General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jaypharm; C., The Gallions Reach H/ Centre, Bentham Road, Thamesmead, LONDON, SE28 8BE

Pharmacy reference: 1040968

Type of pharmacy: Community

Date of inspection: 20/06/2023

Pharmacy context

The pharmacy is in a health centre in a largely residential area, and it receives most of its prescriptions electronically. It provides NHS dispensing services, the New Medicine Service, flu vaccinations, travel vaccinations and a blood pressure check service. It also provides medicines as part of the Community Pharmacist Consultation Service. And the pharmacy supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes and need this support.

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 to help provide them safely. It protects people's personal information. And people can provide feedback about the pharmacy's services. Team members understand their role in protecting vulnerable people. The pharmacy keeps its records up to date and largely accurate. But it 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 had up to date standard operating procedures (SOPs) and team members had signed to show that they had read, understood, and agreed to follow them. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were occasionally recorded on the pharmacy's computer system, but team members said that this was not always done. Team members said that they would use a paper near miss log in future so that this could be completed at the time if the computer was in use. They said that the near misses would then be reviewed 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. Dispensing errors, where a dispensing mistake had reached a person, were recorded the pharmacy's computer and a root cause analysis was undertaken. A recent error had occurred where the wrong strength of medicine had been supplied to a person. The medicines were now kept on different shelves to help minimise the chance of the wrong medicine being picked in future.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And team members used baskets to help 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 counter assistants said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. They would attempt to contact the pharmacist and would inform the superintendent (SI) pharmacist. They knew that they should not sell any pharmacy-only medicines or hand out dispensed medicines if the responsible pharmacist (RP) was not in the pharmacy and there was no second pharmacist.

The pharmacy had current professional indemnity and public liability insurance. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The right RP notice was clearly displayed, and the RP record was completed correctly. The private prescription records were largely completed correctly, but the prescriber's details were not always recorded. The second pharmacist said that she would remind team members to enter the details in future.

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. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

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. He said that most of the complaints were about stock issues from the suppliers. Team members said that they would refer any concerns to the pharmacist or SI.

Team members has completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The dispensers described some potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The SI said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. The team members can make professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There were two pharmacists (one was the SI), three trained dispensers, one trained medicines counter assistant (MCA) and one trainee MCA working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was up to date with its dispensing.

The MCAs appeared confident when speaking with people. They asked people questions to establish whether an over-the-counter medicine was suitable for the person it was intended for. One MCA, when asked, was aware of the restrictions on sales of pseudoephedrine-containing products. And 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.

The pharmacists felt able to make professional decisions. Targets were not set for team members. The pharmacists said that the services were provided for the benefit of people who needed them. The SI said that there were weekly meetings for the pharmacists to discuss any ongoing issues and ensure that all important information had been passed on. The pharmacists were aware of the continuing professional development requirement for professional revalidation. They had recently completed some training for the stop smoking service for hospital referrals, contraception service and blood pressure service. And they said that they had completed declarations of competence and consultation skills for the services offered, as well as associated training. The SI said that team members were not provided with ongoing training on a regular basis, but they did receive some. They had recently been undertaken some training as part of the NHS Pharmacy Quality Scheme.

The second pharmacist said that the pharmacy had regular meetings with the surgery. She said that there had been discussions about when the surgery might refer a person to the pharmacy for an over-the-counter medicine. And she had informed the surgery about which over-the-counter medicines the pharmacy stocked. She explained that she was also involved with the GP registrar training inductions. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. They said that they had ongoing informal performance reviews and a formalised one each year.

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.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Portable air conditioning units were available and the room temperature on the day of the inspection was suitable for storing medicines. Team members said that they would monitor the room temperature and take the necessary action if the temperature went above the recommended maximum.

There were a few chairs outside the pharmacy entrance available for people to use while waiting. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being overheard. The consultation room was accessible to wheelchair users and was in the shop area next to the medicines counter. It was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. 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

The pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. The pharmacy ensures that people who get their medicines in multi-compartment compliance packs receive all the information they need to take their medicines safely.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy could produce large-print labels for people who needed them.

Prescriptions for higher-risk medicines were largely highlighted, so there was the opportunity to speak with most people when they collected their medicines. The SI said that he would speak with a person's GP if he had any concerns about their medicines or blood test results. Prescriptions for Schedule 3 and 4 CDs had the date when not to be handed out after written on them. The SI said team members checked CDs and fridge items with people when handing them out. And the dispensed items were re-checked by the pharmacist before being handed to the counter staff. The second pharmacist said that the pharmacy supplied valproate medicines to a few people. The pharmacy had recently undertaken an audit to check that anyone taking these medicines was on the Pregnancy Prevention Programme (PPP) if they needed to be on one. If they were not on one, they would be referred to their GP. However, the pharmacy did not currently supply valproate medicines to anyone in the at-risk group. The pharmacy was only dispensing whole packs of these medicines to ensure that people were provided with all the relevant information.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months. Items due to expire within the next several months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Fridge temperatures were checked daily and 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. CDs were stored in accordance with legal requirements, and they 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 separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Part-dispensed prescriptions were checked frequently. Prescriptions for alternate medicines were requested from prescribers where needed. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked

regularly and remained in the retrieval system for around two months. Items remaining uncollected after this time were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber.

The SI said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. Team members did not order prescriptions on behalf of people who received their medicines in these packs. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. The prescriptions, backing sheets and medicines were checked by two pharmacists before the packs were assembled. This helped to minimise the chance of any mistakes. And once assembled the packs were given a final accuracy check. And each task was initialled by the team member who had undertaken it.

The pharmacy only delivered medicines to people who were not able to collect them from the pharmacy. And the deliveries were made by the pharmacists. The pharmacy obtained people's signatures for deliveries where possible, and these were recorded in a way so that another person's information was protected.

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

Up-to-date reference sources were available in the pharmacy and online. The pharmacy's main blood pressure monitor was calibrated at regular intervals. And the other ones were replaced in line with the manufacturer's guidance. The weighing scales and the shredder were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed. Suitable equipment for measuring liquids and counting tablets was available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

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.