General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hayes Town Pharmacy, 11 Coldharbour Lane, HAYES, Middlesex, UB3 3EA

Pharmacy reference: 1109250

Type of pharmacy: Community

Date of inspection: 23/10/2019

Pharmacy context

An independent community pharmacy. The pharmacy is on a parade of locally run shops and businesses in Hayes town centre. As well as NHS Essential Services, the pharmacy provides Medicines Use Reviews (MURs), New Medicines Service (NMS) and a delivery service for urgent prescriptions and the housebound. The pharmacy also provides medicines in multi-compartment compliance aids for those who need them and has a minor ailments service. It also provides a dispensing support service to substance misuse clients.

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

In general, the pharmacy's working practices are safe and effective. Its team members understand their roles and responsibilities. They listen to people's concerns and keep people's information safe. They discuss any mistakes they make and share information on what could go wrong to help reduce the chance of making mistakes in future. But team members do not do enough in the way that they gather information and use it to learn and improve. And, they do not always keep the pharmacy's records in the way the law requires.

Inspector's evidence

Staff worked under the supervision of the responsible pharmacist whose sign was displayed for the public to see. They worked in accordance with a set of standard operating procedures (SOPs). Staff said they had read the SOPs relevant to their roles, but they had not signed them. SOPs were last reviewed in April 2016, over three years earlier, and were therefore due for review. According to procedure, all incidents, including near misses were to be recorded and discussed, but the last recorded near miss was three months earlier and a total of four near misses had been recorded in the ten months of the year to date. Staff said that mistakes were relatively rare and that all incidents, including near misses, were discussed at the time. The team had regular discussions to review and discuss any mistakes and ways of preventing a reoccurrence.

The pharmacy had a 100-hour contract, and so, within those hours, it offered an extended-hours dispensing service. But, the near misses which had been recorded did not show the times of the incidents. This information would be relevant in a pharmacy where levels of activity and staff numbers fluctuate throughout the working day. Previous near miss records did not give any contributory factors or learning points. One record indicated that mistakes had occurred because the pharmacy had received medicines indifferent pack sizes to what they were used to. Other records indicated that staff had been rushing or had misread the prescription. Follow up activity included an action for staff to not make assumptions when dispensing. As a follow up staff were also required to 'double check' what they had dispensed. This was small close- knit team and it was clear that discussions about the tasks in hand were integral to the day to day running of the pharmacy. But, without accurate records of what had gone wrong it may be difficult for the pharmacists and staff to conduct a thorough review of their mistakes so that they could learn from them. Near miss incidents had not yet prompted a review of the team's compliance with a robust dispensing procedure or caused team members to identify any steps which could have prevented the error.

However, it was clear that the team discussed any incidents and were aware of the risk of error. The RP pointed out two different pack sizes of gliclazide 80mg tablets. Team members had been made aware of the two sizes and had separated them by placing bendroflumethiazide 2.5mg tablets in between. This prompted team members to check the pack size each time they dispensed gliclazide 80mg tablets. The team had also separated packs of atorvastatin 10mg tablets from packs of the 20mg tablets. And packs of Atenolol 25mg from the 50mg tablets because of their similarities. These measures had been taken to help prevent staff from picking the wrong packs.

The pharmacy team had a positive approach to customer feedback. The RP described how they ordered the same brands of medicines for certain people to help them to take their medicines properly.

Customer preferences included the Teva brands of metformin, fexofenadine and candesartan.

The pharmacy had a documented complaints procedure. A documented SOP for the full procedure was available for reference. Customer concerns were generally dealt with at the time by the responsible pharmacist (RP) and the superintendent informed. Staff said that complaints were rare but if they were to get a complaint it would be recorded. Details of the local NHS complaints advocacy and PALs were available on a leaflet on the counter. The pharmacy had professional indemnity and public liability arrangements so, they could provide insurance protection for staff and customers. Insurance arrangements were in place until 30 September June 2020 when they would be renewed for the following year.

All the necessary records were kept and were generally in order including records for private prescriptions. The RP records were generally in order but had some omissions at the time when the RP's responsibilities ceased, and emergency supply records did not all give a clear reason for supply. Records for unlicensed 'Specials' did not show label patient or prescribers details. CD registers were also generally in order although the running balance totals in the register for Zomorph 60 mg capsules had not been carried forward from the old register to the new. The pharmacy did not have a system for recording the receipt and destruction of patient returned CDs. These records are necessary as they provide an audit trail and give an account of all the non- stock Controlled Drugs (CDs) which pharmacists have under their control. The RP said that it had been a long time since they had any patient returned CDs.

