General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medipharmacy, 1 Lambton Road, Raynes Park, LONDON, SW20 0LW

Pharmacy reference: 1117426

Type of pharmacy: Community

Date of inspection: 22/08/2019

Pharmacy context

This Healthy Living Pharmacy (HLP) is located in a large health centre, a short walk away from the centre of Raynes Park. It dispenses NHS and private prescriptions, sells a range of over-the-counter medicines and provides health advice. The pharmacy offers flu vaccinations in the autumn and winter seasons and a home delivery service. It dispenses some medicines in multi-compartment compliance aids for those who may have difficulty managing their medicines. There is a private chiropractic clinic, and a separate aesthetics clinic open within the pharmacy premises.

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 met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.2	Standard not met	The location of the consultation room and access to it are not appropriate for the protection of people's private and confidential information.
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards not all met	5.3	Standard not met	There is evidence that the privacy and dignity of people using pharmacy services is compromised by the use of a back office as a consultation room. Confidential information is stored where there is a significant risk of it being seen by people using the consultation room.

Principle 1 - Governance ✔ Standards met

Summary findings

Overall the pharmacy manages risk fairly well and has written instructions to tell staff how to complete tasks safely. The pharmacy keeps most of the records it needs to by law and it has adequate insurance in place to help protect people if things do go wrong. The pharmacy's team members understand how they can help to protect the welfare of vulnerable people. But they have not been consistently recording the mistakes they make during the dispensing process, even though they have the forms to do so. Those they have recorded do not have sufficient detail for them to learn from them. This may make it more difficult for the pharmacy to spot patterns and take action to prevent mistakes being repeated.

Inspector's evidence

There were standard operating procedures (SOPs) in place to underpin all professional standards, and all reviewed at varying dates during 2018. The signature sheets were signed by all staff to indicate that they had read and understood them. The pharmacy also had a detailed business continuity plan in place to maintain its services in the event of a power failure or other major problem.

Errors and near misses were recorded using a paper form, showing what the error was, the members of staff involved and the action taken. But the sheet on the wall related to June 2019 and there were no entries recorded. There did not appear to have been any records for July and August 2019, and the last sheet with any near misses recorded was May 2019. Most of the sheets for 2018 – 2019 only recorded two or three near misses with no learning points or actions recorded. There was no evidence of any reflection and learning. There were monthly patient safety reports which identified actions taken to reduce the risk of patient safety incidents. They included separating the different strengths of atorvastatin or separating look alike sound alike medicines (LASAs) and labelling the shelves. There were some labels on the shelves, for example 'check selection, tamsulosin capsules similar appearance fluoxetine capsules' and 'attention check selection propranolol to prednisolone'. Staff were unable to explain what action they would take when near misses happened and said that the manager would tell them. There was no evidence of any reflective learning or of any review meetings to discuss errors and near misses with the staff. The patient incident folder was used to record errors which had left the premises, and there were none recorded since September 2017 and no records of patient incidents recorded on the PMR system.

Roles and responsibilities of staff were not specifically documented in the SOPs. However, those questioned were able to clearly explain what they do, what they were responsible for and when they might seek help. They outlined their roles within the pharmacy and where responsibility lay for different activities.

Staff were able to describe what action they would take in the absence of the responsible pharmacist, and they explained what they could and could not do. The responsible pharmacist (RP) notice was clearly displayed for patients to see and the RP log held on the patient medication record (PMR) computer system was complete apart from two entries where the end time had been missed.

Results of the latest Community Pharmacy Patient Questionnaire (CPPQ) were displayed online at

www.nhs.uk and at the pharmacy reception counter. The results showed 100% satisfaction ratings under each of the main headings. One area for improvement highlighted by the CPPQ was a lack of somewhere to have private conversations and the pharmacy responded by highlighting the availability of the consultation room. The pharmacy complaints procedure was set out on display at the counter. There was no pharmacy practice leaflet available. A certificate of professional indemnity and public liability insurance from Numark valid until June 2020 was on display in the dispensary.

Private prescription records were maintained on the patient medication record (PMR) system and were complete with all details correctly recorded. Dates of prescribing and of dispensing were all correctly recorded. The emergency supply records were completed on the PMR system, and several had not been redeemed against a valid prescription. Reasons for these supplies were recorded but some entries did not contain very much detail. This was discussed and upon reflection the pharmacist agreed to record more detail in future.

The CD registers were seen to be correctly maintained in most instances, with running balances checked at regular weekly intervals in accordance with the SOP. Pages within the registers had their headers appropriately completed but many of the wholesaler's addresses had not been included. The need to include the wholesaler's addresses was discussed and upon reflection the pharmacist agreed to include this in future. Running balances of two randomly selected CDs were checked and both found to be correct. Alterations made in the CD register were asterisked with a note made at the bottom of the page, and they were initialled with the pharmacist's registration number and date. Records of CDs returned by patients were seen to be made upon receipt and subsequent destruction documented and witnessed. Records of unlicensed "specials" were all complete with the prescriber details.

