General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Spatetree Pharmacy, 113 Sheen Lane, East Sheen, LONDON, SW14 8AE

Pharmacy reference: 1041144

Type of pharmacy: Community

Date of inspection: 16/01/2020

Pharmacy context

An independently run community pharmacy. The pharmacy is on a parade of shops just off the main street running through East Sheen. As well as NHS Essential Services, the pharmacy supplies medicines in multi-compartment compliance packs and pouch packs for people living locally. The pharmacy provides a delivery service for the housebound. It also delivers a low number of Medicines Use Reviews (MURs), New Medicines Service consultations (NMS) and seasonal flu vaccinations.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.3	Standard not met	The pharmacy does not do not do enough to ensure that all staff fully understand the procedures they should follow. This means that not all staff are carrying out their tasks as the pharmacist intends them to.
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 not all met	4.3	Standard not met	the pharmacy does not label all of its medicines appropriately, once they have been opened or removed from their original packs. This means that it may be more difficult for them to identify those medicines if there was a problem.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy is not thorough enough in ensuring that all staff fully understand the procedures they should follow. Particularly in the way that they capture information which will help them to learn and improve. But in general, the pharmacy's working practices are safe and effective. Its team members listen to people's concerns and try to keep people's information safe. They discuss any mistakes they make and share information to help reduce the chance of making mistakes in future.

Inspector's evidence

The pharmacy's main activities were centred around the prescription business. And managing the new I-pill pouch pack dispensing service. The pharmacy had introduced the pouch pack dispensing system very recently. Dispensing of pouch packs was delivered in accordance with guidelines produced by the system's manufacturer. The superintendent was in the process of developing an appropriate SOP for staff to follow. In the mean time he was supervising staff. And monitoring how they were operating the system. All dispensing mistakes, including near misses, were recorded and discussed with staff at the time by the accredited checking technician (ACT) or the pharmacist. These were then reviewed each month by the ACT and technician, who then completed a summary report. The team discussed its mistakes in order to find ways of preventing a reoccurrence, and it was clear that they were aware of the risk of error. They were aware of products with similar names such as rosuvastatin and ropinirole. They were also aware of the risks associated with dispensing the less commonly prescribed strengths of drugs. But not all near miss records captured details of what dispensing staff could do differently next time, regarding the checks they might make while dispensing. Therefore there was still scope for the team to use the near miss recording system to help them reflect more fully on the robustness of their own dispensing procedures.

Staff worked under the supervision of the responsible pharmacist (RP) whose sign was on display for the public to see. There was a set of standard operating procedures (SOPs) in place for them to follow although new joins and trainee staff had not yet read those relevant to their roles. The SOPs had been adopted from the previous owner after being reviewed by the superintendent. But they had yet to be signed off by him. The pharmacy team listened and responded to feedback, so they could improve their services. They had listened to feedback from local surgeries to try to improve the efficiency of the prescription ordering service. Consequently, the team were briefed to check before submitting repeat prescription requests. The pharmacy had a documented complaints procedure. Customer concerns were generally dealt with at the time by the superintendent. But if the pharmacy were to get a formal complaint it would be recorded. The pharmacy practice leaflet contained details of its procedure but the details for the local NHS complaints advocacy service and PALs were not up to date. However, customers could find up-to-date details online.

The pharmacy had professional indemnity and public liability arrangements in place, so they could provide insurance protection for staff and customers. Insurance arrangements were in place until 31 January 2020 when they would be renewed for the following year. All the necessary records were kept and were generally in order including records for unlicensed 'Specials', private prescriptions and

emergency supplies. The pharmacy had an electronic CD register which was also in order. The pharmacy had records for the receipt and destruction of patient returned CDs. But although some returned CDs had been destroyed their destruction had not been recorded at the time. A system for recording patient returned CDs is intended to provide an audit trail and give an account of all the non-stock Controlled Drugs (CDs) which pharmacists have under their control. Several records for the RP did not show the times at which the RPs responsibilities had ceased.

Staff had been briefed on the importance of confidentiality. They had also been briefed on information governance in general. Discarded patient labels and prescription tokens were shredded on a regular basis and counter staff knew not to discuss people's prescriptions with them with other people present. Completed prescriptions were stored in an area of shelving through a door way from the counter. Staff had placed a fringe curtain panel over the doorway to help obscure prescription details from anyone standing at the counter. But the panel did not always stay in place. So, the pharmacist was reviewing the prescription retrieval system in order to provide a better of way of protecting people's information. The superintendent, ACT and technician had completed level 2 CPPE training for safeguarding. Remaining staff had yet to be briefed. The pharmacy team had not had any specific safeguarding concerns to report. Contact details for the relevant safeguarding authorities were available online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload safely and effectively and team members work well together. They are comfortable about providing feedback which helps the pharmacy to improve the quality of its services. But the pharmacy does not always do enough to ensure that team members have the right training and qualifications for their job roles.

