General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Fairlight, 186 Rowan Road, LONDON, SW16 5HX

Pharmacy reference: 1041182

Type of pharmacy: Community

Date of inspection: 26/08/2020

Pharmacy context

This is a small independently owned pharmacy in a suburban shopping parade between Mitcham and Streatham Vale in Surrey. It dispenses NHS and private prescriptions, sells a range of over-the-counter medicines and provides health advice. The inspection was carried out during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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 adequately manages the risks associated with its services. It has detailed written instructions to tell its team members how to carry out their tasks. It has also taken sensible precautions to help keep people safe from the coronavirus. The pharmacy keeps all the records that it needs to, and it makes sure that people's private information is secure. Its team members understand how they can help to keep vulnerable people safe and it has adequate insurance in place to protect people if things do go wrong.

Inspector's evidence

There were standard operating procedures (SOPs) in place to support all professional activities in the pharmacy. There were individual tabbed signature sheets in each section which had been signed by all staff to indicate that they had read and understood the procedures. The pharmacy also had a business continuity plan in place to maintain its services in the event of a power failure or other major problem. The responsible pharmacist (RP) described how the pharmacy would maintain its services in the event of closure due to the COVID-19 pandemic.

The recording of errors and near misses had improved since the previous inspection. The record forms were kept in a bound booklet by the main labelling computer for easy access. The importance of recording and learning from all near misses was reiterated during the inspection, particularly as the RP was checking his own work. There had been no recent errors, but any that occurred would be reported to the National Pharmacy Association (NPA). The pharmacist had identified some items that were in similar packaging, such as some brands of warfarin and levothyroxine, and had separated them on the shelves. Staff were able to describe what action they would take in the absence of the responsible pharmacist, and they explained what they could and could not do. The RP notice was clearly displayed for patients to see and the RP log held on the patient medication record (PMR) computer system was complete.

There was a file containing individual staff risk assessments which had been completed to help identify and minimise the risks of spreading the coronavirus. The medicines counter assistant (MCA) was asking people to wait outside of the pharmacy for their prescriptions, so that other people waiting could come in to be served more quickly. Although the pharmacist was not wearing any PPE himself, he ensured that he kept his distance from everyone else in the pharmacy. The MCA was wearing a mask, gloves and apron and served everyone so that the pharmacist could maintain social distancing.

Although the pharmacy didn't carry out a patient survey, most of the people seen during the inspection appeared to know the pharmacist and the MCA so feedback was instant and informal. The pharmacy complaints procedure was set out in the SOP file and was also on display in the pharmacy for people to see. A certificate of professional indemnity and public liability insurance from the NPA valid until 30 November 2020 was on display near the medicines counter.

Private prescription records were maintained in a designated book and were complete with all details correctly recorded as seen previously. The pharmacist confirmed that they still very rarely made emergency supplies as the surgery was close by and he normally directed people there. The CD register was seen to be correctly maintained, with running balances checked every time a CD was dispensed. All

of the pages examined had their 'headers' completed in full, and entries were complete with the wholesaler's addresses. Running balances of two randomly selected CDs were checked and both found to be correct. Alterations made in the CD register were asterisked with a note made at the bottom of the page, and they were initialled with the pharmacist's registration number and date. Records of CDs returned by patients were seen to be made upon receipt and subsequent destruction documented and witnessed, although there hadn't been any CDs returned recently. Records of unlicensed 'specials' were all complete with required patient and prescriber details.

The MCA was able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. All staff had signed the confidentiality SOP and the MCA on duty was able to provide examples of how she protected patient confidentiality, for example by refusing to disclose people's personal details if asked by a third party such as a husband or other family member. Completed prescriptions in the prescription retrieval system were arranged so that people waiting at the counter couldn't read any details. Confidential waste was separated from general waste and shredded onsite. There were safeguarding procedures in place and contact details of local referring agencies were available on the pharmacy computer. The pharmacist had completed level 2 safeguarding training. No staff were dementia friends but were aware of some of the signs to look for. The pharmacist explained that they knew all their patients and would liaise with the local surgery if they seemed to be confused.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely, and they work well together. It provides them with appropriate training to help them carry out their tasks effectively.

Inspector's evidence

There was one MCA and the RP on duty during the inspection. This appeared to be appropriate for the workload and they were working well together. In the event of staff shortages, part-time staff could adjust their working hours to provide additional cover. One member of staff had recently completed the Buttercups dispensing assistant course, and the other had completed the NPA counter assistant course. Staff were able to demonstrate an awareness of potential medicines abuse and could identify patients making repeat purchases. They described how they would refer to the pharmacist if necessary. All staff were asking appropriate questions when responding to requests or selling medicines. There were no targets in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. It keeps them sufficiently clean and secure. And It has made some sensible adjustments to help keep people safe during the pandemic.

