General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medco Pharmacy, 31-33 Park Road, TEDDINGTON, Middlesex, TW11 0AB

Pharmacy reference: 1084101

Type of pharmacy: Community

Date of inspection: 18/05/2021

Pharmacy context

An independent pharmacy. One of two owned by the same company. The pharmacy is in a residential area close to the centre of Teddington. And it provides a range of services which include dispensing prescriptions and selling medicines. The pharmacy provides a delivery service for the vulnerable and housebound. And it provides a flu vaccination service in winter. The inspection was conducted during the COVID-19 pandemic during the second phase of the UK's roadmap out of lockdown.

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 identifies its risks adequately. And its team members have adapted their working practices suitably to minimise risks to people's safety during the COVID-19 pandemic. And it has insurance to cover its services. Team members know how to protect people's private information. The pharmacy generally keeps all the records it needs to keep. But it is not thorough enough in keeping records of its mistakes or reviewing them. So that changes can be made to stop mistakes from happening again. The pharmacy has written procedures in place to help ensure that its team members work safely. But it does not ensure that every team member has read and understood those written procedures which are relevant to their roles.

Inspector's evidence

The pharmacy's main activity was the dispensing and supply of medicines in multi-compartment compliance packs to people living in care homes. It did not have many people visiting the premises day to day. So, it had not had to limit the number of people it allowed in. The pharmacy did not often have more than one or two people in at a time and so social distancing could be easily managed by the pharmacy's team members. The pharmacy had hand sanitiser at the pharmacy counter for people to use. The team had a regular cleaning routine and had access to personal protective equipment (PPE).

The pharmacy provided a core range of essential services as well as a flu vaccination service in winter. Its main service was dispensing and delivering prescriptions to the residents of 26 care and nursing homes. But it also dispensed and delivered prescriptions for people in the local community. In general, the team recorded its mistakes and reviewed them. But due to workload pressures team members had not recorded any mistakes for six months. The responsible pharmacist (RP) agreed that the team should record and review all its mistakes so that it could learn from them and improve. The inspector, RP and pharmacy manager discussed the pharmacy's historic near miss records and it was agreed that records should identify what could be done differently next time to prevent mistakes and promote continued improvement. The inspector discussed with the team how it could benefit from discussing all its mistakes openly.

The pharmacy had standard operating procedures (SOPs) in place. And team members appeared to be following them. The trainee dispensing assistant was observed dispensing medicines into multi-compartment compliance packs. And while she had not started any formal training, she was being supervised by the pharmacy manager, who was also a dispensing assistant. The inspector, RP and pharmacy manager agreed that the trainee should begin her formal training course as soon as possible. And that she should read all the SOPs relevant to her role to ensure that she follows standardised, safe procedures. The pharmacy manager attended to customers promptly. And he referred to the RP when he required her intervention. The RP had put her RP notice on display showing her name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services. Senior pharmacists at head office called the care and nursing homes regularly to ensure that the pharmacy's prescription service was working well for them. Home staff could raise concerns with the pharmacy and in general problems were addressed by the pharmacy team with support from head office. Formal feedback surveys had not been conducted over the last year due to the pandemic. But in general, the pharmacy team had

received many positive comments from people. It had received positive comments from people who were grateful for its advice and support throughout the pandemic. And people had also been positive about the pharmacy's delivery service. Particularly when they were shielding or unwell. People had also been positive about the pharmacy remaining open throughout the pandemic and the team being available for them to consult.

The pharmacy had a complaints procedure which corresponded with NHS guidelines. And team members could provide details of the local NHS complaints advocacy service and the Patient Advice and Liaison service (PALS) if necessary. But customer concerns were generally dealt with at the time by the regular pharmacists or pharmacy manager. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers. Insurance arrangements were in place until 3 January 2022 when they would be renewed for the following year.

The pharmacy generally kept its records in the way it was meant to. This included controlled drug (CD) registers, private prescriptions, emergency supplies and the RP record. The inspector and RP discussed the occasional omissions in the RP log. And the importance of ensuring that all emergency supply records showed who had requested the supply. And gave a clear reason for the decision to make the supply. The RP recognised the importance of maintaining the pharmacy's essential records so that they were complete and accurate. The pharmacy's team members understood the need to protect people's confidentiality. Confidential paper waste was set aside for collection and subsequent disposal by a licensed waste contractor. The pharmacy stored its completed prescriptions in the main dispensary or in a side room where they were out of people's view. The RP and pharmacy manager had completed appropriate safeguarding training. And they could access details for the relevant safeguarding authorities online. Remaining staff had not had any specific safeguarding training. The pharmacy manager agreed to address this.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages its workload safely and effectively. And team members work well together. They are supported by colleagues. And 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 pharmacy had a trainee dispensing assistant, the pharmacy manager and a technician on duty with the RP at the time of inspection. The pharmacy manager was an overseas qualified pharmacist and an accredited checking technician. He had also applied to the GPhC for eligibility to complete an overseas pharmacists assessment programme The pharmacy had carried out general risk assessments but not individual risk assessments for each team member. Team members were satisfied with this arrangement and when asked, they said they felt safe at work.

