General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Crystal Pharmacy, 239 Farnham Road, SLOUGH, Berkshire, SL2 1DE

Pharmacy reference: 1088753

Type of pharmacy: Community

Date of inspection: 23/07/2019

Pharmacy context

This is an independent community pharmacy situated alongside other local shops on a busy main road, on the outskirts of Slough. It serves a diverse local community. Retails sales and NHS dispensing are the main activities, but the pharmacy offers some other NHS funded services including Medicines Use Reviews (MURs) and flu vaccinations. Substance misuse treatment and needle exchange services are also available.

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 adequate standard operating procedures for the services it provides and members of the pharmacy team do not follow them.
2. Staff	Standards not all met	2.2	Standard not met	Some members of the pharmacy team are not qualified or appropriately trained for the activities they carry out.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	Medicines management is inadequate. Stock medicines are not always appropriately packaged or labelled. Out of date medicines are present amongst stock. The pharmacy cannot show that medicines are stored at the right temperature. Controlled drugs management could be improved.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy usually keeps people's personal information safe and it maintains the records required by law. But some of the pharmacy's working processes are unclear and team members do not fully understand their responsibilities, so they might not always work effectively. And they have a limited understanding about safeguarding vulnerable people, so they may be less confident identifying issues or raising concerns.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs) which covered the main activities. These had not been reviewed or updated for several years and did not reflect current practice. There were no SOPs covering confidentiality or the responsible pharmacist, and staff roles and responsibilities were not clearly defined in the procedures. The counter assistant working at the time of the inspection had signed some in 2014, but she was not familiar with them, and she had not signed all those relevant to her role. And other team members had not read and signed any of the SOPs. The counter assistant was not able to properly explain the difference between Pharmacy medicines and general sales list medicine, and what should not be sold when the pharmacist was absent. In reality, the pharmacist rarely left the premises during working hours, so team members always worked under supervision.

The superintendent was the managing director and worked as the regular responsible pharmacist(RP). An RP notice was displayed. It was not immediately visible from the counter and contained the wrong pharmacist's details initially, but this was rectified during the inspection. An RP log was maintained electronically. The log was generally in order, but the time the RP ceased undertaking this responsibility was not always captured, which could cause ambiguity.

Dispensing labels had dispensed and checked boxes, but these were not routinely utilised, so the team members responsible for each prescription supply could not be easily identified. Dispensary benches were cluttered, and baskets were not routinely used to segregate prescriptions during the assembly process, which could increase the likelihood of errors. There was an incident reporting process but completed examples could not be located; the pharmacist could not recall any recent errors. Charts were used to record occasional near misses and included associated learning points. A patient safety review had been documented in December 2018, but these were not completed regularly, so some learning opportunities may be missed. Overall, the pharmacy team could do more to manage and minimise risks.

The pharmacy had professional indemnity insurance. There was a complaints procedure, but the details were not advertised so people may not be aware of this. Any concerns or issues were referred to the superintendent. Formal complaints were rarely received. The pharmacy participated in annual patient satisfaction surveys and results were available on www.NHS.uk website. Recent results were positive.

The pharmacy used a recognised patient medication record (PMR) system to record prescription supplies. Records of Controlled Drugs (CDs) included running balances; audits were completed infrequently, but a random check of one stock item found the quantity matched the amount recorded in the register. Patient returned CDs were recorded in a dedicated register, and destructions were

signed and witnessed. Supplies of unlicensed medicines were recorded appropriately. Private prescription records were recorded in a book and included all the required details. Emergency supplies were recorded on the PMR system. Contemporaneous records could not be produced at the time of the inspection as the PMR system had recently been updated, so the pharmacy could not clearly show these supplies were appropriate. The superintendent agreed to review how emergency supplies were documented and ensure they were available in future.

The counter assistant understood the principles of data protection and confidentiality. Pharmacists had individual NHS smartcards to access the spine. Confidential paper waste was segregated; the superintendent said he usually took this home and incinerated it. Confidential material was not generally accessible to the public. But there was a small risk that people might be able to see other people's personal information, as access to the consultation room was via the dispensary. Details of the pharmacy's privacy policy were not displayed in accordance with GDPR.

The superintendent said he had completed CPPE safeguarding training some time ago. Details of local safeguarding contacts were on the dispensary notice board. The counter assistant had not completed any formal safeguarding training but was Dementia Friends trained, so knew how to support people living with this condition. She said she would report any concerns about patients to the pharmacist. Safeguarding guidance was included with the SOPs, but team members had not been briefed on this, so they might not be aware of some of the other signs to look for.

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

Summary findings

The pharmacy has enough staff to provide its services and team members work under supervision. But some team members are not appropriately trained for the activities they carry out, which could affect how well they care for people. And the lack of structured staff processes means the pharmacy might not identify and support gaps in their skills and knowledge.

Inspector's evidence

The superintendent worked four days a week as the RP. His pharmacist daughter covered his days off and a regular locum covered additional holidays. The pharmacy employed three part-time counter assistants. Usually the pharmacist worked with a single assistant. Only one assistant was present during the inspection. The superintendent's wife could provide ad-hoc cover if needed. Footfall was low, and the team were able to comfortably manage their workload during the inspection.

