General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Woodlands Pharmacy, Woodlands Health Centre, 4 Edwin Hall Place, LONDON, SE13 6RN

Pharmacy reference: 1119025

Type of pharmacy: Community

Date of inspection: 02/07/2019

Pharmacy context

This is a community pharmacy located in a medical centre. Almost all the people who use the pharmacy are registered with the medical centre. The pharmacy dispenses NHS prescriptions and offers other services such as Medicines Use Reviews (MURs) and a small number of deliveries to people's homes. It dispenses medicines in multi-compartment compliance packs to help some people take their medicines safely. The pharmacy is open 100 hours a week.

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	1.7	Standard not met	The pharmacy doesn't protect people's personal information properly, which could mean that unauthorised people could access it.
2. Staff	Standards not all met	2.2	Standard not met	Team members have not all completed or been registered on the required accredited training courses. This could mean that they do not have the knowledge and skills they need to undertake their tasks safely.
3. Premises	Standards not all 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

The pharmacy generally manages the risks associated with its services adequately. And its team members understand their role in protecting vulnerable people. But the pharmacy doesn't protect people's personal information properly, which could mean that unauthorised people could access it. It could do more to record and review mistakes that happen during the dispensing process to help team members learn from these and make its services safer. It mostly keeps the records it needs to by law, but these are not always kept up to date. So, it could be more difficult for the pharmacy to find out further details if there was a future query.

Inspector's evidence

A system was in place to record near misses, but the most recent records found were from August 2018. The superintendent pharmacist (SI) accepted that they may not all have been recorded, as other people may have made picking errors and not told her. Team members were not able to give an example of a near miss where a change had been made to prevent a recurrence. The SI said that she would discuss this with the team members and ensure that near misses were recorded in the future. She showed how they had separated the different strengths of Phenergan on the shelf as the packs looked similar. This was to help avoid a picking error being made. She said that she was not aware of any recent dispensing errors and said that she would record them on the near miss log if there were any. There was not space to record much additional information on the log, such as a person's name or if their GP had been contacted. She said that she would review this and contact the National Pharmaceutical Association to find out how she could report any errors to them.

There was a member of staff on work experience who was currently working on the medicines counter as well as doing some dispensing tasks. He said that he always checked with the pharmacist before selling any medicines. The dispenser was clear about what he could and couldn't do if the pharmacist had not arrived in the morning.

There was a range of standard operating procedures (SOPs), but some had no implementation or review date. So, it was not always clear when they had come into place or when they were due to be reviewed. The SI had written team member's names on some of them to indicate that they had read them, but the team members themselves had not signed them. Some SOPs had no team member names written on them, including the SOP relating to the advice that could be provided by non-pharmacist staff. The locum pharmacist had not read through the SOPs, but the dispenser said that he had read them. The work experience member of staff had not seen them before. And this could make it harder for him to know what the right procedures were. The SI said that she would go through all the SOPs and ask the team members to read and sign the ones relevant to their roles.

The SI showed a list she had created of medicines that she felt were likely to go out of stock in the near future. She explained how she had been able to order additional stock in, and that this had helped reduce the risk of people going without their medicines.

The pharmacy undertook an annual patient survey and the results from the recent one were on the NHS website. The results were positive, with the pharmacy scoring 90% or higher on the level of satisfaction for each question. There were no signs or leaflets to explain to people using the pharmacy

how they could provide feedback or make a complaint. But the SI said that she was obtaining new practice leaflets which contained this information. There was a complaints procedure, but it did not have an implementation or review date. And there was no written evidence to say that staff were familiar with it.

The responsible pharmacist (RP) notice was initially not displayed, but this was rectified immediately. The RP log had several gaps where it was not clear who the pharmacist had been. The most recent entry in the log was 24 June 2019, which was around a week before the inspection. Some entries just had the first name of the pharmacist and no registration number and several different pharmacists worked at the pharmacy. This could make it harder for the pharmacy to identify which pharmacist had been present if there was a query. The SI said that some locum pharmacists had not been making entries and she would go through the log to ensure it was completed. She said that the previous log had been lost around the middle of September 2018 and she believed that a locum pharmacist had thrown it away by accident. Private prescription records and controlled drug (CD) registers examined complied with requirements. CD running balances were maintained, but for several medicines the last recorded check was in January 2019. The SI said that she would check the balances more regularly in the future. Three CD medicines were checked and the quantity in the register matched the amount in stock. Specials records largely complied with requirements. The pharmacy had a current indemnity insurance certificate.

Team members said that they destroyed confidential waste with a small shredder. But the shredder was broken, and many labels containing people's personal information were found in the general waste bin. Most had been torn up, but the information on them was still retrievable in several cases. The pharmacist took the bin liner out and put it aside to sort through later. The door to the consultation room was not locked and it was propped open. Not all the items inside were kept securely. There was a confidentiality procedure in place, and the SI had written team member's names on it. But the work experience team member had not read it. The SI and pharmacist had individual smartcards to access the NHS electronic systems and the SI removed hers when she left.

