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: 28/10/2020

Pharmacy context

This is an independently run, local community pharmacy, in the village of East Sheen in Richmond. It dispenses prescriptions and sells over-the-counter medicines. And it supplies medicines in multi-compartment compliance packs and in medicines 'pouch' systems. It provides a delivery service for the vulnerable and housebound. And the pharmacy also provides a flu vaccination service. The inspection was conducted during the COVID-19 pandemic.

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 satisfactorily identifies and manages the risks associated with the provision of its services. And, in general, its team members manage people's personal information securely. The pharmacy has written procedures in place to help ensure that its team members work safely. And it has insurance to cover its services. The pharmacy has adequate procedures to learn from its mistakes.

Inspector's evidence

The most recent figures showed that the number of cases of COVID-19 in the area was higher than the national average for England for the previous week. To help reduce the risk of spreading coronavirus, the pharmacy had taken steps to reduce risk for its team members and the public. Team members wore masks or face coverings and washed or sanitised their hands regularly. Team members worked at their own workstations in different areas of the dispensary when they could. And, for the most part, they were able to keep apart from one another although it was not always possible to maintain a distance of a metre or more. In general, only one assistant worked at the medicines counter at any time. Team members had applied tape lines to the floor just inside the pharmacy, placing them more than one metre apart, to show people where to stand when they were waiting to approach the counter.

Because the pharmacy had a small retail area, social distancing requirements meant that people would have to stand outside at busy times. And so, the SI and the inspector discussed the importance of how this would be managed during bad weather. The SI described how the team would generally approach anyone waiting outside and offer them the delivery service if appropriate. Staff tried to ensure that only one person stood in the small area in front of the counter at any one time. But people were able to lean over the counter when looking at products on the wall behind it. So, the team was missing opportunities to further protect itself and people from the spread of the virus. The inspector and the responsible pharmacist (RP), who was also the superintendent (SI), discussed how the team might provide further protection for people and team members at the counter. Their discussions included the use of transparent plastic screens which are often used in pharmacies for this purpose. The inspector and responsible pharmacist (RP) also discussed the importance of having contingency plans in place to ensure that the people would be able to obtain their medicines in the event of closure due to the COVID-19 pandemic. The RP was reminded of the requirement to report any COVID-19 infections, believed to have been contracted at work, to the relevant authorities.

The pharmacy had procedures for managing risks in the dispensing process. The accredited checking technician (ACT) or the pharmacist, discussed all dispensing mistakes, including near misses, with the relevant team member at the time. And they recorded them. Each month the ACT and technician reviewed the records. They then completed a summary report. The team discussed and reviewed its mistakes in order to find ways of preventing a reoccurrence, and it was clear that they were aware of the risk of error. The inspector and pre-reg agreed that near miss mistakes should prompt staff to identify what they could do differently to help prevent similar mistakes in future. And that the team should use its mistakes to learn and improve.

The team worked under the supervision of the responsible pharmacist (RP). The RP's notice had been placed on display for people to see. The pharmacy had a set of standard operating procedures (SOPs) for team members to follow. The SI was in the process of reviewing the pharmacy's written SOPs to

bring them up to date with current practice and accepted that their review was overdue. The pharmacy team sought customer feedback through satisfaction surveys and general conversations with people. The customer satisfaction survey from 2019 demonstrated a high level of customer satisfaction overall. The team had also received a lot of positive feedback from people and from local surgeries throughout the pandemic. Particularly when local surgeries had to limit access by the public. But the team had also received complaints from people during the early stages of the pandemic when the team were at their busiest. Complaints arose from people's prescriptions not being ready when they expected them to be or when the team were unable to supply all of their medication at the same time. But although both of these issues were largely out with the direct control of the pharmacy, the team had offered the pharmacy's delivery service, when appropriate, so that people did not have to come back again.

The pharmacy had a complaints procedure which corresponded with NHS guidelines. And it had a SOP for staff to refer to. But customer concerns were generally dealt with at the time by the RP. Staff could provide details of the local NHS complaints advocacy service and the Patient Advice and Liaison service (PALS) if necessary. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services. Insurance arrangements were in place until 31 January 2021 when they would be renewed for the following year. The pharmacy kept its records in the way it was meant to. The RP recognised the importance of maintaining the pharmacy's essential records, including RP records and records of CDs, returned by people, for destruction so that they were up to date and complete.