Inspector's evidence

The pharmacy premises were clean, tidy and generally in a good state of repair with access via a single door to the wide pavement outside. There was a small dispensary, providing sufficient space to work safely and effectively, and the layout was suitable for the activities undertaken. There was a clear workflow in the dispensary. The dispensary sink had hot and cold running water. There was handwash available.

The medicines counter was immediately in front of the dispensary. There was a large Perspex screen across the front of the counter to help reduce the spread of the coronavirus. There were notices in the window near the entrance advising people of the need to maintain social distancing and to wear a face covering. There was also a notice limiting the number of people in the pharmacy to one at a time. There was a consultation room available for confidential conversations, consultations and the provision of services. The door to the consultation room was kept closed but not locked when not in use. The room had not been used for any services during the pandemic and appeared to be in use as extra storage space. There was no confidential information visible. Room temperatures were appropriately maintained by a combined air-conditioning and heating unit, keeping staff comfortable and suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, so that people with a range of needs can access them safely. The pharmacy sources, stores and manages its medicines safely, and so makes sure that the medicines it supplies are fit for purpose. And people only get medicines or devices which are safe for them to take.

Inspector's evidence

A list of pharmacy services was displayed in the shop window and there was also a limited selection of health information leaflets available. The pharmacy provided a very limited range of services and the RP explained that he focussed mainly on dispensing prescriptions. There were some controls in place to reduce the risk of errors, such as having only one prescription on the workbench at a time. The pharmacist checked his own work only after having taken a short break between assembling and checking prescriptions. Prescription labels were initialled to show who had dispensed and checked them. Owings tickets were used if the pharmacy was unable to supply all of the medicines and the prescription was kept in the 'owings' box until the stock arrived. If they couldn't obtain the stock the RP contacted the GP to suggest an alternative. Completed prescriptions for schedule 2 CDs were only assembled when people came in to collect them. This was intended to ensure that prescriptions for CDs weren't handed out after their 28-day expiry. The pharmacist checked the retrieval shelves every month and that any expired Schedule 3 or 4 CDs still awaiting collection were then removed. Prescriptions for medicines that needed to be stored in the fridge were also assembled only when people came in to collect them.

The pharmacist was aware of the risks involved in dispensing valproates to women in the at-risk group. He explained that the pharmacy had no female patients currently taking valproates, only males. And that if there were any people in the at-risk group, he would make a record of any counselling on the PMR system. There was a purple folder on the workbench containing information leaflets and cards to be given to people in the at-risk group. People taking warfarin were not asked if they knew their current INR levels as the local surgery would only provide a prescription if they had that information. There were steroid cards, lithium record cards and methotrexate record cards available to offer patients who needed them.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance, Sigma and OTC Direct. Unlicensed 'specials' were obtained from Sigma. The pharmacy did not have the scanners and software necessary to comply with the Falsified Medicines Directive (FMD). Routine date checks were seen to be in place, record sheets were seen to have been completed, and no out-of-date stock was found. Opened bottles of liquid medicine were annotated with the date of opening. There were no plain cartons of stock seen on the shelves and no boxes were found to contain mixed batches of tablets or capsules. Fridge temperatures were recorded daily, rounded up to the nearest whole number, but all were seen to be within the 2 to 8 Celsius range. The pharmacist explained how he would note any variation from this and check the temperature again until it was back within the required range.

Pharmacy medicines were displayed behind the medicines counter, preventing unauthorised access or self-selection of those medicines. The pharmacist described how patient-returned medicines were normally screened to ensure that any CDs were appropriately recorded, and that there were no sharps

present. Patients with sharps were signposted to either the local surgery or the local council for disposal. During the pandemic they had been placing returned medicines directly in the designated waste containers to minimise the risk of spreading the coronavirus. There was a list of hazardous medicines present and a separate purple-lidded container designated for the disposal of hazardous waste medicines. Denaturing kits for the safe disposal of CDs were available for use. The pharmacy received drug alerts and recalls from the MHRA, copies of some were seen to be kept in the patient safety folder. The pharmacist explained that he received alerts by email and didn't always print them off. He checked them first and only printed those where there was any of the affected stock present. The team knew what to do if they received damaged or faulty stock and they explained how they would return them to the wholesalers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has suitable equipment for the services it provides. It takes sensible precautions so that people can safely use its facilities when accessing its services. It also uses its facilities and equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy had the necessary resources required to accurately measure liquids, tablets and capsules. There were suitable reference sources including the BNF and BNF for children. The pharmacy also had internet access and used this as an additional reference source. Staff were seen frequently cleaning worksurfaces, the medicines counter and pens to help reduce the spread of the coronavirus. Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Computer screens were positioned so they were not visible to the public. Staff were seen to take precautions such as moving to the rear of the dispensary when making telephone calls so as not to be overheard. NHS smartcards were seen to be used appropriately and with no sharing of passwords. They were left in a secure location within the premises overnight. Confidential information was kept secure and items awaiting collection were not visible from retail area

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.