General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ryemead Pharmacy, Gateway House, Ryemead Way, HIGH WYCOMBE, Buckinghamshire, HP11 1FY

Pharmacy reference: 1089903

Type of pharmacy: Community

Date of inspection: 26/04/2019

Pharmacy context

This is a community pharmacy located near a retail park in High Wycombe in Buckinghamshire. A range of people use the pharmacy's services. The pharmacy dispenses NHS prescriptions and some private prescriptions. It also offers a few services such as Medicines Use Reviews (MURs), the New Medicine Service (NMS), a flu and a travel vaccination service. The pharmacy supplies some people with their medicines inside multi-compartment compliance aids if they find it difficult to take their medicines on time.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 and manages some risks appropriately. Pharmacy team members deal with mistakes that occur during the dispensing process responsibly. But, they don't formally review them or record all the details. This could mean that opportunities to spot patterns or trends are missed. Team members understand how they can help to protect the welfare of vulnerable people. But, some of the pharmacy's records are not always kept in accordance with the law. This means that the team may not have all the information needed if problems or queries arise.

Inspector's evidence

The pharmacy was organised and its workload was manageable.The responsible pharmacist (RP) checked prescriptions for accuracy in a designated space. This helped reduce errors from distractions.

Staff recorded near misses. They described pharmacists passing back any mistakes for them to identify these and this helped facilitate their learning. They also explained that they warned each other if they saw similar packaging and stated that their regular pharmacist reviewed near misses. A documented review of the risks for holding similar medicines on the dispensary's shelves was seen. However, the near miss record routinely documented the action taken in response as 'double-check' only with no details about possible causes and contributing factors or learning. There were no documented details of the review of near misses seen.

The locum RP described handling incidents by apologising, rectifying the situation, documenting details and if any medicines were taken incorrectly, this would be reported to the person's GP. There was information available to inform people about the pharmacy's complaints procedure. Staff obtained feedback from people about their services, annually through surveys and used a noticeboard to help with this.

A notice was on display to inform people about how their privacy was maintained. Confidential waste was segregated prior to being shredded. Sensitive details on bagged prescriptions awaiting collection were not visible from the retail area. Staff had completed relevant training online on recent changes in data protection law.

The pharmacy displayed information about its chaperone policy. Staff could readily identify groups of vulnerable people and signs of concern to safeguard them. They referred to the RP in the first instance. The RP was trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE) and staff to level 1. Relevant local contact details were available.

The inspector located three sets of documented standard operating procedures (SOPs) at the pharmacy. The first set seen, were new and from the NPA although relevant details were not filled in and some of the staff declarations were incomplete in these. The second set were dated from 2011 to 2014 and 2015 and were due for review in 2017. The third set was from the Informacist and the last review was marked as 2017 and due for review in 2019. Staff had read and signed the latter SOPs and subsequently confirmed with the inspector, that these were currently in use. Not all of these SOPs reflected the pharmacy's current practice (see Principle 4 and the date-checking process). To help prevent confusion on the pharmacy's current operating procedures, appropriately archiving all other SOPs was discussed at the time. In a follow-up email from the superintendent pharmacist, he

explained that he was in the process of reviewing the SOPs from the NPA and the other sets were being used to assist him in streamlining the pharmacy's processes.

The correct RP notice was on display and this provided details of the pharmacist in charge, at the time. The CD returns register was maintained as a full audit trail of receipt and destruction. Documented records of private prescriptions seen were maintained in line with legal requirements. One private prescription seen was processed by the pharmacy and had the date included in a different pen (10 April 2019). There were no details on this to indicate who or which prescriber made the amendment. There were gaps in the electronic RP records where pharmacists had failed to record the time their responsibility ceased.

On checking a sample of registers for controlled drugs (CDs), these showed that incomplete addresses for wholesalers were sometimes being recorded (such as 'AAH Pharmaceuticals' without address details of the depot or invoice number being documented). Balances for CDs were last seen recorded in January 2019 and August 2018. The only details about the overage for one CD seen documented in the current register was from March 2019. On randomly selecting two CDs held in the cabinet their quantities matched balances stated within corresponding registers.

