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: 19/02/2020

Pharmacy context

This is a community pharmacy based in a large doctor's surgery. It is open 100 hours a week. It mainly dispenses NHS prescriptions, and offers some additional services such as Medicines Use Reviews and the New Medicine Service. It supplies medications in multi-compartment compliance packs to some people in their own homes to help them manage their medicines. And it offers a text messaging service to inform people when their medicines are ready.

Overall inspection outcome

✔ **Standards 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 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

Overall, the pharmacy adequately manages the risks associated with its services. When a mistake happens, the team responds well. The pharmacy largely keeps the records it needs to by law to show that medicines are supplied safely and legally. And it adequately protects people's personal information. Team members know how to protect vulnerable people. People using the pharmacy can provide feedback and raise concerns. But the pharmacy could do more to inform people of how they would do this.

Inspector's evidence

Dispensing mistakes that happened and were identified before the medicine was handed out, referred to as near misses, were recorded in a book in the dispensary. The superintendent pharmacist (SI) explained how she discussed any that occurred with the team members. She said that she reviewed the near misses periodically and discussed the results in the team, but the reviews were not documented. A near miss had occurred where the wrong strength of methotrexate had been selected, and the SI said that she had since talked through the different strengths and colours of tablets with the staff. The pharmacy only had one box of each strength in stock at the time of the inspection. The SI was not aware of any recent dispensing errors where the medicine had reached the person. She initially said that she would record an error on the near miss log. When it was highlighted that the log did not provide much space to record all the relevant details, she showed that the pharmacy had an error log template in the standard operating procedures (SOPs). And said that she would use that in future. The SI was the regular pharmacist and usually dispensed and checked medicines herself. She described taking a mental break between the two processes.

A range of up-to-date SOPs was available. Most of the SOPs seen had staff names to indicate that they had read and understood them, but some had no names on them. This included SOPs around controlled drugs (CDs), including dispensing CD prescriptions. The SI said that she would go through these SOPs with the staff and explained that she wrote the team member's name on the SOPs when she had explained the SOP to them. A roles and responsibilities matrix had been filled in in the SOPs. The SI was the only member of the team working for most of the inspection, and she said that she had been through with staff what they could and couldn't do if she was absent from the premises.

The SI said that the pharmacy did an annual patient survey but was unable to locate the results from the previous one. The results were also not found on the NHS website. There was a complaints procedure in the SOPs, but team members' names were not on it and it did not have a clear implementation date. The SI said that she would go through the procedure with the team so that they understood it. No information such as signs or leaflets was found in the public area, which could make it harder for people how to make a complaint or provide feedback.

The SI was unable to locate the indemnity insurance certificate during the inspection. Following the inspection, the inspector contacted the pharmacy's indemnity insurer who confirmed that the pharmacy had current cover. Private prescription records and emergency supply records seen contained the required information. The responsible pharmacist (RP) notice was partially obscured, and this was discussed with the SI during the inspection. The RP records seen had been filled in correctly. Records for unlicensed medicine supplies largely complied with requirements. CD registers examined

generally complied with requirements, but in one place a sticker had been used to record a CD running balance check. This could make it harder for the pharmacy to show that the record had not been altered, and the SI said that she would not use stickers in the future. A random check of a CD running balance matched the amount of physical stock present.

Other people's personal information was not visible to people using the pharmacy. A shredder was used to destroy confidential information. The consultation room had some items inside, but the SI said that it was locked when not in use. The SI had not done any training on the General Data Protection Regulation but said that she would look into it. There was a confidentiality procedure in the SOP and the SI said that she had been through it with the team members. She confirmed that she had completed the level 2 safeguarding course and could describe what she would do if she had any concerns. She said that she could obtain details of local safeguarding agencies online. She described how she had talked with other team members about safeguarding and examples of signs to look out for.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just enough staff to provide its services. They receive some ongoing training to help keep their knowledge and skills up to date. And they can raise concerns. Team members can take professional decisions to help keep people safe. But the pharmacy could do more to make sure that team members are registered on relevant training courses in a timely manner.

Inspector's evidence

At the start of the inspection there was the SI and one part-time medicines counter assistant (MCA) trainee. The MCA trainee was undertaking an accredited counter assistant course. The pharmacy did not employ any other staff, except for a regular locum pharmacist. The MCA was observed using the dispensary computer at the start of the inspection. She finished work soon after the inspection started, which left the SI as the sole team member. The SI said that the MCA trainee had been working in the dispensary for around two weeks and said that she gave her experience in the dispensary periodically to help increase her knowledge, and always supervised her when she was dispensing. From the records in the near miss log, the MCA trainee had started working in the dispensary from at least 14 November 2019, and there were one or two near miss records dated before that in around July 2019. The MCA trainee was not registered on an accredited dispenser course. It had been highlighted on two previous inspections that staff had not been registered on the appropriate accredited training for their role. The SI said that the MCA trainee also helped put stock away in the dispensary, and it was not clear that she had done the appropriate training modules so that she knew how to do this safely. Following the inspection, the SI provided evidence that the MCA trainee had been registered on an accredited dispenser course.

Dispensing was relatively up to date. There were baskets containing part-dispensed prescriptions on parts of the workbench, but the SI explained that she was waiting for the remaining stock to arrive in.

The SI said that there had been problems in recruiting and retaining staff members. She felt able to take any professional decisions and was observed counselling people on how to use their medicines. There was a whistleblowing policy in the SOPs, and team member’s names had been written on it. The SI was the regular pharmacist and was easily contactable. She explained how she informed staff about any new products that came out or any issues that arose. Staff did not have any numerical targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are largely suitable for its services, and they can be kept secure from unauthorised access. People can have a conversation with a team member in a private area. But the pharmacy could do more to keep some areas tidier and free from clutter.