Inspector's evidence

The superintendent (SI) was the regular RP. Days off and additional pharmacist cover was generally provided by his wife who worked as a locum. The rest of the team included a full-time ACT and a full-time technician. At the time of the inspection remaining staff were either working their probationary period or had yet to be registered on a recognised training course. There were three full-time dispensing staff. One was a new join who had worked as a dispenser with her previous employer. But she had not completed a dispensing assistant's course. The second had not had any formal training either but he was about to leave the business. The third dispensing assistant was a pharmaceutical sciences graduate. He was also the pharmacy manager and had worked at the pharmacy for some time. He had registered on a formal training course several years earlier but had not completed it. There was also a full-time, trainee medicines counter assistant (MCA) and a part-time, trainee MCA. Neither of the MCAs had been registered on recognised training courses, but the part-time MCA was due to leave shortly.

On the day of the inspection the RP was supported by the ACT and technician, the dispensing assistants and both MCAs. The SI had worked closely with staff to provide direct one-to-one training. But had been unaware of the need to have all staff trained on an accredited training course suitable for their job roles, after no more than three months. And so, both the pharmaceutical sciences graduate and the full-time MCA were registered on the relevant training courses that day. The SI said that he would register the new join once she had completed her probationary period successfully. Team members were observed to work well together. They assisted each other when required. The daily workload of prescriptions was in hand and customers were attended to promptly.

It was evident that the team held regular discussions as part of the day to day running of the pharmacy. Team members had discussions to keep each other up to date on any issues and to make suggestions or raise concerns. The ACT described how she had suggested moving her checking area for accuracy checking pouch packs, to a separate bench away from the main dispensing area. She found this had helped her to focus on accuracy checking as there were fewer interruptions. The pharmacist was both the SI and a director of the business and hence was able to make his own professional decisions in the interest of patients. He would offer an MUR or NMS when he felt it beneficial for someone. But his main focus was to offer a good service to his customers.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean and professional looking. They provide a safe, secure environment for people to receive healthcare services. But there was a lack of storage space which meant that it was not as tidy and organised as it could be.

Inspector's evidence

The pharmacy's premises were opposite the local health centre. And were adjacent to the main street running through East Sheen. They had a traditional appearance with a double front. They had full height windows and a glass door to provide natural light. Aisles were generally clear and there was a small seating area for waiting customers. Items stocked included a range of baby care, healthcare, beauty and personal care items. The pharmacy had an L-shaped counter, with the dispensary behind. It had a swing gate to the side of the counter which allowed staff to pass through while preventing unauthorised access. It had a consultation room which the pharmacist used for private conversations and services such as MURs. The door to the room was through the swing gates and the doorway at the side of the counter. Completed prescriptions were stored on shelves next the consultation room but the pharmacist said he always stood between the prescription storage area and people entering or leaving the room, to hide prescriptions from view. The room was compact, but the pharmacist gave assurances that it could be used by wheelchair users.

The dispensary was relatively spacious. Dispensary benches were tidy and generally uncluttered. There appeared to be just enough work surface for the workload. There were several areas of dispensing bench including an island used for different dispensing activities. There were separate areas for multi-compartment compliance pack dispensing, pouch pack dispensing and general dispensing. The area of bench space immediately overlooking the counter and shop floor was generally used by the pharmacist when accuracy checking. A combination of drawers and open shelving was used for storing medication. Work surfaces were well used but looked clean. And there was a clear work flow. The pharmacy was adequately lit and ventilated with temperature control systems in place. It had staff facilities, a storage area and a door to the outside. The pharmacy had a professional appearance. Shelves, worksurfaces, floors and sinks were generally clean. But there did not appear to be enough storage space, with baskets of dispensed pouch packs on the floor, where they were at risk of being kicked or knocked over.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy doesn't carry out all of its checks as thoroughly as it could. And it does not label all of its medicines appropriately, once they have been opened or removed from their original packs. The pharmacy does not always give people the advice and information they need to help them use their medicines properly. But in general, it provides its services safely and effectively and tries to make them available to everyone. And it checks to make sure that its medicines are fit for purpose.

