacy, 62 Sydenham Road, Sydenham, LONDON, SE26 5QE

Pharmacy reference: 1040960

Type of pharmacy: Community

Date of inspection: 03/09/2019

Pharmacy context

This is a community pharmacy on a busy main road in Sydenham. It is near a railway station. It supplies medication in multi-compartment compliance packs to some people who need help managing their medicines. And it offers travel vaccinations and other medicines under patient group directions. The pharmacy provides Medicines Use Reviews and New Medicine Service checks.

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 identifies and manages the risks associated with its services. It asks people who use it for their feedback and it largely keeps the records it needs to by law. It generally protects people's personal information appropriately. Team members know how to protect the welfare of vulnerable people. They follow written procedures to provide the pharmacy's services safely. But the procedures are overdue for review, which may mean that they do not reflect current best practice. Team members take action to help prevent a recurrence when mistakes are made during the dispensing process. But they do not always record all their mistakes. And this could mean that they are missing out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

Paper sheets were available in the dispensary for recording near misses, but they were not used regularly. On some recent sheets there was only one near miss recorded for each month. The pharmacist accepted that all the near misses that occurred had not been recorded and said that he tended to record down the more significant ones. The pharmacist was not aware of any regular review of near misses that occurred. But he said that the pharmacy had identified a pattern of near misses where the wrong quantities were dispensed. As a result, he explained that team members now laid out all the medicines on the dispensing bench to count them before handing them for the final check. He said that this had helped reduce the number of these types of mistakes. He showed that medicines that looked or sounded alike had been separated on the shelves.

The pharmacist explained how they would report dispensing errors on a form and send a copy to the superintendent pharmacist but was unable to find any filled-in forms. The dispenser was able to show the blank form that would be filled in, and it was similar in appearance to the forms used by the National Reporting and Learning System. The pharmacist described an error that had occurred where a person's medicines were sent to the wrong house, due to the bag label becoming detached from the bag. He said that they now stapled the bag labels to the bags to help prevent a repetition.

A range of standard operating procedures (SOPs) was in place, but they were mostly overdue for review. The date of the last review seen on many of the SOPs was 2016. This could mean that the SOPs do not reflect current best practice. There were some staff signatures on the SOPs, but none of the team members present during the inspection had signed them. The trainee dispenser said that she was familiar with the SOPs as she had signed them at another branch.

The trainee dispenser was clear about her own role and responsibilities. The dispenser could describe what she could and couldn't do if the pharmacist was absent but thought that she could sell General Sales List medicines if the pharmacist had not turned up. The inspector reminded her of the requirements.

A sign was displayed in the public area to inform people how they could make complaints or provide feedback. The pharmacy undertook an annual patient survey and the results from the 2017 to 2018 survey were displayed on the NHS website. The results were largely positive, with around 96% of respondents rating the pharmacy as very good or excellent overall. The trainee dispenser said that the pharmacy had recently had a visit from a mystery shopper and she had passed the assessment. The

pharmacist said that they had received a recent complaint from a person whose medicines had become out of sync with each other. He had spoken with the person and agreed to dispense half of them and potentially delay the rest to help the medicines become in sync again.

The pharmacy's indemnity insurance provider confirmed that the pharmacy had current indemnity insurance. The wrong responsible pharmacist (RP) notice was displayed but it was changed to the right one when this was highlighted. The RP log had largely been filled in correctly. Most emergency supply records were complete, but two did not indicate the reason as to the nature of the emergency. This could make it harder for the pharmacy to show why a supply was made in an emergency without a prescription. Only two records of supplies of unlicensed medicines could be found and they did not contain the required information. The inspector signposted the pharmacist to the published MHRA guidance on the information that should be recorded. A few private prescription records did not contain the prescriber's details. The pharmacist said that he would ensure these were recorded in the future. Controlled drug (CD) registers were maintained properly. The CD running balances were usually checked regularly. A random check of a CD showed the balance matched the physical quantity in stock.

