General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Copes Pharmacy, 570 Streatham High Road, LONDON, SW16 3QQ

Pharmacy reference: 1041184

Type of pharmacy: Community

Date of inspection: 26/06/2019

Pharmacy context

This is a community pharmacy situated on a local high street and close to a GP surgery. It serves a mixed local population. The pharmacy sells a wide range of over-the-counter medicines and dispenses NHS prescriptions. It also supplies medicines in multi-compartment compliance aids and provides flu and travel vaccinations.

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 generally manages risks well to make sure people are kept safe. It records mistakes that occur during the dispensing process and learns from them. The pharmacy largely keeps the records it needs to by law. But the responsible pharmacist record is not always complete which may make it harder to identify the pharmacist responsible, in case of a query. It generally manages confidential information well and team members know how to protect vulnerable people.

Inspector's evidence

The majority of prescriptions were received electronically; these were dispensed in advance to help the team manage its workload. Walk-in prescriptions were mainly dispensed on the front bench and multi-compartment compliance aids were dispensed either at the back of the dispensary or in one of the storage rooms.

Baskets were used throughout the dispensing process to help prevent transfer between people's prescriptions. Workbenches were cluttered and there was limited clear space to dispense and check prescriptions. Unsealed, part-assembled multi-compartment compliance aids for one person were found on the back workbench. The pharmacist said that these had been assembled the previous week but that this was not normal practice. The pharmacy was waiting for a specific brand of a medicine to add to the compliance aids.

Standard operating procedures (SOPs) were in place and these had last been reviewed in July 2018. All current members of the team had read and signed the relevant SOPs to confirm they had understood them. The roles and responsibilities sections within each SOP were blank which may mean that members of the team might not have clear information about what they can or can't do.

Near-misses were seen to be routinely recorded and were reviewed at the end of every month, alongside any incidents and other patient safety alerts. The previous month's review was kept on a notice board to ensure all members of the team were aware of them.

Members of the team were now highlighting prescriptions for schedule 3 CDs with a coloured stamp to ensure these prescriptions were not handed out past the valid date on the prescription. They had highlighted some medicines on the shelves, for example memantine and metoclopramide tablets following a near miss. The technician said that look alike, sound alike medicines, such as amlodipine and amitriptyline, and prednisolone and propranolol were highlighted on the prescriptions.

Prescription interventions were documented, with details of any action taken by the team. For example, they had contacted the surgery after identifying a number of duplicate prescriptions being issued to people.

Any risks identified were documented on a 'risk review' table which was displayed in the dispensary. The pharmacist had identified that fridge temperatures were not always being recorded and had briefed the dispensary team to double-check that entries were being made.

The regular pharmacist described how she would handle dispensing errors, firstly by apologising to the person involved, then investigating the error, informing the prescriber, and reporting it on the National Reporting and Learning System. A recent incident was discussed where an antihypertensive medication was supplied instead of an antidepressant. The pharmacist said the medication may have been stored in the wrong section as the packaging looked very similar. She had informed the team about the similar packaging and had asked staff involved to review their accuracy checking procedure. The person had not taken any of the incorrect medication.

In-date indemnity and public liability insurance was in place.
The correct responsible pharmacist (RP) sign was displayed in the retail area. There were a significant number of gaps in the RP register, where pharmacists had not recorded the time they ceased responsibility. The regular pharmacist had placed two messages near the computer terminals to remind pharmacists to sign out, but this did not appear to have helped. She had also recently started printing out the RP log and amending it by hand.

Necessary records were maintained but were not always complete. For example, details of the medicine supplied were not recorded for a number of entries checked in the private prescription register. Records for emergency supplies made included the nature of the emergency. ‘Specials’ records for the supply of unlicensed medicines were completed in line with MHRA requirements.

Controlled drug (CD) registers were held electronically; samples of these examined were in order. CD balance audits were generally conducted every month. Random stock checks of two CDs agreed with the recorded balance. An expired CD was clearly marked and segregated from in-date stock. A destruction register was available to record CDs people had returned.

Although a complaints procedure was in place, it was not displayed for people to see. Feedback was sought from people via annual Community Pharmacy Patient Questionnaires (CPPQ). Members of the team said they now did not mention the name of the medicine when selling some products of a sensitive nature, following a complaint.