The pharmacist confirmed that he had completed level two safeguarding training and could describe what he would do if he had any concerns. The dispenser said that the SI had spoken with him about safeguarding, and what to do if he had any concerns. Team members said that there was a folder containing information about local safeguarding agencies, but they were unable to find it during the inspection. The pharmacist said that he sometimes worked as a locum in the area and had already obtained the contact details for the local agencies.

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

Summary findings

The pharmacy has enough team members to manage its workload. But they have not all completed or been registered on the required accredited training courses. This could mean that they do not have the knowledge and skills they need to undertake their tasks safely. Team members are given some ongoing training, but this is not very structured, and records are not made. This may make it harder for the pharmacy to identify and address any gaps in the team's knowledge or skills.

Inspector's evidence

At the start of the inspection there was the SI, a work experience team member, and a dispenser. The work experience team member had worked at the pharmacy for around a week. The SI explained that the team member was undertaking work experience with a view to employing him in the dispensary. The dispenser had worked at the pharmacy for over three months but had not yet been registered on the required accredited training course. She had to leave and attend to another matter part-way through the inspection. A locum pharmacist came in during the inspection and the SI left around an hour after that. For most of the inspection there were only the locum pharmacist and the work experience team member present. Another dispenser came in at the end of the inspection. He was doing a pharmaceutical sciences degree at university. He had been working as a dispenser for around two years and was registered on an accredited counter assistant's course, but not the dispenser's course.

The pharmacy also employed another dispenser who had worked there for around a year. They were not registered on the required accredited training course. On the previous inspection, the pharmacy also had team members who had not completed or been registered on the required accredited training courses.

The SI said that she had experienced difficulty in recruiting and retaining staff at the pharmacy, and sometimes found it hard to obtain locum pharmacists. The team was managing the workload adequately, and dispensing was up to date. The pharmacy was relatively quiet through most of the inspection but there were some busy periods. The pharmacist and SI felt able to take professional decisions to help protect people's wellbeing.

The team members felt comfortable about raising any concerns. The pharmacist showed how he wrote notes to pass messages on to the SI if she was not present. The SI described how she had provided training for the staff, such as selling over-the-counter medicines and discussing new products that were released. But this ongoing training was not recorded. The dispenser confirmed that the SI had talked with him about over-the-counter medicines, and how she had prepared pamphlets for him to update him on new products when he came back in after university. Team members did not have numerical targets set for them.

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

Summary findings

The premises generally allow the pharmacy to provide its services safely and securely. But the pharmacy could do more to make sure that the room temperature is monitored and kept at a suitable level.

Inspector's evidence

The pharmacy was limited in size but was generally clean and tidy. The dispensary had an open layout, but people's personal information could not be seen in the dispensary from the counter. Some work benches were cluttered with baskets of items being dispensed, but there was still an adequate amount of clear work space available.

The pharmacy did not have air conditioning. The weather outside on the day of inspection was sunny, and around 21 degrees Celsius. The room temperature in the dispensary was measured during the inspection and reached 26.5 degrees Celsius. The SI agreed to monitor the room temperature during the summer months and said that she would take action if it got too high. Handwashing facilities were present in the dispensary and the small nearby toilet area. Cleaning products were available. The premises were secure from unauthorised access when closed.

The consultation room was cluttered and untidy. The door to the room was propped open and bags of dispensed medicines could be seen just inside. People's personal information was potentially visible to people looking inside the room. The room was lockable; the SI did not have a key but said that she would obtain one from the surgery and keep the door locked in future. The room allowed a conversation to take place inside which would not be overheard. The SI said that they rarely needed to use the consultation room, and she said that they cleared away the bags and other items when they needed to.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy largely provides its services safely. And it gets its medicines from reputable sources and generally manages them well to make sure that they are safe for people to use. But it doesn't always highlight prescriptions for higher-risk medicines. So, the team may be missing opportunities to provide additional information to people about how to take their medicines safely.

Inspector's evidence

There was step-free access from outside and also through the surgery. The SI explained how they used clipboards to help people who couldn't reach the counter to sign their prescriptions. She said that she could communicate using sign language and was able to use this to help several people who used the pharmacy. Some other team members were multilingual.

Baskets were used during the dispensing process to help prevent people's medicines becoming mixed up. There was a clear workflow through the dispensary. Two computer terminals were available for team members to use.