Confidential material was kept away from the view of people using the pharmacy. Confidential waste was placed into a designated bin and collected by a contractor for destruction. The regular pharmacist's smartcard was found in the computer and she was not working on the day of inspection. The card was removed, and the trainee dispenser used her card instead. The pharmacist and locum dispenser said that they would talk with the local NHS commissioning service to activate their smartcards and would ensure that they were used in the future. Computer terminal screens were turned to face away from people using the pharmacy and the terminals were password protected. A current information governance policy was not found, but the trainee dispenser and locum dispenser said that they had signed confidentiality agreements at another branch of the pharmacy.

The pharmacist confirmed that he had completed the level 2 safeguarding training and he could describe what he would do if he had any concerns. The trainee dispenser had not completed any formal safeguarding training but with some prompting she could describe sign of maltreatment and said that she would refer any concerns to the pharmacist. The locum dispenser said that she had completed safeguarding training as part of her employment with the locum agency.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They have completed or are doing the required accredited training for their roles. They do ongoing training to help keep their knowledge and skills up to date. And they feel comfortable about raising any concerns and are able to take professional decisions.

Inspector's evidence

At the time of the inspection there was one pharmacist (locum), one trainee dispenser, one trained dispenser (locum), and one pharmacy degree student. Team members were able to describe what accredited training they had completed or were undertaking. The pharmacy also employed a regular pharmacist, who ran the travel clinic and supplied medicines under patient group directions (PGDs). The team was one or two days behind on dispensing, but the trainee dispenser explained that they were printing administration charts on the day of inspection and would be able to catch up later in the week. She said that they were normally up-to-date with dispensing.

Team members undertook ongoing training on an irregular basis and said that they were usually prompted by head office when training needed to be done. The trainee dispenser said that she had recently undertaken training on children's oral health and how to be a Dementia Friend. She said that the training was not always recorded, but that the regular pharmacist did have some records; these records were not available during the inspection. Team members had access to e-Learning modules and were prompted by head office when they needed to complete one. Staff did not generally get training time set aside to complete their training and usually had to complete it in their own time.

Team members felt comfortable about raising concerns and said that they worked well together. The pharmacist said that the superintendent pharmacist was receptive to any suggestions or issues that came up. There were some targets set, but the pharmacist said that he still felt able to take professional decisions and prioritise people's safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally suitable for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The premises were generally clean and tidy. There were several baskets containing medicines on the work surfaces but there was an adequate amount of clear space for dispensing. Storage space was limited, and it was a little untidy in places. In the centre of the dispensary there were stacks of empty delivery trays; the team members said that the stock had just arrived, and they would be cleared away. The premises were able to be secured from unauthorised access.

The consultation room was clean and tidy. It allowed a conversation to take place inside which would not be overheard. Handwashing facilities were available but there was not running hot water in the toilet area as the water heater was broken. The hot water tap in the dispensary was not fully working and it sprayed out water at the user. The team members said that they would raise this with the regular pharmacist and report the maintenance issue to head office. The pharmacy had air conditioning and the room temperature was suitable for storing medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and effectively. It gets its stock from reputable sources and mostly stores it properly. It takes the right action in response to safety alerts to make sure that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access from the street and a list of opening times was in the window. There was a wide space in the shop area to help people with wheelchairs or pushchairs manoeuvre more easily. The trainee dispenser said that the travel vaccination service was very popular locally. The regular pharmacist, who was not present during the inspection, did the vaccinations. Team members were observed signposting people to other local services such as a mobility centre.

Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Deliveries of medicines to people's homes were done by drivers who were based at another branch. A driver came in during the inspection and said that he obtained signatures from recipients to indicate safe delivery. The records were not available to be examined during the inspection. The pharmacy maintained a list of people whose medicines were out for delivery each day, in case there were any queries.

Multi-compartment compliance packs were mostly of a disposable type. The packs examined were not always labelled with a description of the medication and this could make it harder for the person or their carer to identify the medicines inside. Patient information leaflets were not always supplied with the packs; this could mean that people don't have all the information they need to take their medicines safely. The trainee dispenser said that they would include the descriptions and patient information leaflets in the future. Staff explained that the Lewisham Integrated Medicines Optimisation Service (LIMOS) assessed each person's needs before referring them to the pharmacy to receive their medicines in packs. LIMOS also monitored people on an ongoing basis to check they were managing their medicines properly. The trainee dispenser showed how they recorded any clinically significant events (such as communication with the prescriber or medicine changes) on the individual person's electronic record.