Records of emergency supplies were recorded electronically. The team had occasionally documented details of the nature of the emergency, odd records were noted as 'to follow' with no reason recorded and the rest included random digits which did not justify why a prescription-only medicine had been supplied without a legally valid prescription. Professional indemnity insurance to cover the services provided were in place through the National Pharmacy Association (NPA) and due for renewal after January 2020.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. The pharmacy's team members understand their roles and responsibilities. And, the pharmacy provides resources to help encourage its team members to keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy dispensed approximately 4,000 to 5,000 prescription items every month, with 39 to 40 people receiving their medicines inside multi-compartment compliance aids and 14 people with instalment prescriptions.

The pharmacy's team members included a regular pharmacist, the pharmacist owner, a trained dispensing assistant and three medicines counter assistants (MCA), two of whom were trained and one was undertaking accredited training with Buttercups. There were also two delivery drivers who were shared with the pharmacy's other branch. A locum pharmacist was present during the inspection. The team's certificates of qualifications obtained were seen.

In the absence of the RP, team members knew which activities were permissible and the process involved if the pharmacist failed to arrive. Before selling over-the-counter (OTC) medicines, staff asked a range of questions to ensure suitability. They referred to the RP when unsure or when required and held a sufficient knowledge of OTC medicines.

To assist with training needs, staff were provided with ongoing training resources from the CPPE, Numark and the NPA. There were individual records kept for each staff member to demonstrate this. As they were a small team, details were discussed verbally amongst them. Informal appraisals were described as held regularly to check the team's progress. The RP had not been set any formal targets to achieve services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an appropriate environment for the delivery of its services.

Inspector's evidence

The premises consisted of a smaller retail area and spacious dispensary at the rear. People's privacy could be maintained when they received supervised consumption of medicines as there was a segregated space to one side of the dispensary. There was also an office, additional storage areas with a staff room and WC facilities.

The pharmacy was well ventilated, sufficiently lit and was well presented. All areas were clean. Pharmacy only (P) medicines were stored behind the front counter. Staff were always within the vicinity to help prevent P medicines being accessed by self-selection.

Two signposted consultation rooms were available to provide services and private conversations. Both were kept unlocked. They were both of a suitable size for the services provided. One consultation room could be accessed from the dispensary. At the point of inspection, there were bagged prescriptions stored on the floor of this consultation room and confidential information accessible within folders that were present in the second consultation room. This meant that unauthorised access to confidential information and prescription-only medicines were possible.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy sources, stores and manages most of its medicines appropriately. The team are making some checks to ensure that medicines are not supplied beyond their expiry date. But, the pharmacy has no up-to-date written details to demonstrate this. So, the team may not always be able to provide assurance that all stock is fit for purpose. The pharmacy provides most of its services safely and effectively. But, members of the pharmacy team don't always highlight prescriptions that require extra advice or record information when people receive some medicines. This makes it difficult for them to show that appropriate advice has been provided when these medicines are supplied. The pharmacy team sometimes fill compliance aids then leave them unsealed overnight while they wait for them to be checked. This means the medicines are not very well protected and could be damaged or contaminated. It may also increase the risk of mistakes happening. The pharmacy delivers prescription medicines safely to people’s homes and keeps records of this. But, people can see other people’s private information when they sign to receive their medicines.

Inspector's evidence

People could enter the pharmacy at street level and through a wide, front door. The retail space was made up of clear, open space. This meant that people requiring wheelchair access could easily access the pharmacy’s services. There were two seats available for people waiting for prescriptions.

The pharmacy’s opening hours were on display on the front door. There was also a noticeboard available in the retail space to provide people with relevant information. This included a section to inform people about healthier living. The team described holding regular campaigns on, for example smoking cessation, children's oral health and healthier eating. Staff provided advice opportunistically and signposted people to other organisations if needed. There was documented information present to assist with the latter.

The RP on the day, was not accredited to provide vaccination services.The team used baskets to hold prescriptions and medicines once assembled. This assisted in preventing any inadvertent transfer of items. Staff involvement in dispensing processes was apparent through a dispensing audit trail. This was via a facility on generated labels.