People were referred to the pharmacy by the Lewisham Medicines Optimisation Service (LIMOS), and multi-compartment compliance packs were one possible outcome of their initial assessment for people who needed help taking their medicines. The SI explained how LIMOS monitored people receiving additional help to take their medicines, to make sure that the service was effective for them. Other people could be supplied with administration charts to help them take their medicines. Dispensed compliance packs were labelled with a description of the tablets and capsules. This helped people identify their medicines. The packs had an audit trail of who had dispensed and checked them. Patient information leaflets were routinely supplied with the packs.

The SI said that she had provided an MUR previously for a person and advised them how to take their medicines safely. But she explained that she had not had much chance to provide any MURs recently. The pharmacist was aware of the additional guidance about pregnancy prevention to be provided to people in the at-risk group who were taking valproate. But the team members present at the time (pharmacist and work experience team member) were unable to find any of the additional literature such as cards or leaflets. A bag of dispensed medicines was found in the consultation room, and this contained valproate for a person in the at-risk group. The prescription for the medicines could not be located. The pharmacist checked on the person's electronic record, and no indication was found on there that the person had been appropriately counselled about the Pregnancy Prevention Programme (PPP). The pharmacist was a locum who did not often work at the pharmacy and did not know if the person had been counselled about the additional precautions they needed to take. Following the inspection, the SI confirmed that she had talked with the person about the PPP on several occasions. She said that the computer flagged up other higher-risk medicines when dispensing, and that she had spoken with team members about which medicines these were. But the prescriptions or dispensed medicines were not routinely highlighted. This could make it harder for the team member handing out the medicine to know that the person would benefit from additional counselling from the pharmacist.

The pharmacy rarely delivered medicines to people's homes, and the SI said that the pharmacy usually

only delivered to around one or two people a month. An audit trail was kept for this, with recipients signing separate pages to show the medicines had been delivered safely.

Copies of prescriptions and original prescriptions for dispensed items were kept in a retrieval system in a small box. The documents had been sorted into alphabetical surname order, but the box was crowded and messy. Some of the copies only included some of the information on the original prescription. They appeared to have been copied on a fax machine, and they were of different widths. Several copies seen were very narrow, and the original prescription date or the full name of the person was missing. One copy of a prescription was for gabapentin and was dated 29 January 2019. The dispensed medicine it related to could not be found, and the prescription was not highlighted to alert team members that it had a shorter validity date. The pharmacist and work experience team member did not fully know how the retrieval system worked. And said that in practice they did not usually check the copy of the prescription when handing out a dispensed medicine. This could increase the chance that a medicine was handed out when the prescription was no longer valid. Following the inspection, the SI said that she had gone through the box a few days later and removed all the prescriptions for items that had been collected. She said that she had discussed with the team members the importance of finding the prescription or copy and removing it from the box when people collected dispensed items.

Medicines were obtained from licenced wholesale dealers or specials suppliers. The medicines were kept in a tidy and organised way. The SI showed how they had separated different strengths of the same medicine where the packaging was similar. Some medicines such as eye drops were stored in drawers in the dispensary. The drawers were not labelled, and the pharmacist was observed having to go through several to find an item. Team members said that they did regular date checking, but the most recent records for this found were from August 2018. One date-expired medicine was found amongst stock. The SI said that they would ensure that they regularly date-checked the stock and would record this clearly in the future.

CDs requiring safe custody were stored securely. Medicines requiring cold storage were stored in a suitable fridge and the current temperatures were within the appropriate range. The temperatures were recorded on the computer, but although the records were relatively frequent in January 2019 there were only four entries since the start of February 2019. The pharmacist said that he would discuss this with the SI and ensure that the temperatures were monitored and recorded daily.

The pharmacy had not got the equipment and systems in place to comply with the Falsified Medicines Directive (FMD). The SI said that she would investigate the options and would ask the NPA for advice. She initially believed that the FMD systems were just to be implemented as guidance, and the inspector reminded her of the legal requirements.

The pharmacist and the work experience team member did not know how the pharmacy received drug alerts and recalls, or how they dealt with them. They were not aware of any of the recent recalls. Following the inspection, the SI said that she received alerts and recalls via email from their suppliers and these were kept in a file in the pharmacy. She explained the action they took in response and said she had recently dealt with a recall for a type of insulin. She said that she would sign up to the MHRA email alert system to ensure that all the safety alerts were received.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

A range of calibrated glass measures was available for measuring liquids. The SI said that she had taken the blood pressure machine home to practice with it and had only started using it for services in the last few months. She said that she would record when the meter was first used, so that she knew when to replace or recalibrate it. She was intending to offer a service which included body mass index measurements, but this had not yet started.

Empty bottles were capped to prevent contamination. Up-to-date reference sources were available online. The fax machine was in the dispensary and away from people using the pharmacy, but the pharmacist said that they did not generally receive any faxes. The cordless phone could be moved somewhere more private to help protect people's personal information. This was important due to the open layout of the dispensary.

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.