General Pharmaceutical Council

Registered pharmacy inspection report

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

Pharmacy reference: 1041182

Type of pharmacy: Community

Date of inspection: 20/03/2023

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 pharmacy's new owners are introducing a selection of new services including a travel health service.

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 manages the risks associated with its services. It has detailed, and up-to-date, written instructions to tell its team members how to carry out their tasks. The pharmacy generally keeps adequate records of the things it needs to. And it makes sure that people's private information is secure. Its team members understand their role in helping to keep vulnerable people safe. The pharmacy has appropriate insurance in place to protect people if things do go wrong.

Inspector's evidence

There were standard operating procedures (SOPs) in place, introduced when the pharmacy's new owners took over. They were dated 28 June 2021 and currently being reviewed by the superintendent pharmacist (SI). Those examined had been signed by 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 they would work with the other pharmacy they owned, and others nearby, to maintain its services in the event of an unplanned closure.

Errors and near misses were recorded together with the actions taken to help prevent them being repeated. The RP explained how he encouraged team members to think about the concrete actions they could take. For example, they had separated the different strengths of levothyroxine tablets as the 50mcg and 100mcg packs were the same size and similar in appearance. 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 discussed during the inspection, particularly as the pharmacy currently employed a trainee pharmacist in their foundation year. Near misses and errors were all collated into the monthly patient safety review. These in turn were collated and submitted once a year to the NHS as one of the requirements for the Pharmacy Quality Scheme (PQS).

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 people to see, as required by the regulations. But the RP record on the patient medication record (PMR) computer system did not include the times at which the RP's responsibilities ceased each day. The record was otherwise complete. The RP was unaware that the PMR system didn't automatically log them out when closing the system down, so would now ensure that they did so in future.

Although the pharmacy was no longer required to carry out a patient questionnaire for the NHS, the RP did monitor feedback posted online. The RP described how patient feedback led them to amend the wording of the text messages they sent to let people know that their prescriptions were ready for collection. They also attended a regular monthly meeting held with GPs, councillors etc to listen to local people's views about their services. The pharmacy had a complaints procedure and the RP tried to resolve problems straight away wherever possible. A certificate of professional indemnity and public liability insurance from the NPA valid until June 2023 was on display near the medicines counter.

Private prescription records were maintained electronically using the PMR system. Most of the records examined didn't include details of the prescriber. When this was pointed out the RP agreed to ensure this was completed in future. There were no emergency supply records available to examine but the

trainee pharmacist was able to describe the records they would keep, including the reason for the supply.

The controlled drug (CD) registers were generally correctly maintained, with running balances checked on a weekly basis. Some of the pages didn't have their 'headers' completed in full. Stock balances of two randomly selected CDs were checked and both found to correspond with the entries in their respective registers. Alterations made in the CD register were asterisked with a note made at the bottom of the page, but they didn't identify the person making the adjustment. Upon reflection the RP agreed to rectify this for the future. Records of CDs returned as no longer needed by people were seen to be made upon receipt, and there were some awaiting destruction and safe disposal. Records of unlicensed 'specials' were present, although some of those examined didn't include the patient, labelling and prescriber details as required. The RP agreed to ensure these were properly completed in future.

Staff were able to demonstrate an understanding of data protection and the importance of maintaining patient confidentiality. The RP added that they were currently preparing to complete the NHS data security and protection (DSP) toolkit. 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 collected by a suitably licensed waste contractor for shredding. There were safeguarding procedures in place and contact details of local referring agencies were available online if required. The RP and trainee pharmacist were both signposted to the NHS safeguarding app as an additional resource. The pharmacist had completed level 2 safeguarding training and was looking into level 3. The trainee pharmacist and trainee technician had also completed level 2 training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a well-motivated team of people who manage the workload safely and efficiently. They work well together. The pharmacy provides them with appropriate training and actively supports them with their development.

Inspector's evidence

There was one trainee pharmacy technician, one trainee pharmacist 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. The trainee technician had only recently started the required accredited training course and the SI was her authorised witness. The trainee pharmacist was preparing for the forthcoming registration assessment in the summer and seemed very happy with her progress to date. She described the regular meetings she had with the SI who was her supervising pharmacist. They also had frequent brief one-to-one chats about her progress. They were all were able to demonstrate an awareness of potential medicines abuse and could identify people 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 formal targets in place although the RP had set himself some goals to meet. The RP stated that both he and the SI were committed to the development of those working for them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. The pharmacy is making better use of its consultation room now but isn't keeping its contents secure enough. It keeps its premises sufficiently clean and they are secure when the pharmacy is closed.