Team members were seen to work effectively together. Each going about their own tasks quietly. The RP spent most of the inspection time checking multi-compartment compliance packs in the pharmacy's side room rather than in the main dispensary. But the technician and pharmacy manager were available to support the trainee dispensing assistant and knew to refer the trainee to the RP when they were unable to assist her. The daily workload of prescriptions was in hand and customers were attended to promptly. The pharmacy had a small close-knit team. The RP was able to make her own professional decisions in the interest of patients and could raise concerns with the superintendent, and her other colleagues. The pharmacy manager, trainee dispensing assistant and technician also felt supported by their colleagues and could raise concerns if they needed to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an adequate environment for people to receive its services. They are sufficiently clean and secure. But the pharmacy does not have a regular enough cleaning routine and it does not have enough space for the workload.

Inspector's evidence

The pharmacy had sectioned off a section of its retail space several years previously to create a separate side room. So, the retail space was now quite small. The pharmacy's dispensing activity took up most of the pharmacy's space. The new side room was used for checking multi-compartment compliance packs and storing them as there had been a lack of space in the main dispensary. But dispensary work surfaces and floors were still cluttered with stock and prescriptions. Plans were in place to extend the main dispensary into the storage rooms behind. And work had already begun. But the current lack of space meant that there weren't enough storage facilities. This had led the team to store completed prescriptions in tote boxes in the retail area until they were taken away for delivery. The tote boxes were close to the pharmacy's waiting area where names and addresses could be read by people waiting there. The pharmacy manager and RP agreed that they would be removed from the retail area and stored safely where people could not see them.

The team had also stacked empty tote boxes in the retail area and in various locations around the pharmacy. The tote boxes cluttered up the floor and took up much needed space. The pharmacy manager had asked the pharmacy's wholesalers to collect them, but this had not yet happened. It was agreed that the team would make further attempts to have them removed.

The dispensary layout was generally suitable for the pharmacy's dispensing activities with separate areas for dispensing and checking. But did not provide enough free space for dispensing activities as well as all the necessary storage. The team had a cleaning routine but agreed that the pharmacy's surfaces and floors should be cleaned more regularly to ensure that contact surfaces were kept hygienically clean.

The medicines counter was immediately in front of the dispensary. It had a small Perspex screen to help reduce the spread of the coronavirus. While the entry from the customer area into the general pharmacy area did not have a screen, the pharmacy manager said that team members would draw people to the screened area when they approached. The pharmacy had a notice on the door advising people of the need to wear a face covering. The pharmacy had a consultation room available for confidential conversations and consultations. The RP had not used the room much during the pandemic. But she knew that it was important to wear a face mask. And clean contact surfaces in the room and wash or sanitise her hands between consultations. And that people using the room should also be asked to sanitise their hands and wear a face covering. The pharmacy's seating area had chairs placed less than a metre apart. So, the pharmacy manager agreed that they would be placed further apart. But if that was not possible, he would remove extra chairs to ensure that people using them could keep an appropriate distance from each other. The pharmacy had staff facilities to the rear.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. And makes them easily accessible for people. The pharmacy team gets its medicines and medical devices from appropriate sources. 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. The pharmacy generally stores its medicines properly. But it does not do enough to ensure that all medicines are packed and labelled correctly when it puts them back into stock.

Inspector's evidence

The pharmacy's entrance had a small ramp which provided step-free access from the pavement outside. This made access easier for wheelchair users and those with mobility difficulties. The pharmacy had a sign in its front window advertising the times of opening. The customer area was used to store tote boxes and was quite cluttered. But if these obstacles were removed it would be suitable for wheelchair users. The Pharmacy's consultation room was to the side of the counter. Entry into the room by a wheelchair user may have been difficult due to the turning angle. The pharmacy 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 had reduced its range of services during the pandemic. And currently offered a core range of services and a flu vaccination service in the winter. It also provided COVID-19 lateral flow tests for people. Its team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. The pharmacy provided multi-compartment compliance packs for people living at home who needed them. But the greatest number of packs were dispensed for people in care or nursing homes. The labelling directions on compliance packs gave the required advisory information to help people take their medicines properly. Compliance packs had been labelled with a description of each medicine, including colour and shape, to help people to identify them. And patient information leaflets (PILs) were supplied with new medicines and with regular repeat medicines. Multi-compartment compliance packs used for single medicines only had been labelled with details of the medicine and its batch number and expiry date. The RP gave people advice on a range of matters. And would give appropriate advice to anyone taking high-risk medicines. The pharmacy had a small number of people taking sodium valproate medicines. But no-one taking it was in the at-risk group. The RP was aware of the precautions she would need to take, and counselling she would give, if it were to be prescribed for someone new.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines, appropriately and in their original containers. But one of the team had placed some loose Sando-K tablets in an unlabelled dispensing bottle without the knowledge of the pharmacy manager or RP. The inspector discussed this with the team, and it was agreed that team members should review their understanding of the correct procedures to follow when making changes to multi-compartment compliance packs. Stock on the shelves was generally tidy and organised to assist selection of the correct item. The pharmacy team date-checked the pharmacy's stocks regularly. And they kept records to help them manage the process effectively. A random sample of stock checked by the inspector was in date. In general, short-dated stock was identified and highlighted. And the team put its 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 to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

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 keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies. Team members washed or sanitised their hands at regular intervals throughout the day.

The pharmacy had three computer terminals. Two were in the dispensary and had a facility for keeping patient medication records (PMRs). The third was in the side room used by the RP. The dispensary computers were located at different work areas of the dispensary, in a way that meant that team members using them were not close to one another. Computers were password protected and their screens could not be viewed by people. Team members 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.