Inspector's evidence

The pharmacy was not advertising the full range of its services at the premises. It advertised its services on the NHS website but the list needed updating due to recent changes to the range of services on offer. The pharmacy entrance had a small step-up from outside, which meant that access to the pharmacy was difficult for wheelchair users. And the short route to the consultation room from the counter area, had two right angle turns which would be difficult for a wheelchair to manoeuvre. And so, wheelchair users may not be able to access the full range of services. But the RP said that he would help anyone in who needed it, by either helping them in the door or attending to them outside. The pharmacy had previously had a ramp which the pharmacist was due to replace.

There was a set of SOPs in place. CD stock was audited regularly as per the CD SOP. And the quantity of stock checked (MST 60mg tablets) matched the running balance total in the CD register. The pharmacy supplied medicines in multi-compartment compliance packs to 160 people living in the community. The medication in compliance packs was given a description, including colour and shape, to help people identify them. The pharmacy also supplied medicines in the pouch pack system to between 120 and 140 people living in the community. The RP intended to move all compliance pack patients on to the pouch pack system in due course. The pouch pack system was a robotic system, capable of storing and dispensing 224 drugs. The bar codes on medication packs were scanned for accuracy before the drugs were de-blistered and put in individual containers recognisable by the robot. Prescription details were processed through the robot computer and the medicines dispensed into individual pouch packs. The robot placed the medicines together in the packs in accordance with daily dosage requirements. The packs were then sealed. Each pack contained a description of the contents, the name of the patient, the date and the dosage instructions. The pharmacy issued patient information leaflets (PILs) with new medicines in pouch packs and compliance packs. But they were not provided regularly with repeat medicines. This meant that people may not be provided with all the manufacturer's information about the medication they were taking.

The RP was aware of the risks associated with supplying sodium valproate to people in the at-risk group. He had not yet checked records for patients in the at-risk group who may be taking the drug, but he believed there weren't any. He did not have any additional warning cards, leaflets or guidance documentation from the MHRA but gave assurances that he would obtain them. Packs of sodium valproate in stock bore the updated warning label. Medicines and medical equipment were obtained from: AAH, Alliance Healthcare, Sigma, Colorama and DE Pharmaceuticals. Unlicensed 'specials' were obtained from Thame Laboratories and IPS. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. A CD cabinet and a fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read and

recorded electronically. An alarm would sound if temperatures were to go outside of the required range of between two and eight degrees Celsius.

The pharmacy checked the expiry dates of its stock regularly. But it didn't always keep records to show what had been checked and when. Short-dated stock was generally highlighted. But there was a pack of Actrapid 100iu insulin in the fridge, which was due to expire at the end of the month and had not been highlighted. However, this type of insulin was rarely prescribed and hence the pharmacist felt the risk of it being dispensed, was low. There were also several amber bottles of tablets which were labelled with only the name and strength number of the items inside. The units in which the strength was quantified was not given nor was the quantity or drug form. The bottles had not been labelled with any of the other manufacturer's information such as, PL number, batch number or expiry date. These had been put into stock by the untrained dispensing assistant. There were also several loose trips of tablets on shelves which had been removed from their original packaging.

The pharmacy had the equipment and software for scanning products in accordance with the European Falsified Medicines Directive (FMD). The RP was aware of FMD requirements, but the team were not yet scanning products with a unique bar code. Waste medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. But staff did not have a list of hazardous waste to refer to or a separate container, so they could ensure that they were disposing of all medicines appropriately. Drug recalls and safety alerts were responded to and records were kept. The pharmacy had not had any of the faulty stock identified in the recent recall for ranitidine tablets or Emerade injections.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. In general, the pharmacy uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures and tablet triangles were of the appropriate BS standard and clean. Precautions were taken to help prevent cross contamination by using a separate triangle for counting loose cytotoxic tablets. And amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris. CD denaturing kits were used for the safe disposal of CDs. There were up-to-date information sources available in the form of a BNF, a BNF for children and the drug tariff. Pharmacists also used a range of reputable online information sources through the NHS, patient.org and EMC websites.

The pharmacy had six computer terminals available for use. It had one on the counter and one in the consultation room, two on the main dispensing and accuracy checking bench, and two on the dispensing island. One of these was also the robot computer. All computers had a PMR facility, were password protected and were out of view of patients and the public. It was noted that the technician was using her own smart card when working on PMRs. Staff used their own smart cards to maintain an accurate audit trail and to ensure that access to patient records was appropriate and secure. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was collected for safe disposal.

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.