Staff had been briefed on the importance of confidentiality. Completed prescriptions were stored in the dispensary in a way that patient details couldn't be viewed from customer areas. And discarded patient labels and prescription tokens were shredded on a regular basis. The pharmacy's delivery records had a separate page for each patient to sign, so that their details could not be viewed by anyone else. The pharmacist on duty had completed level 2 CPPE training for safeguarding children and vulnerable adults. Support staff had completed the Avicenna on line training module. The pharmacy team had not had any specific safeguarding concerns to report. Contact details for the relevant safeguarding authorities were available online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload safely and effectively and team members work well together. They are comfortable about providing feedback to employers and are involved in improving the pharmacy's services

Inspector's evidence

The pharmacy was run by two regular responsible pharmacists (RPs) who shared shifts between them. Both RPs were directors and one was also the superintendent. RPs were supported by a full-time dispenser, a trainee apprentice technician who attended college one day per week, a full-time medicines counter assistant (MCA) and two-part time MCAs. On the day of the inspection the RP was supported by the apprentice technician, the dispenser and a MCA. A work experience student was working at the pharmacy temporarily. There appeared to be an adequate level of appropriately skilled staff. Staff were observed to work well together, each attending to their own tasks and assisting one another when required. The MCA generally managed the counter, filled stock, tidied displays and dealt with reps. Staff were up to date with the daily workload of prescriptions, and customers were attended to promptly. The work experience student was found cleaning dispensary shelves and date checking stock. She was observed to remove small batches of stock at a time. She had not had any dispensing training, but the pharmacist was observed checking the stocks after she had put them back.

The MCA described being able to raise concerns and make suggestions about how to improve the quality of services. She had worked at the pharmacy for over 7 years and said she could have informal discussions with pharmacists if she needed to. The trainee technician had suggested to the pharmacist that every morning they check what prescriptions had been dispensed a month ago and order the same stock in. He suggested this because, now that patients were ordering their own repeat prescriptions, the pharmacy didn't know when to expect their prescriptions. By ordering the stock in advance like this, they were more likely to have it available in time for people. The pharmacist was not set targets for services such as MURs and was able to make autonomous professional decisions. He could prioritise his tasks in accordance with people's needs.

Principle 3 - Premises ✔ Standards met

Summary findings

In general, the pharmacy's premises are clean, tidy and organised. They provide a safe, secure and professional environment for people to receive healthcare services. But the pharmacy's decor does not look as clean as it could in some areas and needs to be refreshed.

Inspector's evidence

The pharmacy was on a parade of shops, on a busy main road running through the town centre. The pharmacy had a modern appearance. It had a double front with full height windows, and a glass door, which provided natural light. The shop floor was to the front with the counter and dispensary to the rear. The shop floor was kept clear of obstructions and there was enough room for wheelchair users. The pharmacy also had a seat for waiting customers. Items stocked included a range of baby care, healthcare, beauty and personal care items. The pharmacy was tidy and organised and had a professional appearance. Shelves, worksurfaces, floors and sinks were clean, but the age and fabric of the floor tiles made them appear less so.

The dispensary had approximately nine to ten metres of U-shaped dispensing bench to three sides and a further three metre run of bench with a sink to the opposite side. The front of the dispensing bench was where most of the dispensing and checking took place. Completed prescriptions were stored in the dispensary so that names and addresses could not be viewed by the public.

There was a consultation room on the shop floor. The back-shop area also had a stock room and a staff toilet. All these areas were clean and tidy although back shop areas were in need of refreshing. Access to the dispensary and consultation area was authorised by the Pharmacist.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes them available to everyone. The pharmacy generally manages its medicines safely and effectively. It checks stocks of medicines regularly to make sure they are in date and fit for purpose. But, it does not carry out all of its checks as thoroughly as it could. And it does not store all of its medicines appropriately, once they have been removed them from their original packs. Team members generally give people the advice they need. But, they do not always give people enough information to help them take their medicines safely and properly.

Inspector's evidence

The pharmacy's services were advertised at the front window and there was a small range of information leaflets available for customer selection. The pharmacy had step-free access at the entrance suitable for wheelchair users. The shop floor was wide enough for wheelchair users to move around. The consultation area could also be accessed by someone using a wheelchair. The pharmacy offered a prescription ordering service for those who had difficulty managing their own prescriptions. It also had a prescription collection service although, an increasing number of electronic prescriptions meant that, very often, there were none to collect.