The pharmacy's team members understood the need to protect people's confidentiality. They shredded discarded patient labels and prescription tokens on a regular basis. The pharmacy stored its completed prescriptions on an area of shelving through a doorway next to the counter. The SI had placed a fringe curtain over the doorway to help obscure prescription details from anyone standing at the counter. But the panel did not always stay in place. And anyone leaning across the small gate next to the counter could potentially see people's details on the completed prescription bags. So, as per the previous inspection, the pharmacist continued to review 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. But as per the previous inspection, the SI had yet to brief everyone else in the team. The RP could access details for the relevant safeguarding authorities 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 to one another, so that they can maintain the quality of the pharmacy's services.

Inspector's evidence

The SI was the pharmacy's regular RP. The pharmacy also had a regular locum to cover the times when he was not in the business. The locum was also available to provide additional support alongside the RP when needed. At the time of inspection, the RP was supported by a pre-reg, an ACT, a technician, four dispensers (two of which were in training) and a medicines counter assistant (MCA). In general, staff had read the relevant SOPs. And those in training had been gradually working their way through them. The MCA understood her job role and responsibilities and consulted the pharmacist and her other colleagues when she needed to. During the early days of the pandemic the RP had conducted an informal risk assessment to identify anyone who might need to shield. But since then the pharmacy had not carried out any formal risk assessments for individual team members. The inspector discussed this with the RP who agreed that he would seek guidance from the NPA or PSNC so that he could complete the assessments. This means that he would be more able to identify and protect any of the pharmacy's more vulnerable team members.

Team members were observed to work effectively together. They were seen assisting each other when required and discussing prescription issues. The daily workload of prescriptions was in hand and customers were attended to promptly. The pharmacy had a small close-knit team and staff could raise concerns and discuss issues when they arose. During the early stages of the first UK lockdown in March 2020, the team had discussed their concerns about working closely together. And they decided to make changes to the layout of the dispensary. They did this to help them to keep appropriately distanced while they were working. The RP 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 flu vaccinations to people who needed them when he could. But his main focus was to provide people with a friendly, professional service, so that he could support them with their healthcare needs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a suitable environment for people to receive its services. They are sufficiently clean and secure. The pharmacy has made some adjustments to help keep people safe during the pandemic. But it is missing further opportunities to ensure that the consultation room is used for services in a way which meets published guidance.

Inspector's evidence

The pharmacy was opposite the local health centre. And adjacent to the main street running through East Sheen. It had a traditional appearance. Staff had placed notices in the window near the entrance advising people of the need to maintain social distancing and to wear a face covering when they came into the pharmacy. And staff managed the numbers of people allowed in at any one time. The pharmacy had a consultation room and a small seating area for waiting customers. Pharmacists used the consultation room for private conversations and Flu vaccinations. The door to the room was through the swing gates and a doorway at the side of the counter. Completed prescriptions were stored on shelves next the consultation room but the pharmacist generally stood between the prescription storage area and people entering or leaving the room, to hide prescriptions from view. The pharmacist and inspector discussed the importance of ensuring that the consultation room and any touch points were thoroughly cleaned after each consultation to minimise the risk of transmitting coronavirus. The inspector signposted the RP to notable practice guidance on the GPhC website and to PSNC guidance on providing a flu vaccination safely during the pandemic.

The pharmacy appeared to have enough space for the workload. Work surfaces were generally tidy and uncluttered. And the pharmacy team had reorganised the layout of some dispensary benches to improve social distancing and workflow. The pharmacy had several areas of dispensing bench including an island used for different dispensing activities. And separate areas for multi-compartment compliance pack dispensing, pouch pack dispensing and general dispensing. The pharmacist generally used the area of bench space immediately overlooking the counter and retail area for accuracy checking. And the ACT used a separate area for her accuracy checking. The pharmacy was adequately lit and ventilated with temperature control systems in place.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely. And it helps people to access them. Staff understand the actions to take if any medicines or devices are not safe to use to protect people's health and wellbeing. The pharmacy team gets its medicines and medical devices from appropriate sources. And it stores them properly. Team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use, to protect people's health and wellbeing. But the team may be missing opportunities to provide people with all the information they need about their medicines.