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 was stained and had hot and cold running water. There was handwash available. The pharmacy appeared to be brighter than at the previous inspection. The RP had replaced all the lighting and removed all posters from the windows so that people would have a clear view in and out.

The medicines counter was immediately in front of the dispensary. To one side, there was a consultation room available for confidential conversations, consultations and the provision of services. The door to the consultation room was closed but not locked when not in use. There was an open sharps bin in the room so the RP was advised to either keep the door locked or otherwise secure the bin so that people couldn't access it unobserved. There were anaphylaxis kits on open shelving for easy access. There was no confidential information visible although there were some files relating to some of the services provided by the pharmacy. 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

There was a leaflet display in the consultation room with a selection of material for people to read. The pharmacy practice leaflet included a list of services available from the pharmacy. Between all members of the team, they could speak Arabic, Polish, Urdu, Romanian, Russian and Farsi (Persian). The RP and SI had been gradually increasing the range of services, although dispensing prescriptions was still the main activity. There were some controls in place to reduce the risk of errors, such as using baskets to keep individual prescriptions apart. The ‘dispensed by’ and ‘checked by’ boxes on the dispensing labels were initialled so that there was an audit trail to show who had undertaken each step in the process. 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. The RP explained that there was a whatsapp group with other nearby pharmacies which they used to see if the stock was available elsewhere locally. If they couldn’t obtain the stock the RP contacted the GP to suggest an alternative. Completed prescriptions awaiting collection had a CD sticker on if there was a schedule 2 CD in the cabinet. Fridge lines were highlighted with a fridge sticker so that staff would know to look in the fridge. CD stickers with space for a date were discussed as a way of helping ensure CDs weren’t handed out after their 28-day expiry. The pharmacist checked the retrieval shelves every month any expired Schedule 3 or 4 CDs still awaiting collection were then removed. Prescription bags were highlighted with purple marker to indicate that a text message had been sent to let the person know that their prescription was ready for collection.

The pharmacist was aware of the risks involved in dispensing valproates to women who could become pregnant. He explained that the pharmacy had no-one in the at-risk group currently taking valproates. And that if there were any people in the at-risk group, he would ask if they were on the pregnancy prevention programme (PPP) and make a record of any counselling on the PMR system. There were information leaflets and cards available for people taking valproates. Very few people locally were now taking warfarin, but they were asked if they knew their current INR levels. The pharmacy had recently ordered more steroid cards, lithium record cards and methotrexate record cards for people who may need them.

Medicines were obtained from licensed pharmaceutical wholesalers. Unlicensed ‘specials’ were obtained from BNS Specials. Routine date checks were seen to be in place, 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, and all were seen to be within the required temperature range.

The pharmacy offered a delivery service to a small number of people who couldn’t visit the pharmacy in person. Deliveries were recorded on paper drop sheets, but the RP was researching the newer digital apps available. The delivery driver had worked at the pharmacy for a long time before the current

owners had acquired the pharmacy. So the RP was uncertain about what training he may have had. He was signposted to one of the pharmacy membership organisations and the training available.

The pharmacy provided a seasonal flu vaccination service which was due to finish shortly. PGDs valid until 31 March 2023 were available on the Sonar digital platform. This was also used to record the vaccinations and to notify the NHS. The pharmacy was due to start providing a COVID-19 vaccination service when phase six of the programme started in April. They wee expecting revised PGDs to include a new vaccine that hadn't been previously available. There were anaphylaxis kits containing adrenaline ampoules that were all in date.

Pharmacy medicines were displayed behind the medicines counter, preventing unauthorised access or self-selection of those medicines. Patient-returned medicines were screened to ensure that any CDs were appropriately recorded, and that there were no sharps present. Patients with sharps were signposted to the local council for disposal. Denaturing kits for the safe disposal of CDs were available for use. The pharmacy received drug alerts and recalls from the MHRA, and there was evidence of the recent recall of pholcodine-containing products having been actioned. 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 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. The pharmacy used appropriate online reference sources including the BNF and BNF for children. 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 generally used appropriately although the trainee pharmacist was still waiting to be issued with her own smartcard. 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.