The counter assistant said she had completed a medicines counter course but was unsure where her certificate was. The superintendent said the other two assistants had not completed any formal training although they had worked at the pharmacy for some time. The pharmacy did not have structured staff management policies, training records or appraisal process.

The counter assistant spoke openly about her role. She understood when to refer to the pharmacist and was aware of over-the-counter medicines liable to abuse and what should be referred to the pharmacist. She felt able to raise concerns or discuss issues with the superintendent if needed. There was a whistleblowing policy, but she had not read it. No commercial targets were set for the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for the delivery of healthcare services. But clutter in some areas impacts on general organisation and detracts from the overall professional image.

Inspector's evidence

The pharmacy occupied a standard retail unit. The public facing areas were bright, clean and reasonably well maintained. There were a couple of chairs in the retail area for people to use if they were waiting, and the floor space was free from obstructions.

A basically fitted consultation room was located at the back of the pharmacy. It was not clearly signposted and inaccessible to wheelchair users. Which means that some people might not always be able access a suitable space for private and confidential discussions.

The dispensary had enough bench space for the volume of dispensing. A separate sink was available for medicines preparation which was fitted with hot and cold running water. Toilet facilities, a staff kitchen and storage areas were situated behind the dispensary. The dispensary, consultation room and storage areas were less well organised and cluttered.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy's services are generally accessible and suitably managed. But its systems for supplying multi-compartment compliance packs increases the likelihood of errors, and means people might not get all the information they need to take their medicines safely. The pharmacy gets its medicines from reputable sources. But it does not always manage them safely to make sure they are in good condition and suitable for supply.

Inspector's evidence

The pharmacy's services were reasonably accessible. There was a level threshold and double doors at the entrance. Staff could offer assistance if needed. Opening times were displayed at the entrance, but there was limited advertisement of pharmacy services and a practice leaflet was not readily available, so people might not always be aware of what services the pharmacy offers. The pharmacy offered ad-hoc deliveries for housebound patients. The team members spoke other languages which was often useful, and the superintendent was observed speaking in Punjabi when counselling people.

The RP dispensed and checked all prescription medication, and tried separate the two processes where possible in order to minimise potential errors. Walk-in prescriptions were uncommon, so he was rarely working under pressure. The team ordered repeat prescriptions on behalf of patients and kept audit trails, so these could be tracked. Only a handful of deliveries were undertaken each week. These were not routinely documented which could make it difficult for the pharmacy to resolve queries.

Methadone instalments were prepared in advance. Containers were frequently re-utilised (for the same patient) which could increase the risk of contamination. Concerns or more than three missed doses were reported to the key worker or prescriber. The needle exchange service was busy. Team members did not handle returns in order to minimise the risk of needle stick injuries.

A small number of people received their medicines in weekly multi-compartment compliance packs to help make sure they take them safely. There were basic records showing details of each patient's regular medication, but these were not regularly updated. Packs were assembled before the prescription was received but checked against it retrospectively before they were handed out. This practice could potentially cause confusion and lead to errors. Patient leaflets were supplied on a monthly basis. Completed packs had backing sheets with patient and descriptions of the individual medicines they contained, but not every pack was labelled in accordance with the requirements. So people may not always have access to all the information that they need to take their medicines safely. The superintendent agreed to review compliance packs procedures to make sure all packs were appropriately labelled in future.

The superintendent was aware of the risks of the supplying of valproate-based medicines to people who may become pregnant. He was aware of one regular patient in the at-risk group who had been provided with the relevant information.

Stock medicines were sourced through reputable wholesalers and specials through a licensed manufacturer. The pharmacy was not currently compliant with requirements as part of the European

Falsified Medicines Directive (FMD). Stock medicines were stored in a reasonably orderly manner. Some items were not stored in their original packaging and numerous loose strips, off-cuts and de-blistered items in amber bottles with no batch and expiry date details were found on the dispensary shelves. Some short-dated medicines were highlighted although a couple of out-of-date medicines were found amongst stock. So there was a possibility that the pharmacy could supply medicines that are not fit for use.

The pharmacy fridge was fitted with a maximum and minimum thermometer and the temperature was checked and recorded and seen to be in range. But the thermometer's internal probe was immersed in water, so the readings might not be accurate. Fridge temperature records could only be produced for the last week. The pharmacy did not have air conditioning. A fan was used to ventilate the dispensary, but the room temperature was not monitored. So the pharmacy was not easily able to demonstrate that medicines were stored at the right temperature.

CDs were stored in cabinets. Obsolete CDs had accumulated, and a destruction was needed. Other expired and patient returned medicines were placed in appropriate waste containers, prior to collection by waste contractors.

Alerts and recalls for faulty medicines and medical devices were received via email. These were checked by the superintendent and a recent alert relating to Emerade had been actioned. But it was not clear if these were checked in his absence and there was no associated audit trail demonstrating this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides.

Inspector's evidence

The pharmacy had access to the internet and paper-based reference materials. Two or three glass crown-stamped measures were available for measuring liquids. Separate measures were marked for use with CDs. Counting triangles were available for loose tablets; a separate triangle was marked for use with cytotoxic medicines. The pharmacy had disposable medicine containers for dispensing purposes and these were stored appropriately. Two small CD cabinets were sufficient for the volume of stock.
Electrical equipment appeared to be in working order. A domestic fridge was used to store cold chain medicines. Computer systems were password protected and screen were located out of public view.

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.