All staff were able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. They were able to provide examples of how they protect patient confidentiality, for example inviting them into the consulting room when discussing sensitive information. The driver's delivery sheets were arranged in such a way as to avoid potential breaches of confidentiality. People signing for their delivery were not able to see other people's personal details. Completed prescriptions in the prescription retrieval system were out of sight of people waiting at the counter, but they were clearly visible to anyone leaving the consultation room. Confidential waste was kept separate from general waste and shredded onsite. A privacy notice was on display near the prescription reception counter.

There were safeguarding procedures in place and contact details of local referring agencies were seen on display near the entrance to the consultation room. The pharmacist had completed level 2 safeguarding training, and the rest of the team understood the signs to look out for. All staff were dementia friends.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are well-trained and have a satisfactory understanding of their roles and responsibilities. They work well as a team and feel able to make suggestions to improve safety and workflows where appropriate.

Inspector's evidence

There was one medicines counter assistant (MCA), one dispenser and the RP on duty at the beginning of the inspection. This appeared to be appropriate for the workload and everyone was working well together. The RP's shift finished part way through the inspection and responsibility was passed to a second pharmacist who remained on duty until the pharmacy closed. The MCA also finished her shift and another trainee dispensing assistant arrived to start work. In the event of staff shortages the pharmacist could call upon the weekend staff to help where possible.

Training records were seen confirming that all staff had completed the required training. Staff were able to demonstrate an awareness of potential medicines abuse and could identify patients making repeat purchases. They described how they would refer to the pharmacist if necessary. The dispensers and pharmacist were seen to serve customers when the MCA was busy, and all asking appropriate questions when responding to requests or selling medicines. The pharmacist confirmed that she was comfortable with making decisions and did not feel pressurised to compromise her professional judgement. Team members said that they could raise concerns and there was a whistleblowing policy in place. There were targets in place, but they were applied reasonably and did not impact upon the professional judgement of the pharmacist.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy's premises are very modern and provide a safe, secure and professional environment for people to receive its services. But it is using its office as a consultation room since it started renting the original consultation room to another service provider. This means that people can see other people's private information as they enter and leave the consultation room.

Inspector's evidence

The pharmacy premises were very modern, clean, tidy and in a good state of repair with step-free access and wide entrance doors. They were on the ground floor of a large modern health centre building. There was a large dispensary, providing plenty of space to work safely and effectively, and the layout was suitable for the activities undertaken. There was a clear workflow in the dispensary. The dispensary sink had hot and cold running water, and handwash was available. There were lockable shutters to secure the pharmacy from the medical centre when the pharmacy was closed. Staff from the GP practice did not have access to the pharmacy area.

There were two separate consulting rooms with direct access to the sales floor. One of which was rented to a local chiropractor (Wimbledon Chiropractic Clinic) and the other was rented to a separate company (The MediClinic) offering aesthetic services such as botox treatments. The aesthetic clinic had only recently opened and was operated by the pharmacist employed at the pharmacy.

The pharmacy's consultation room was used for confidential conversations, consultations and the provision of pharmacy services. Access to this was through the entrance to the dispensary and at the rear of the area used for prescription retrieval. This access area was also used for storing some bulky creams and also for conducting some wholesaling activity. This consulting room was also used as an office. Patient details on prescriptions awaiting collection were clearly visible to people going through this area, and also on the PMR systems on the front dispensing bench. The door to the consultation room was left open when the room was not in use. There was a sink with hot and cold running water and a password-protected PMR terminal in the room.

The toilet areas were clean and well maintained. Room temperatures were appropriately maintained by a combined heating and air-conditioning unit, keeping staff comfortable and suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, and people with a range of needs can access them. The pharmacy sources, stores and manages medicines safely, and so makes sure that all of the medicines it supplies are fit for purpose. The pharmacy responds well to drug alerts or product recalls to ensure that people only get medicines or devices which are safe. But it doesn't keep adequate records of the checks it makes, and the advice it gives when people are supplied with high-risk medicines. The pharmacy doesn't currently have a hazardous waste bin to dispose of hazardous waste medicines and this may increase the risk to staff and the environment.

Inspector's evidence

A list of pharmacy services was displayed in the shop window but there was very little information on display in the pharmacy itself. The pharmacy provided a limited range of services including seasonal flu vaccinations during the autumn and winter.

Controls were seen to be in place to reduce the risk of picking errors, such as highlighting those medicines considered to be vulnerable to errors. They used colour-coded baskets to keep individual prescriptions separate, and to highlight those waiting for collection and those for delivery. Prescription labels were initialled to show who had dispensed and checked them. Owings tickets were in use when medicines could not be supplied in their entirety. Patients were referred back to their GP or another pharmacy if the pharmacy was unable to obtain their medicine.