There was a set of SOPs in place although they were in need of review. In general, staff appeared to be following the SOPs. But, a CD stock balance had not been carried out for almost 18 months, when the SOP stipulated that an audit should be done every week. The pharmacist said that a balance check was carried out every time a CD was dispensed, which meant that regularly dispensed items were audited frequently. And, less regularly used items were audited less frequently which meant that any discrepancies could remain undetected. But, when checked, the quantity of Zomorph 60mg capsules matched the running balance total in the CD register.

Multi-compartment compliance packs were provided for people who needed them. Patient information leaflets (PILs) were offered to patients with new medicines but not on a regular basis thereafter. While labels on compliance packs had the required BNF advisory information, to help people take their medicines properly, the packs were supplied without a description of colour and shape, so it would have been difficult for people to identify which medicine was which. The pharmacist understood the risks for people, in the at-risk group, taking sodium valproate. He had read the MHRA safety alert and said he would provide counselling. Packs of sodium valproate in stock bore the updated warning label. The pharmacist could not locate warning cards, booklets or the MHRA guidance sheet. But, the pharmacy did not currently have any patients in the at-risk group taking the medicine.

The pharmacy had equipment and software for scanning products in accordance with the European Falsified Medicines Directive (FMD) and were scanning all packs with a unique barcode. Medicines and Medical equipment were obtained from: Alliance Healthcare, DE Group, Colorama and AAH. Unlicensed 'specials' were obtained from Thame laboratories. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. However, there was a quantity of loose tablets in an unlabelled amber dispensing bottle. The bottle had been placed inside the empty tablet carton for Faramsil 400mcg from where they had come. A quantity of ramipril 1.25mg tablets had been placed in

an amber bottle and placed in the original tablet carton in the same way. Neither of the amber bottles had any information to show the name, form, strength, batch number or expiry date. No other manufacturer's details were available such as the product licence number or a PIL. Staff were unsure as to why the tablets had been stored this way or for how long. Another amber dispensing bottle had been labelled as containing 'Olanzapine 15mg'. Again, there were no further details such as batch number, expiry date, product licence number, PIL or any other manufacturer's details.

A CD cabinet and a fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read and recorded daily. General stock was regularly date checked and records kept. Although date checking records could not be found, date checking was seen to be taking place during the inspection. Stock with an expiry date of three months or less was removed and disposed of. Expired stock was seen to have been removed from stock and put in the Doop bin. Patient returns, and expired medicines, were disposed of in the appropriate containers for collection by a licensed waste contractor. But, staff did not have a list of hazardous waste to refer to, which would help ensure that they were disposing all medicines appropriately. Drug recalls and safety alerts were generally responded to although records could not be located. The pharmacist said that the recent recall for Dovobet and Clexane had been acted upon with none of the affected stock found. Other more recent recalls had identified none of the affected batches.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities for the services it provides. In general, it uses its facilities and equipment to keep people's information safe.

Inspector's evidence

The pharmacy had a CD cabinet for the safe storage of CDs. The cabinet was secured into place in accordance with regulatory requirements. The pharmacy used CD denaturing kits for the safe disposal of CDs although it did not currently have any of the kits in stock. The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures were of BS standard except for the methadone measure which was made of plastic and did not have the appropriate crown stamp or ISO number. Measures were generally clean although several were lime-scaled. Counting triangles were generally clean although one of the tablet triangles contained a dusty residue from tablets counted on it before. But, staff said they would always clean equipment before use. Precautions were taken to help prevent cross contamination by using a separate triangle for counting loose cytotoxic tablets. And amber dispensing bottles were stored with their caps on. Bottles were capped to prevent contamination with dust and debris.

There were up to date information sources available in the form of paper copies of the BNF, BNF for children and the drug tariff. Pharmacists also used the NPA advice line service and had access to a range of reputable online information sources such as EMC. There was two computers available for use in the dispensary. Both computers had a PMR facility. There was a further computer in the consultation room which did not have a PMR facility and was used mainly for training. All computers were password protected and out of view of patients and the public. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was shredded. But staff were all observed to use the smart card belonging to the RP or the other regular pharmacist who was not present. Staff should use their own smart cards to maintain an accurate audit trail and to 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.