General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Shadforth Pharmacy, 266 Brentwood Road, ROMFORD, Essex, RM2 5SU

Pharmacy reference: 1086915

Type of pharmacy: Community

Date of inspection: 17/07/2019

Pharmacy context

This is a community pharmacy located next door to a GP practice in a residential area. The pharmacy belongs to a small group of pharmacies. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs. It also carries out health checks.

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	1.2	Good practice	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
2. Staff	Standards met	2.2	Good practice	Team members get time set aside for training, training is monitored through regular conversations and any gaps in knowledge are identified.
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's working practices are generally safe and effective. The pharmacy asks its customers for their views. It largely keeps the records it needs to so that medicines are supplied safely and legally. Team members know how to safeguard vulnerable people. They are good at recording and learning from any mistakes. This helps them make the pharmacy's services safer.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). These were sent to the pharmacy from head office. The superintendent pharmacist (SI) emailed the team to notify them of any new SOPs. Members of the team had read SOPs relevant to their roles. The responsible pharmacist (RP) SOPs had recently been updated by head-office. There was no audit trail to show that team members had read and understood these.

Near misses were recorded by team members when a mistake was identified. Each team member had an individual log which they used and at the end of each weekend reviewed their own near misses and had a discussion with the pharmacist. On some occasions the team had a meeting to discuss commonly occurring mistakes. At the end of the month the regular pharmacist completed a review of all near misses and incidents and shared findings with the team. A copy of this review was sent to the SI. As a result of near misses, the team had labelled shelf edges in some places to remind team members to take more care when picking certain medicines. And had also moved items on the shelves that had similar names such as pantoprazole and pravastatin. Head office had also sent warning cards for medicines which looked-alike and sounded-alike (LASA) which had also been attached to shelf edges. The meeting to discuss reviews was usually done on a Monday, when most team members were in. The pharmacy manager and a dispenser who did not work on Mondays came in over lunch when the pharmacy was closed.

Dispensing incidents were investigated and a patient safety incident report form was completed with a copy sent to head office. The pharmacist said that she would discuss the incident whoever was involved and the incident was also discussed and reviewed as part of the monthly review. Following an incident were someone was supplied with fluoxetine 20mg instead of the 60mg strength, the pharmacy manager had asked the pharmacist who had checked the prescriptions to implement marking the medicine's name and strength as part of her checking process.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaint procedure, details of this were available in leaflets displayed on the shop-floor. The pharmacy also completed an annual patient satisfaction survey. The team had received some feedback that people wanted the pharmacy to offer the warfarin service. However, launching the service was not within the pharmacy's control as the service was no longer being commissioned by the local Clinical Commissioning Group. As a result of other feedback, a notice board with healthy living advice had been introduced.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. Records for emergency supplies, responsible pharmacist (RP), unlicensed specials and controlled drug (CD) registers were well maintained. Private prescription records were generally well maintained but the details of the prescribers were not always accurate. This

could make it harder for the pharmacy to find out these details if there was a future query.

CD balance checks were carried out every quarter and each time a particular medicine was supplied. A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received.

Assembled prescriptions were stored in the dispensary. An information governance policy was in place, and all team members had completed training. Team members had also completed training provided by head office on the General Data Protection Regulation, the pharmacist said that the team was in the process of completing updated training for this. Team members had smartcards to access NHS systems. Pharmacists who had completed relevant training had access to Summary Care Records and gained consent from people to access these in writing.

The pharmacists had completed level two safeguarding training and had information for safeguarding contacts available. Team members had also completed safeguarding training. The team had contacted the safeguarding board in the past for a concern that they had relating to a child.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services provided, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively. Team members get time set aside for ongoing structured training. This helps them keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy usually had two trained dispensers working each day and an additional trained dispenser covered the middle shift to ensure there was overlap. At any given time, there were always two trained medicines counter assistants covering the counter and shop floor. The pharmacy had two pharmacists covering every day except for Saturdays. On the day of the inspection the pharmacy manager was supported by a relief pharmacist, who was the RP. Holidays for dispensers was covered by the company's relief dispenser. Team members who worked on the counter covered their holidays between themselves. The pharmacist who was the manager said that there were enough team members for the services provided.

The pharmacy manager carried out appraisals with team members every six months. Prior to the meeting the team member filled out what they thought they did well and what their key responsibilities were. Following this a chat was held to discuss any additional training needs and what they wanted to do in terms of next steps. Following the last review, a member of the team had been enrolled on the NVQ 3 technician training and another dispenser was to be trained on how to manage the multi-compartment compliance packs service. Pharmacists had appraisals with head office and the pharmacy manager was asked to provide feedback.

