General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Regents Park Pharmacy, 61 Regents Park Road, Shirley, SOUTHAMPTON, Hampshire, SO15 8PF

Pharmacy reference: 1087643

Type of pharmacy: Community

Date of inspection: 17/07/2019

Pharmacy context

An independent pharmacy located on a small parade of shops in a residential area of Southampton. It is a family-run business and the superintendent and his wife both work there regularly. The pharmacy dispenses NHS and private prescriptions, sells a range of over-the-counter medicines and provides health advice. The pharmacy also provides Medicines Use Reviews (MURs), New Medicines Service (NMS), multi-compartment compliance packs (MDS trays or blister packs) for patients in their own homes and a supervised consumption service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not have complete or up-to-date SOPs in place which means that team members may not complete procedures in a consistent manner, and they cannot refer to the SOPs if they were unsure of a procedure.
		1.2	Standard not met	The pharmacy does not regularly record incidents and is missing opportunities to learn from its mistakes.
		1.5	Standard not met	The pharmacy could not show that it had appropriate indemnity insurance arrangements in place.
		1.6	Standard not met	The pharmacy is not maintaining its Responsible Pharmacist record to the required standard in accordance with the law.
2. Staff	Standards not all met	2.1	Standard not met	The counter assistant was putting stock away while unqualified to do so.
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 not all met**

Summary findings

Overall the pharmacy does not manage risk adequately. It does not record all its near misses or errors, so it may be missing opportunities to prevent similar mistakes happening in the future. The pharmacy does not have up-to-date or complete written procedures in place. This means that there may be a risk of team members not completing processes in a consistent manner. And they have nothing they can refer to if they need to check how to complete a particular task. The pharmacy keeps some records it needs to by law, but it does not display an accurate responsible pharmacist notice or keep a complete responsible pharmacist record. This means that it may be difficult for people to identify the pharmacist. The team also does not check its stock balances regularly. This may make it harder for them to easily detect and correct any discrepancies. The pharmacy does not have evidence to show that they have appropriate insurance in place to protect people if things go wrong.

Inspector's evidence

The team held a near miss log in the dispensary, but in 2019 only 11 entries had been made and they did not include detail explaining why the incident had occurred and the action they took as a result. There was no evidence of a formal review of the near misses or incidents in the pharmacy. The team explained that if an error was made, they would report it on the NRLS website. However, incident reports were not seen to be held in the pharmacy.There was a workflow in the pharmacy where labelling, dispensing and checking were all carried out at different areas of the work benches. Multi-compartment compliance packs were prepared in a dedicated area at the back of the pharmacy to reduce distractions. Dispensing labels were seen to have been signed by two different people indicating who had dispensed and who had checked a prescription.

An expired certificate of public liability and professional indemnity insurance from the NPA was on display in the dispensary. When asked for current insurance details, the superintendent did not provide them. SOPs were in place for some of the dispensing tasks, but SOPs for Responsible Pharmacist and for Controlled Drugs were not present. The team had not signed the SOPs present to say they had read and understood them. The pharmacist explained that she and the superintendent were in the process of reviewing the SOPs, but this was said during the last inspection in September 2018.

Staff explained that they would refer to the pharmacist if they received a complaint. The team carried out an annual Community Pharmacy Patient Questionnaire (CPPQ) and the results of the latest one were seen to be displayed on the nhs.uk website and were generally positive. Records of controlled drugs and patient returned controlled drugs were all seen to be complete and accurate. A sample of pethidine 50mg tablets was checked for record accuracy and was seen to be correct.

The responsible pharmacist record was held electronically but had several missing entries. From the 1st of July 2019, to the 17th July 2019, only 7 responsible pharmacist entries had been made. The responsible pharmacist notice was on display, but the pharmacist’s registered name was not used. The maximum and minimum fridge temperatures were recorded electronically and were always in the 2 to 8 degrees Celsius range. The private prescription records were completed electronically. The specials records were seen to be mostly complete, but some were seen without the patient details or the dispensing label.

The computers were all password protected and the screens were not visible to the public. Confidential

information was stored away from the public and conversations inside the consultation room could not be overheard clearly. There were cordless telephones available for use and confidential waste paper was collected in a confidential waste basket and later shredded.

The pharmacist had completed the Centre for Pharmacy Post-Graduate Education (CPPE) Level 2 training programme on safeguarding vulnerable adults and children. The team explained that they were aware of things to look out for which may suggest there is a safeguarding issue. The team were happy to refer to the pharmacist if they suspected a safeguarding incident. The pharmacy team were all Dementia Friends and had completed this learning online.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough staff to provide its services safely. But some members of the team complete tasks which they are not qualified for. Team members have access to formal training initially, but not to ongoing training which could affect how well they care for people and the advice they give. Pharmacy team members make decisions and use their professional judgement to help people. They can share information and raise concerns to keep people safe.