Members of the team described signposting people to the consultation room for additional privacy. Telephone numbers had been removed from bag labels to ensure these were not visible to people. Bags of medicines awaiting collection were kept inside the dispensary and were not visible to those waiting in the retail area. The pharmacist also conducted spot checks to ensure people’s personal information was not left on the counter. Computers were password protected and access to the electronic patient medication record (PMR) system was via individual NHS Smartcards. Cordless telephones were available; the pharmacist said she conducted calls for the New Medicine Service in the consultation room.

An information governance file, containing guidance and policies, was available but these had not been signed by all current members of the team to confirm they had read them. The pharmacist said she would ask all remaining staff to read and sign these. Confidentiality agreements had been signed by locum pharmacists and current staff, including the delivery driver. Confidential waste was shredded at the pharmacy. A privacy notice and information on how the pharmacy managed people’s information were displayed for people to see. People requesting needle packs were asked to fill an anonymised form, but this was kept in the retail area. So it was possible for others to see that people where collecting needles. The forms were moved behind the medicines counter during the inspection.

The pharmacists and technicians had completed the level 2 safeguarding module from the Centre for Pharmacy Postgraduate Education (CPPE). The trainee dispenser and trainee medicine counter

assistant (MCA) had completed level 1 training. The pharmacist said that there had not been any safeguarding incidents at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services it provides. Members of the team are provided with training resources and sometimes have time set aside to complete them. This helps them to keep their skills and knowledge up to date.

Inspector's evidence

During the inspection, there was a regular pharmacist and two technicians. The owner worked at the branch two days a week. The pharmacy also employed a trainee dispenser and a trainee MCA. Staff wore lab coats and name badges.

Members of the team said there was sufficient cover, particularly since there was now a trainee dispenser who helped with the workload. They were managing their workload well and felt they were on top of all the tasks.

Protected study time was sometimes provided for team members. They were all set one online module to complete every month, either through CPPE or the Avicenna Training platform. One technician had recently completed a module on vulnerable groups. The other technician described completing CPPE modules every month, most recently about medicine optimisation. As a result, she had contacted a local prescriber about clarifying instructions for 'when required' or 'as directed' prescriptions.

Members of the team also had access to pharmacy magazines, information booklets and leaflets as well as email updates, for example, on new products. Formal performance reviews had recently been introduced by the regular pharmacist. Team members had the opportunity to discuss what they were doing well in, any areas for improvement, concerns and suggestions.

One technician said that the current pharmacist had made a number of changes since starting at the branch, for example, re-organising folders and the retrieval system and introducing individual paper record for people receiving multi-compartment compliance aids.

Some members of the team said they had tried to clear some of the clutter in the storage rooms but had not been able to as they needed the owner's intervention, but he did not have the time to sort these out.

Members of the team were happy about raising concerns to the regular pharmacist; one technician said she could openly inform the pharmacist if another member of the team had not completed set tasks in a timely manner. Some targets were set, for example, the number of Medicines Use Reviews conducted. The team felt that there was no pressure to meet these targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally suitable for the pharmacy’s services. But the pharmacy could do more to make sure that it keeps the space as organised as possible at all times.

Inspector's evidence

This was a spacious pharmacy with ample work space. However, workbenches were cluttered with baskets of part-dispensed prescriptions, stock and part-assembled multi-compartment compliance aids. There was limited clear space to work on but it was adequate. Some bags of medicines awaiting collection were stored on the dispensary floor.

There were two storage rooms, but they were cluttered and disorganised. There were empty cardboard boxes piled in front of the back door; members of the team said that this door was not an emergency exit.

Two spacious, clearly signposted consultation rooms were available. One was currently not being used for services or private conversations and was extremely untidy, with boxes, totes and paperwork all over the place. Not all the items inside the rooms were stored securely.

A sink, with hot and cold running water, was used for the preparation of medicines. But it was not clean. Members of the team said they would clean the area more frequently.

The room temperature and lighting were suitable for the provision of pharmacy services. There were several chairs in the retail area for people wanting to wait for a service. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy generally provides its services safely. But team members are not all aware of what advice to give people taking some higher-risk medicines. This could mean that people might not get all the information they need to take their medicines safely. The pharmacy generally manages its medicines well to make sure that they are safe for people to use.