The MCA counselled patients on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She would always refer to the pharmacist if unsure and was aware of the maximum quantities of some medicines which could be sold over the counter. The MCA described handing out prescriptions in line with the SOPs and also checked that the number of items in the bag corresponded to what people were expecting. She was aware that gabapentin was a CD and said that a prescription for it would be valid for 28 days. The pharmacy manager had also attached a poster near the area where prescriptions were handed out from to prompt team members to check the expiry dates on prescriptions. The MCA also carried out blood pressure checks. She said that during the check if any test results obtained were outside of the normal limits she would refer to the RP.

All team members had individual training records which the pharmacy manager used to store certificates for training that they had completed. A trainer from head office came in from time to time to provide training. Training evenings were also held by the company. If the pharmacist identified a need for additional training the trainer would come and give additional support. The RP gave an example of retraining a colleague on blood pressure monitoring as they had not been very confident carrying out the measurements. The company also sent training for the team to do such as for new products like CBD and for conditions like hay fever. Pharmacists attend training sessions held by the Local Pharmaceutical Committee and manufacturers. The team were due to attend a training session held by Astra Zeneca on diabetes.

Team members on formal training courses were given some time on Thursdays to complete their training. Other training was done as team members were working or they would take it in turns to go and sit in the consultation room to complete their reading. They were able to do their training in work time.

Monthly meetings were held for the whole team. This covered everything including patient safety reviews. In addition to this the team also used a diary to communicate and had a group chat on an electronic messaging application or alternatively left notes. Team members said that they felt able to raise concerns or share ideas with the pharmacy manager and pharmacists. The pharmacist said that she felt able to share concerns and raise ideas with the management team.

The pharmacy received key learning summaries from the SI. In the past they had received information on the new guidance from The National Institute for Health and Care Excellence (NICE) for teething and over-the-counter sales of products containing lidocaine. Team members including the MCAs were aware of this. Other information received included alerts for disruption of supply. The pharmacy manager said that summaries were sent as often as there was something new which needed to be told. The SI also sent information to share learning from incidents that may have occurred. This included a summary of what happened and what the team needed to look out for. The SI occasionally visited the pharmacy. Team members said that the head office team were very supportive and tried to help the team if there were any problems or issues.

Targets were in place for the services offered such as Medicines Use Reviews (MUR) and New Medicine Service (NMS). The pharmacist said that there was no pressure from head office but the pharmacy generally met their targets. The targets did not affect the pharmacist's professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services.

Inspector's evidence

The dispensary was clean, spacious and laid out in a professional manner. The workbenches were kept clutter free providing plenty of clear space to dispense and check on. Workbenches were also allocated, with separate areas of the dispensary used for dealing with queries and managing repeat prescriptions. A back room with a large table was used to dispense and check repeat prescriptions, a segregated area within this room was allocated for the management and preparation of multi-compartment compliance packs. This helped avoid distractions. Cleaning was carried out by the team with a rota in place and the pharmacy also had a cleaner. Medicines were arranged on shelves in a tidy and organised fashion. There was a clean sink in the dispensary, with hot and cold running water, which was used for the preparation of medicines. The premises were kept secure from unauthorised access. The pharmacy had good lighting and was well ventilated, temperature control systems were available.

A clearly signposted consultation room was available for private conversations. The room was clean and tidy with confidential information stored inside a lockable cupboard. The small window in the door was able to be covered with a blind to ensure patient privacy and dignity was maintained. There were a number of posters and leaflets displayed within the room. The pharmacist said that a chair would be removed from the room to accommodate people with mobility aids.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally delivers its services in a safe and effective manner. It obtains its medicines from reputable sources. And it manages them appropriately so that they are safe for people to use. The pharmacy's team members are helpful and they largely make sure people have all the information they need so that they can use their medication safely.

Inspector's evidence

The pharmacy was easily accessible and had a step-free entrance. There was easy access to the medicines counter. A free delivery service was also offered. Team members helped anyone who required assistance. There was a seating area at the front for people waiting for their prescriptions. The pharmacy had the ability to produce large print dispensing labels. Team members were multilingual and the pharmacy manager had displayed a poster to prompt team members on different ways of communication.

Services provided by the pharmacy were advertised in the pharmacy. Team members were aware of the need to signpost people to other providers. Team members used the internet to find other services if they were not familiar with the details. The team also had a notice board on the shop floor which was used to display details of other healthcare providers. The team said that they had recently obtained a number for an eye clinic to refer babies with eye infections.

The pharmacist felt that the New Medicine Service had the most impact. She said that it allowed her to answer any questions that people had which they may have not asked their GP. People who were started on new blood pressure medicines were asked to come in and have a free blood pressure check. The RP said that the pharmacy received a number of queries for chlamydia testing as it used to be offered previously. People were now referred to another provider. New services were discussed at the manager's meeting, the pharmacist said that management was open to suggestions.