Inspector's evidence

During the inspection, there was one pharmacist, one trainee technician and two dispensers who were completing the NVQ 2 course with the NPA. The staff were seen to be working well together and supporting one another, but during the inspection, the medicines counter assistant was observed to be putting away the pharmacy delivery.

The team explained that they would often be coached on current professional topics by both the regular pharmacists and would have access to journals and materials posted to the pharmacy. The pharmacist explained that she would encourage the team to attend local training events and one of the dispensers had recently attended training to become a smoking cessation advisor but had not yet completed the training course.

The pharmacy team explained that they were always happy to raise anything with one another whether it was something which was causing them concern or anything which they believed would improve service provision. There were no targets in place and the team explained that they would never compromise their professional judgement for business gain.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's prmeises are generally suitable for services it provides, and are secure when closed. Pharmacy team members use a private room for sensitive conversations with people to protect their privacy. But the pharmacy is very cluttered and untidy, which makes it difficult to locate find things and increases the risk of mistakes occurring.

Inspector's evidence

The pharmacy was based on the ground floor of the building and included a retail area, medicine counter, consultation room, dispensary, stock room and an MDS room/staff rest room. Although the whole pharmacy was dated in appearance, it was laid out with the dispensary clearly defined away from the main retail area of the pharmacy. All the products for sale within the pharmacy area were healthcare related and relevant to pharmacy services.

The pharmacy was professional in appearance and clean from the public view. However, the pharmacy was very cluttered and untidy in the dispensary, consultation room and stock room. Prescriptions were stored in baskets on the floor, the prescription retrieval system was full, and stock and paperwork were stored in an untidy and disorganised manner in the consultation room and dispensary.

The team explained that they would clean the pharmacy between themselves and a cleaning rota was on display in the pharmacy. Medicines were stored on the shelves in an untidy and messy fashion with some medicines being mixed up on the shelf.

The dispensary was suitably screened to allow for the preparation of prescriptions in private and the consultation room was advertised as being available for private conversations. Conversations in the consultation room could not be overheard.

The ambient temperature was suitable for the storage of medicines and lighting throughout the store was appropriate for the delivery of pharmacy services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people with different needs and its team members source, store and generally manage medicines appropriately. However, some people on high-risk medicines may not always be identified. This means it may be difficult for the pharmacy to show that some of those supplies are safe.

Inspector's evidence

Pharmacy services were displayed in the window of the pharmacy. There was a range of leaflets available highlighting the services on offer in the pharmacy and general health promotion in the retail area of the pharmacy by the front door.

There were two steps to access the pharmacy which the team explained did not seem to cause many problems. And the team offered their delivery service to patients who could not access the pharmacy. There was also seating available should a patient require it.

The pharmacy team prepared multicompartment compliance packs for domiciliary patients. Those packs examined were seen to include accurate descriptions of the medicines but not all packs were provided with Patient Information Leaflets. The team explained that they were all aware of the requirements for women in the at-risk group to be on a pregnancy prevention programme if they were on valproates and they had checked the PMR to see if they had any patients affected by this. The pharmacist explained that the team would not normally ask warfarin patients for their INR levels, their last blood test dates or their warfarin dosage when providing prescriptions for warfarin.

The team was aware of the European Falsified Medicines Directive (FMD) and the pharmacist explained that they have the updated scanners, but they have not yet registered with SecurMed or updated their PMR system. The pharmacist explained that the superintendent would be looking into this.

The pharmacy obtained medicinal stock from Phoenix, AAH, Alliance, OTC Direct and EuroChem. Invoices were seen to verify this. Date checking was carried out regularly and the team highlighted items due to expire with coloured stickers and displayed the date checking rota in the dispensary.

There were destruction kits available for the destruction of controlled drugs and doop bins were available and seen being used for the disposal of medicines returned by patients. The team also had a seperate bin for the disposal of hazardous waste.

The fridges were in working order and the stock inside was stored in an orderly manner. The CD cabinets were appropriate for use and secured to the walls of the dispensary. Expired, patient returned CDs and CDs ready to be collected were segregated from the rest of the stock.MHRA alerts came to the team via email and the team explained that they would action any appropriate notices.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. It looks after this equipment to ensure that it works properly.

Inspector's evidence

There were several crown-stamped measures available for use, including 100ml, 50ml and 10ml measures. Amber medicines bottles were seen to be capped when stored and there were clean counting triangles available as well as capsule counters.

Up-to-date reference sources were available such as a BNF, a BNF for Children, and a Drug Tariff as well as other pharmacy textbooks. Internet access was also available should the staff require further information sources and the team could also access the NPA Information Service. The computers were all password protected and conversations going on inside the consultation could not be overheard.

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.