Inspector's evidence

The pharmacy had posters on the window advertising a small range of services including flu vaccinations. And it had a small range of information leaflets for people to take away. It also had a website where people could go to book a flu vaccination appointment or order their repeat prescription. The pharmacy entrance had a small step-up from outside, which meant that access to the pharmacy was more difficult for wheelchair users. But team members would help people who needed it by either helping them in the door or attending to them outside. The pharmacy also delivered medicines to people who found it difficult to visit the pharmacy. The RP described how demand for deliveries had increased during the pandemic. The pharmacy's consultation room was situated to the side of the counter. And it was compact. Access to the room involved getting around two tight corners which wheelchair users may find difficult to manoeuvre.

The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. The RP and inspector agreed that it was important to have a system for identifying any completed prescriptions containing CDs so they could remove them from storage after their prescription's 28-day expiry date. This was important for all CDs including prescriptions containing schedule 4 CDs. They pharmacy used stickers to identify prescriptions which had additional items stored elsewhere such as the fridge, so that they did not leave any items behind when transferring people's prescriptions to them.

The RP gave people advice on a range of matters. He was aware of the guidance about pregnancy prevention to be given to people in the at-risk group who took sodium valproate. And would give appropriate advice to anyone taking high-risk medicines. The pharmacy provided multi-compartment compliance packs for people who needed them. And it also provided medicines in pill pouch packs. Team members labelled compliance packs and pouch packs with a description of each medicine, including colour and shape, to help people to identify them. And the labelling directions on compliance packs and pouch packs gave the required advisory information to help people take their medicines properly. But while the pharmacy included patient information leaflets (PILs) with new medicines in compliance pack systems, they did not supply them routinely with regular repeat medicines. This meant that that people may not have access to all the manufacturer's information about the medicines they were taking.

The pharmacy offered a flu vaccination service. But at the time of the inspection it was unable to provide the service due to a general shortage of vaccines. And it was awaiting further supplies. In general, the person receiving the vaccination would be appropriately briefed and asked to sign a consent form or give verbal consent. The inspector and RP discussed how important it was that the RP

sanitised his hands before and after each consultation and before and after donning and doffing PPE. Further protection could be provided by the wearing type II fluid resistant face masks during any close consultations in the consultation room, as recommended for use in pharmacies. The person receiving the vaccination was required to wear a face mask. The RP and inspector discussed the importance of cleaning down all surfaces, equipment, pens and door handles in the consultation room after each vaccination and the importance of having each person sanitise their hands before and after leaving the room. This was necessary to leave it clean and safe, ready for the next person. Records were kept of the consultation for each vaccination, including details of the product administered. The RP would discard used vaccines safely into a sharps bin. And he had procedures and equipment for managing an anaphylactic response to vaccinations. The RP had access to PSNC guidance on providing a flu vaccination service during the pandemic and the detail provided in the service specifications. The RP would refer to this guidance when resuming the vaccination service to ensure that the service is supplied as safely as possible.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team stored its medicines, appropriately and in their original containers. And stock on the shelves was tidy and organised to assist selection of the correct item. The pharmacy team date-checked the pharmacy’s stocks regularly, checking a different section each time. And it identified and highlighted any short-dated stock. A random sample of stock checked by the inspector was in date. Team members kept records to help them manage the process and to show what had been checked, when and by whom. And they put any out-of-date and patient returned medicines into dedicated waste containers. The team stored items in a CD cabinet and fridge as appropriate. And it monitored its fridge temperatures daily to ensure that the medication inside was kept within the required temperature range. The pharmacy responded promptly to drug recalls and safety alerts and kept appropriate records.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And, it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy used crown marked measures for measuring liquids. It had equipment for counting tablets and capsules, including a separate tablet triangle for methotrexate so that staff could identify it and use it for methotrexate only. Team members had access to a range of up-to-date reference sources. And they had access to PPE. They had access to the face masks, aprons and gloves, which were appropriate for use in pharmacies. Team members washed or sanitised their hands, or changed their gloves, at regular intervals throughout the day. And they cleaned down surfaces and equipment daily.

The pharmacy had six computers with a patient medication record (PMR) facility. This appeared to be adequate for the workload. Computers were password protected and their screens could not be viewed by people. Team members generally used their own smart cards when working on PMRs, so that they could maintain an accurate audit trail and ensure that access to patient records was appropriate and secure.

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.