Inspector's evidence

Access into the pharmacy was step-free and via an automatic door. There was ample space in the retail area for people with wheelchairs or pushchairs; the pharmacist had recently moved the chairs in the retail area to create more space for people with wheelchairs. All members of the team had completed Dementia Friend training.

Some members of the team were multilingual and described translating for people when possible. Services were listed on the window, the NHS website and the practice leaflet. There was a wide range of information leaflets in the retail area and consultation room. Dispensing audit trails were maintained to help identify team members involved in dispensing and checking prescriptions.

People who were newly prescribed higher-risk medicines were counselled on their medicines. The pharmacist said that she checked if people taking these medicines were being monitored. Yellow books from people taking warfarin were photocopied, and the copies were attached to repeat prescription requests. But these copies were not retained at the pharmacy and INR levels were not routinely recorded for reference. This could make it harder for the pharmacy to check people's previous results if there was a query.

The pharmacist and one of the technicians had read the valproate guidance. Both technicians could not describe what checks to make for patients in the 'at-risk' group who were prescribed this medicine. The pharmacist said that prescriptions for valproate were flagged up with a 'speak to pharmacist' stickers. Information cards and warning stickers were available to hand. All members of the team could not describe what the age range was for patients in the at-risk group.

People receiving compliance aids were organised over a four week cycle. Tables were used to keep track of when prescriptions were ordered, received and dispensed. The pharmacist had introduced individual record sheets, and these were seen to be neat and clearly updated with any changes. Prescriptions were also cross-checked with the electronic patient medication record (PMR) system. Medicine descriptions were provided to help people identify the medicines in the compliance aids, and patient information leaflets (PILs) were routinely supplied. Sodium valproate was placed in the compliance aids for a person as per the prescriber's request. Although the pharmacist had informed the prescriber of the potential effects of de-blistering the valproate in the compliance aids, a record of this conversation had not been kept.

Prescriptions for another branch were dispensed at this pharmacy. Prescriptions were received electronically and processed as normal but were then collected by a delivery driver on a daily basis. A

record of prescriptions and medicines sent to the other branch was maintained. The other branch was informed of any issues, for example, stock supply problems or delays. Schedule 2 CDs were not dispensed through this service. Written procedures for this activity were available and had been signed by team members.

A delivery service was available. The pharmacist said that people were asked to sign individual record sheets to confirm receipt of their medication. Records for 2015 were found in a storage room but more recent ones could not be found at the time of inspection as the pharmacist said these were kept with the delivery driver. She had not seen the recent records. This could make it harder for the pharmacy to show that the medicines had been safely delivered. The technician said that medicine was returned to the pharmacy if the person was not at home; it was not posted through the letterbox in case there were pets or children at the household.

Medicines were obtained from licensed suppliers. Expiry date checks were conducted every three months and were documented. Medicines with short expiry dates were marked with a coloured sticker. No expired medicines were found at the time of inspection.

The date of opening was not written on a CD liquid which had a limited shelf life after the seal was broken. This made it harder for team members to know if the CD was still safe to dispense.
Fridge temperatures were checked and recorded daily; these were kept within the recommended range of 2 to 8 degrees Celsius.

There were several bags of waste medicines, some in the dispensary and some in a storage room. Some returned medicine had not been sorted and was left on the dispensary floor near the waste medicine bins. The pharmacist said she was looking to arrange more frequent collections with the waste contractor.

Drug alerts and recalls were received electronically, printed out, annotated with action taken and filed for reference. Recent alerts were seen to have been actioned by the team.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And it generally maintains them appropriately.

Inspector's evidence

There were several glass measures available, but some were not clean. Members of the team said they would clean these more frequently. Measures used for CD liquids were clearly marked to help prevent the chance of cross-contamination. The fridges were clean and suitable for the storage of medicines.

Members of the team said that the blood pressure monitor was only a few months old but did not know how often it was replaced or calibrated. They did not know if the weighing scales were checked or calibrated. The pharmacist said that she manually checked the accuracy of the tablet weighing scales, but these checks were not documented. The pharmacist said that the tablet weighing scales were not calibrated.

Uncapped amber medicine bottles were stored in the staff toilet area. The pharmacist said she would review the storage of these for hygiene purposes. Clean counting triangles were also available, including a separate one for cytotoxic medicine. This helped avoid cross-contamination. Members of the team had access to the internet and several reference sources.

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.