The pharmacy had an established workflow in place. The pharmacy manager said that a large number of people were part of the repeat dispensing service. To help manage this, the pharmacy had worked with the head office team to generate record cards for each person which tracked when each prescription was dispensed and collected. The pharmacy worked three weeks ahead of when people were due to collect their medicines. Most assembled prescriptions were stored in the back area and were colour coded depending on when they were due. These were then brought into the main dispensary the week that they were due to be collected.

Dispensed and checked by boxes were available on labels; these were initialled by team members when they were dispensing or checking. A quad box was also printed on the prescriptions which team members initialled when completing various steps of the dispensing process. The pharmacy team used colour-coded baskets to ensure that people's prescriptions were separated, to reduce the risk of errors and to manage the workflow.

The pharmacist was aware of the change in guidance for dispensing sodium valproate and the pregnancy prevention programme. Warning labels had been attached on the shelf edge and dispensers had been briefed to check the age group when dispensing. The pharmacist would also check and where necessary would intervene by contacting the prescriber. An audit had also been carried out and the

pharmacy did not have anyone who fell in the at-risk group. The computer system flagged up a warning when dispensing valproate which was printed and attached to the prescription. The pharmacist was aware of the need to use the warning stickers but the pharmacy had run out of these. The pharmacist said she would speak to head office about getting some more.

Separate cards were available and used to highlight things at the point of handout such as incomplete prescriptions. Or if something additional needed to be done such as with high-risk medicines or if a medicine needed to be reconstituted. The pharmacy had forms which they completed when people collected prescriptions for warfarin and lithium. The information from this was then entered onto the electronic patient medication record. For people who had high-risk medicines delivered a form was sent out with the driver. The pharmacist would then contact the person or their GP if there were any issues.

A list of people who were supplied their medicines in compliance packs was organised and divided into weeks. The pharmacy ordered prescriptions from the surgery. Each person on the service had an individual record card which listed all the medicines they were taking. This was used to compare against the prescription when it was received. Team members ticked to say if there was a prescription available and a record was made of who had prepared the pack. The list was ticked as each medicine was placed in the pack. The team members called the surgery if there were any missing or new items after which a record was made on the person's electronic record and on the individual record card. The pharmacy had people's telephone numbers available as well as contact details for next of kin and carers. People who were admitted into hospital were added to a list. The local hospital usually called and notified the pharmacy. The team asked people or their representatives to bring in discharge letters. Once this was received they then liaised with the surgery and worked to get a new prescription. Packs were usually prepared by one of two dispensers. Backing sheets were first prepared after which stock was picked. Once these had been checked by a pharmacist the packs were prepared. A third dispenser was also being trained to help if someone was on leave.

Assembled packs observed were labelled with product descriptions. There was no audit trail on the actual pack, but team member signed a separate sheet to show who had prepared and checked the packs. Patient information leaflets were supplied on a monthly basis. Mandatory warnings were missing from assembled packs and backing sheets were also placed loosely within the packs. This means that people may not always have the information they need to take their medicines safely and there is a risk that the backing sheets could become displaced.

The pharmacy had two delivery drivers. Signatures were obtained when people's medicines were delivered. In the event that someone was not available medicines were returned to the pharmacy and the delivery record was annotated. Medicines were obtained from licensed wholesalers and stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of medicines. CDs were kept securely.

Date checking was completed every three months. Short-dated stock was logged and marked with a red dot. No date-expired medicines were observed on the shelves checked. A date-checking matrix was in place. Dispensers were allocated sections which they were required to check. A separate rota was used for the removal of short-dated medicines each month.Out-of-date and other waste medicines were segregated at the back of the pharmacy away from stock and then collected by licensed waste collectors.

The pharmacy was compliant with the Falsified Medicines Directive (FMD). The dispenser placed 'tamper evident' warning card with the prescriptions if stock was compliant to prompt team members when the medicines were handed out. The medicine was scanned alongside the prescription at the point of dispensing and the system generated a label to be scanned once the prescription had been

handed out.

Drug recalls were received via email, these could be accessed by all team members. Alerts were printed out and a drug alert audit sheet was completed with details of who had actioned the recall and if any stock was found.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

Calibrated glass measures were available. Tablet triangles were available. A separate triangle for use with cytotoxic medicines was available to avoid cross-contamination. A fridge of adequate size was available. Up-to-date reference sources were available including access to the internet.

The blood pressure monitor calibration was organised by head office and the monitor was sent for calibration annually. Other equipment was calibrated by external agencies who provided the equipment. The computers were password protected and screens were not visible to people using the pharmacy. Confidential waste was shredded.

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.