Staff were somewhat aware of risks associated with valproate and people who may become pregnant. There was no documented information seen to provide to people at risk or about whether an audit had been undertaken to identify people who may become pregnant prescribed this. The inspector was told that prescriptions for this medicine seen were mostly for men.

Prescriptions for higher risk medicines were not identified or flagged in any way to ensure relevant safety checks were made. This included asking about the International Normalised Ratio (INR) level for people prescribed warfarin. There were no details recorded to verify this.

The pharmacy was not currently providing multi-compartment compliance aids for new people. Existing people’s trays were initially set up by liaising with the people’s GPs. The pharmacy ordered prescriptions on behalf of people and once these were received, staff cross-checked details on prescriptions against individual records. This helped to identify changes or missing items. If changes were identified, staff confirmed this with the prescriber. Details were documented on records as an

audit trail. All medicines were de-blistered into compliance aids with none left within their outer packaging. The pharmacy provided descriptions of medicines that were supplied inside trays. Patient information leaflets (PILs) were routinely provided. Mid-cycle changes involved retrieving old compliance aids and supplying new ones. Compliance aids were sometimes left unsealed overnight in the dispensary.

There were records in place to verify when, where and to whom medicines were delivered. CDs or fridge items were highlighted and checked prior to delivery. Signatures from people were obtained upon receipt. There was a risk of accessing confidential information from the way these signatures were obtained. Failed deliveries were brought back to the pharmacy with notes left to inform people. Medicines were not left unattended.

The pharmacy obtained medicines and medical devices from licensed wholesalers such as AAH, Alliance Healthcare, Phoenix and Sigma. Staff aware of the European Falsified Medicines Directive (FMD). The pharmacy was set up to comply with the process. Relevant equipment was in place and being used where possible. Staff had received instruction from the pharmacists as guidance.

Medicines were stored in an organised manner. Every month, medicines approaching expiry were removed, details of these were documented in a book. There was no schedule used to demonstrate when medicines had been checked for expiry. This was not in line with the pharmacy's SOP which described using 'date control forms' and 'dividing into zones'. There were no mixed batches or date-expired medicines seen and short-dated medicines were identified with stickers.

In a follow up email from the superintendent pharmacist, he explained that staff regularly date-checked medicines and he also personally carried out random checks of medicines, to check their expiry on a monthly basis. In general, CDs were stored under safe custody. The key to the cabinet was maintained in a way that prevented unauthorised access during the day. Prescriptions when assembled were attached to bags. Fridge items and CDs (schedules 2 and 3) were identified with stickers. Staff described removing uncollected prescriptions every few months. Schedule 4 CDs were not routinely identified.

Medicines returned by the public, that required disposal were accepted, stored in designated containers and removed via the pharmacy's contractual arrangement. Sharps brought back for disposal, were accepted provided they were in sealed bins. People returning CDs were brought to the attention of the RP and relevant details recorded. See Principle 1 regarding the audit trail of receipt and destruction.

Staff described receiving drug alerts by email, checking stock and acting as necessary. However, there was no audit trail or records of previous safety alerts available at the inspection and staff were unable to bring up details on the email system. The superintendent pharmacist confirmed in a follow up email, that the pharmacy team kept a folder where records of drug alerts were kept.

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

The pharmacy was equipped with current versions of reference sources and staff could use online sources. The dispensary sink used to reconstitute medicines was clean. Hot and cold running water was available with hand wash present.

The team could use a range of clean, crown stamped, conical measures for liquid medicines, counting triangles and a separate one for cytotoxic medicines. Counting triangles seen were dusty and required cleaning. This meant that a risk of cross contamination could occur. This was discussed at the time. The CD cabinet was secured in line with legal requirements. There was information on display here to indicate its contents. Once the risk was highlighted to the RP, this was subsequently removed.

Medicines requiring cold storage were stored at appropriate temperatures within a fridge. Computer terminals were positioned in a manner that prevented unauthorised access. A shredder was available to dispose of confidential waste. The team used their own NHS Smart cards to access electronic prescriptions. These were stored securely overnight.

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.