Completed prescriptions for schedule 2 CDs were highlighted with a CD sticker so that staff would know that they needed to look for a bag in the CD cupboard. Schedule 3 CDs scripts were highlighted. Schedule 4 CDs were not highlighted so the pharmacist agreed to find ways of reducing the risk that they may be handed out after the prescriptions had expired. The manager explained that they cleared the retrieval shelves every three months and that any expired Schedule 4 CDs still awaiting collection were removed. Fridge lines in retrieval awaiting collection were highlighted so that staff would know that there were items to be collected from the fridge.

Compliance aids were dispensed at the rear of the dispensary, facing away from distractions. There were well-organised folders with separate individual files containing records of each persons' medication, when they were taken, any known allergies, any discharge information from the hospitals and contact details. Changes were recorded in the file and also on the patient's PMR. Medication times were checked, and any discrepancies were followed up before dispensing. The compliance aids were always sealed as soon as she had assembled them ready for the pharmacist to complete the final check. They were placed in a designated checking area before being checked by the pharmacist. Compliance aids were seen to include product descriptions on the backing sheet and patient information leaflets (PILs) were always supplied. There were also a number of compliance aids ready for delivery to individual patients. These were also seen to have product descriptions but didn't all contain PILs. Warfarin, Epilim and alendronic acid were supplied separately.

Staff were aware of the risks involved in dispensing valproates to people who could become pregnant, and all such patients would be counselled and provided with leaflets and cards highlighting the importance of having effective contraception. Patients on warfarin were asked if they knew their

current dosage, and whether their INR levels had been recently checked. These interventions were not recorded and the figures themselves were not routinely asked for. Upon reflection the pharmacist and the dispensers all agreed that they would start asking for this information and recording the intervention on their PMR system. Patients taking methotrexate and lithium were also asked about blood tests. There were yellow warfarin books, lithium record cards and methotrexate record cards available to offer patients who needed them. The Patient Group Direction (PGD) for the seasonal influenza vaccination service expired at the end of the season in March 2019. Records were seen of consent and vaccinations provided, for both the private and the NHS services.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance, Sigma. Unlicensed “specials” were obtained from Quantum. The pharmacy had the scanners necessary to comply with the Falsified Medicines Directive (FMD) but they were waiting for their software to be registered before starting to decommission products.

Routine date checks were seen to be in place, and record sheets were seen to have been completed. Stock with a shelf life of less than three months was highlighted and then disposed of one month prior to expiry. Opened bottles of liquid medicine were annotated with the date of opening, and there were no plain cartons of stock seen on the shelves. No boxes were found to contain mixed batches of tablets or capsules.

Fridge temperatures were recorded daily and all seen to be within the 2 to 8 degrees Celsius range. Staff explained how they would note any variation from this and check the temperature again until it was back within the required range. Pharmacy medicines were displayed behind the medicines counter, preventing unauthorised access or self-selection of those medicines.

Patient-returned medicines were screened to ensure that any CDs were appropriately recorded, and to see whether there were any sharps present. Sharps were only accepted if in a closed sharps bin, otherwise people were signposted to the local council. There was no list of hazardous medicines and no separate purple-lidded hazardous waste container present. Denaturing kits for the safe disposal of CDs were available for use. The pharmacy received drug alerts and recalls from the MHRA, copies of which were seen to be kept in a file. Each alert was annotated with any actions taken, the date and initials of those involved. The team knew what to do if they received damaged or faulty stock and they explained how they would return them to the wholesalers.

The pharmacy manager had just opened an aesthetics clinic offering botox treatments in the former consultation room at the front of the pharmacy. This was discussed with the superintendent pharmacist (SI) who confirmed that the service was not a part of the pharmacy itself and that it had been established as a separate company by their employed pharmacist. The pharmacist confirmed that he had separate professional indemnity insurance to cover this activity.

Principle 5 - Equipment and facilities **Standards not all met**

Summary findings

The pharmacy has the right equipment for the range of services it provides, and it makes sure that it is properly maintained. The pharmacy has not adequately considered the need to keep other people's private information safe when using the facilities in the consultation room.

Inspector's evidence

The pharmacy has the necessary resources required for the services provided, including a range of crown stamped measuring equipment, counting triangles (including a separate one for cytotoxics), reference sources including the BNF and BNF for children. The pharmacy also had internet access and used this as an additional reference source.

The blood pressure meter was replaced every six months and the current one was less than a month old. Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Computer screens are positioned so they are not visible to the public except when accessing the consultation room.

Staff were seen to take precautions such as moving to the rear of the dispensary when making telephone calls so as not to be overheard. NHS smartcards were seen to be used appropriately and with no sharing of passwords. They were not left on the premises overnight. Confidential information was kept secure and items awaiting collection were not visible from retail area

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.