Inspector's evidence

The pharmacy was relatively small, and there was limited storage space. It had an open design, with the counter in front of an oblong-shaped room which was used as the dispensary. A barrier was used to help restrict access to the dispensary. The pharmacy was clean, but there were some areas which were cluttered. Most of the worksurfaces in the dispensary had items on them such as baskets or stock, but these items were generally kept in an organised manner. There was an adequate although relatively small space for dispensing. There was metal flooring throughout and lighting was good. Some boxes of stock were on the floor in the dispensary, and the SI explained that she was going to put them away that evening to clear the floor. She said that she had had to order additional stock in due to the difficultly in sourcing certain products. There was space available to store these boxes on the top of the dispensary storage units.

The consultation room was a little untidy. The SI said that the room was kept locked when not in use as there were some items inside. The room was seen to be in use for most of the inspection. And it allowed a conversation to take place inside which would not be overheard. The premises could be secured from unauthorised access, and there was an internal door into the surgery, as well as an external door. The room temperature on the day of inspection was suitable for the storage of medicines. Staff had access to handwashing facilities.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. It gets its stock from reputable sources and generally stores it properly. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services. It dispenses medicines into compliance packs safely. But it doesn't always highlight prescriptions for higher-risk medicines. And this could mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

The pharmacy had step-free access from outside and through the surgery. And there was an adequate amount of space to help people with wheelchairs or pushchairs manoeuvre. The pharmacy was open extended hours and stayed open later than the surgery. The pharmacy offered a text messaging service to remind people to collect their medicines. The SI explained that the surgery offered additional services such as blood pressure and glucose monitoring.

Dispensed multi-compartment compliance packs were labelled with a description of the medicines inside to help people and their carers identify them. Patient information leaflets were routinely supplied. The packs were initialled to show who had dispensed and checked them. The SI showed how she recorded changes to people's medicines or communication with the prescriber on the person's electronic record. People were assessed to see if the packs were suitable for them by the local medicines optimisation service (LIMOS). LIMOS also undertook some degree of ongoing monitoring to see how people were managing their medicines.

The pharmacy offered a delivery service to a few people in their own homes. Only a small number of people had their medicines delivered, and signatures were obtained from recipients on individual pages to indicate safe delivery.

No dispensed higher-risk medicines, such as warfarin or methotrexate, were found on the shelves. The SI said that she did not usually highlight prescriptions for higher-risk medicines but said she did use stickers if she wanted to convey any messages on handout. She showed a prescription for an injection which had been highlighted as she wanted to speak with the person about how to use it. She said that she routinely highlighted prescriptions for CDs, but no dispensed CD prescriptions were found on the shelves. Prescriptions were not usually kept with dispensed items, which could make it harder for team members to answer queries about them on handout. The SI said that most of the prescriptions were electronic and she could access these on the pharmacy's computer if there was a query. She was aware of the guidance around pregnancy prevention to be given to some people taking valproate and said she had counselled one person who had been in the at-risk group. Most of the packs of valproate seen had warning cards already attached, and the pharmacy had the associated information leaflets. The SI could not find the stickers for use with split packs of valproate and said she would order more in if necessary.

Medicines were ordered from licensed wholesale dealers and specials suppliers, and they were largely stored in an organised manner in the dispensary. No part-dispensed bulk medicine bottles were found. Date-checking of stock was done regularly, although the records the SI showed just indicated 'cleaning'. She explained that the date-checking was done at the same time and she would make the records

clearer. No date-expired medicines were found on the shelves sampled. Medicines for destruction were separated from stock into designated bins. But some unsealed bins were stored in the toilet area, which could make them less secure from unauthorised access. People using the pharmacy did not use the toilet, and there was available one in the surgery. The SI was aware of the Falsified Medicines Directive and said she had done some investigation into the equipment the pharmacy needed to get. She said that she was looking at what type of equipment to obtain and thought she would obtain it in the next month or two.

CDs were stored securely. Medicines requiring cold storage were stored in a medical fridge. The minimum and maximum temperatures had been recorded, but this had not been done every day. The most recent record found was from 16 February 2020 and the one before that from 13 February 2020. The temperature records seen were within the appropriate range. However, the current maximum temperature on the inbuilt fridge thermometer was 17.5 degrees Celsius. There was also a separate thermometer inside, and this showed a maximum of 18 degrees Celsius. It was unclear if the temperature range was being reset daily, as the SI said that the technician who installed the fridge had not explained how to reset it. The fridge was reset during the inspection and for the rest of the visit the current temperature was well within the appropriate range. The SI said that the fridge door may have been left accidentally open at some point recently.

The pharmacy received drug alerts and recalls from its wholesalers, and the SI described what she had done in response to a recent one involving ranitidine. She said that she kept a record of alerts and recalls in a file but was unable to find it. During the inspection, she signed up to the MHRA email alert service.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. It uses its equipment to help protect people's personal information.

Inspector's evidence

A range of calibrated glass measures was available for use with liquids. Staff had access to up-to-date reference sources and the internet. Tablet counting triangles were clean, and a separate one was used for cytotoxic medicines to help avoid cross-contamination. The phone was cordless and could be moved to some extent to a more private area to help protect people's personal information. During the inspection, there were usually only one or two people in the pharmacy at a time. The SI had installed a room divider in the dispensary to allow for increased confidentiality and to allow her to concentrate on tasks.

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.