Team members were aware of the additional guidance around pregnancy prevention to be given to people taking valproate. The pharmacy had one person in the at-risk group who took valproate. The pharmacist was unsure if the person or their carers had been counselled about the new guidance and said that he would discuss this with the regular pharmacist. The pharmacy did not have any of the additional literature for valproate such as cards or leaflets and the pharmacist said that he would reorder more in. Prescriptions for higher-risk medicines were not highlighted. This could mean that the pharmacy misses out on an opportunity to speak with people collecting these medicines. A dispensed bag of medicines containing warfarin was found on the shelf and it had not been highlighted. The pharmacist said that all the people taking warfarin went to the anticoagulant clinic at the other branch. He said he had been to that branch and seen that people were routinely counselled about taking their warfarin. One bag of dispensed medicines contained a Schedule 4 CD and it had not been highlighted that this was inside. This could make it harder for the team member handing the medicine out to know

if the prescription was still valid.

The pharmacy had a scanner to comply with the Falsified Medicines Directive (FMD) but the team members understood that only the regular pharmacist was using it routinely. The trainee dispenser said that the regular pharmacist had spoken with her about the FMD requirements. The pharmacist on the day of the inspection was not routinely using the scanner and said he would speak with the regular pharmacist about it.

A range of patient group directions (PGDs) was examined, but the team members explained that the regular pharmacist was the person who mainly used them. The PGD for sildenafil had expired, but the regular pharmacist understood that a current version was available electronically. The electronic version could not be accessed during the inspection as only the regular pharmacist had access. There was evidence that the regular pharmacist had completed a course on Yellow Fever vaccinations.

Medicines were obtained from licensed wholesale dealers and specials suppliers. The medicines were stored in an orderly manner. Team members explained that the stock was regularly date checked, but the most recent records found were from May 2019. No date-expired medicines were found in the sample of medicines checked. Two boxes of medicines in stock were found to contain mixed batches. This could make it harder for the pharmacy to respond to safety alerts or to date-check the stock properly. The boxes were immediately removed. Bulk liquids were marked with the date of opening to help team members know that the medicines were still suitable to use. Medicines for destruction were separated from stock and placed into designated destruction bins.

Medicines that needed cold storage were kept in a suitable fridge. The minimum and maximum temperatures were recorded daily, and the previous records seen were within the correct range. The maximum temperature on the day of inspection showed as 9 degrees Celsius; the pharmacist said that they had received a lot of stock that day and the fridge door had been opened many times. CDs were stored securely.

Drug alerts and recalls were received via email. The trainee dispenser showed the emails and described how they went through to see if they had any affected stock. She understood that a record was made of the action that had been taken, but she was unsure where the records were stored and they could not be found during the inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs for its services. It uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had suitable calibrated measures for measuring liquids. The dispensary sink was untidy and contained used mugs; these were cleared out and the sink cleaned during the inspection. Tablet counting triangles were clean. Team members said that they used a separate marked triangle for cytotoxic medications to help avoid cross-contamination. The triangle could not be located during the inspection.

There were two blood pressure machines. The first had started being used in October 2016 and this was recorded; the pharmacist said that this meter would be replaced. He said that the second meter was only a few months old, but the date it had been first used had not been recorded. This could make it harder for team members to know when the meter should be replaced or recalibrated. The recent records of calibration checks for the Cobas B machine (used to test blood for HBA1c and cholesterol) could not be located. The only records found dated from August 2019. However, the trainee dispenser confirmed that she had seen the regular pharmacist undertaking the calibration checks on the machine every day. There was an anaphylaxis kit available for when vaccinations were done.

The fax machine was away from the public area and the cordless phone could be moved somewhere more private to help protect people's personal information. Team members had access to up-to-date reference sources including the internet.

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.