General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Salus Pharmacy, 40 Liberty Bridge Road, East Village, Olympic Park, LONDON, E20 1AS

Pharmacy reference: 1122706

Type of pharmacy: Community

Date of inspection: 17/03/2023

Pharmacy context

This is a community pharmacy inside a health centre in the East Village area of Stratford, London. The pharmacy dispenses NHS and private prescriptions. It offers local deliveries, the New Medicine Service (NMS), travel and yellow fever vaccinations. The pharmacy also provides some people's medicines inside multi-compartment compliance packs if they find it difficult to manage their medicines at home.

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

The pharmacy identifies and manages the risks associated with its services in a satisfactory way. Members of the pharmacy team monitor the safety of their services by recording their mistakes and learning from them. They understand their role in protecting the welfare of vulnerable people. The pharmacy largely keeps the records it needs to by law. But the team could do more to protect people's private information appropriately.

Inspector's evidence

The pharmacy had a range of documented standard operating procedures (SOPs) to provide its team with guidance on how to complete tasks appropriately. There was evidence that some staff had read and signed them in 2021, but this was observed to be work in progress for newer members of the team. Team members were clear on their roles and responsibility, and members of the pharmacy team knew what their tasks involved. The team knew which activities could take place in the absence of the responsible pharmacist (RP). New staff were still learning about this but were appropriately supervised. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

The pharmacy had systems in place to identify and manage risks associated with its services. Team members described paying attention when dispensing and during the accuracy checking process. They concentrated on one task at a time, minimised conversations to prevent distractions and worked in designated areas. Staff routinely recorded errors that occurred during the dispensing process (near miss mistakes). The details were collated and regularly reviewed by the regular pharmacist which helped identify any trends or patterns. The findings were subsequently discussed with the team to raise awareness. Staff in training explained that the regular pharmacist also held individual coaching sessions with them if more mistakes than usual were seen. Look-alike and sound-alike medicines were separated, and a common theme previously identified was incorrect selection of creams. This was because they had been stored in a disorganised way. The team explained that subsequently tidying this section of stock and placing them in an alphabetical arrangement had assisted in reducing the number of errors now made here. The RP described handling dispensing incidents which reached people and complaints in a suitable way, the relevant details were recorded and investigated appropriately.

Once prescriptions had been assembled, pharmacists usually, but on occasion, the accuracy checking technician (ACT) carried out the final accuracy-check. The ACT was not involved in any other dispensing process other than the final check. The regular pharmacist was said to clinically check the prescription first before it was assembled by other staff. Although the ACT was verbally informed when this process had taken place, there was no method being used to help easily identify that this stage had been completed.

The RP had been trained to level three to safeguard the welfare of vulnerable people through the Centre for Pharmacy Postgraduate Education (CPPE). Members of the team could recognise signs of concern; they had been trained appropriately. The pharmacy had contact details available for the local safeguarding agencies so they could refer suitably in the event of a concern.

The pharmacy had processes in place to ensure people's confidential information was protected but some areas for improvement were identified. This related to the consultation room (see Principle 3)

and NHS smart cards (see below). Staff described ensuring that no confidential material was left on the front counter. Bagged items waiting collection could not be viewed by people using the pharmacy and the team separated confidential waste from normal waste before this was disposed of securely via an authorised carrier. The pharmacy's computer systems were password protected. However, only a few members of the team held their own NHS smart cards to access electronic prescriptions. They were seen to be in use when these members of staff were not initially present at the pharmacy and had their passwords written onto the back of the smart cards. This meant that team members knew each other's passwords. This limited the pharmacy's ability to control access to people's private information.

The pharmacy had current professional indemnity and public liability insurance. A sample of registers seen for controlled drugs (CDs) and records of supplies of unlicensed medicines had been maintained in accordance with legal requirements. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of CDs that had been returned by people and destroyed at the pharmacy had been maintained. The RP record was mostly complete, but some details of when the pharmacist's responsibility had ceased were missing. Within the electronic register for supplies made against private prescriptions, some details of the prescribers were missing or were seen to be incomplete. This could make it harder for the pharmacy to find these details in the event of a future query. Unclear abbreviations were also often used to record the nature of the emergency when a supply of a prescription-only medicine was made, in an emergency without a prescription. This could make it harder for the pharmacy to justify the supplies made. This was discussed at the time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload appropriately. The pharmacy provides its services using a team with different levels of experience. And the pharmacy's team members are supported in their roles. But they are not provided with many resources to complete ongoing training. This could affect how well their skills and knowledge are kept up to date.

Inspector's evidence

During the inspection, the pharmacy team consisted of a locum pharmacist, a pre-registration trainee pharmacist, an ACT, two trainee dispensing assistants and a medicines counter assistant (MCA). The latter was relatively new. The pharmacy had enough staff to support the workload and the team was up to date with this. Team members were observed to work well together, they described being supported by the regular pharmacist and said that they liked working at the pharmacy. The MCA asked relevant questions before selling medicines and had some awareness of medicines which could be abused. Staff knew when to refer to the pharmacist appropriately.

As they were a small team, meetings and discussions took place regularly. Staff performance was managed by the regular pharmacist and was said to be an informal process. Some members of the team were enrolled onto appropriate accredited training in line with their role(s). Training for this was completed at the pharmacy and at home. The ACT used resources such as CPPE to keep his knowledge current. Other members of the team described updates and in-house training being delivered by the regular pharmacist. But they were not provided with any training materials for ongoing training. The trainee pharmacist was on a four-week cross placement transfer and was in her final days at the pharmacy. She confirmed that she was given regular study time and that she had a training plan in place, but this was not available to view during the inspection.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment to deliver services from. The pharmacy is professionally presented and secure. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy’s premises were presented professionally. The pharmacy was clean overall and tidy with modern fixtures and fittings. The retail area was spacious. The lighting and ambient temperature within the pharmacy was appropriate for storing medicines and safe working. The premises were also secure from unauthorised access. The dispensary was open plan, it had enough space for staff to carry out dispensing tasks safely and dispensing benches were kept clear of clutter. There was a clean sink in the dispensary for preparing medicines which had hot and cold running water. However, the WC for staff required cleaning. The pharmacy had two separate consultation rooms in the shop area which were used to hold private conversations and provide services. The rooms were of an appropriate size and accessible for people using wheelchairs. Conversations at a normal level of volume could take place inside without being overheard. But they were unlocked when not in use and unauthorised access to confidential information was possible from one room. The door to this room was closed when highlighted. CCTV covered this area and team members were always in the vicinity to help monitor this situation. Keeping this locked was advised.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is open for extended hours and some people with different needs can easily access the pharmacy's services. The pharmacy largely provides its services safely. It obtains its medicines from reputable sources, and it generally stores as well as manages them appropriately. But the pharmacy's team members are not always identifying people who receive higher-risk medicines or making the relevant checks. This makes it difficult for them to show that people are provided with appropriate advice when these medicines are supplied.

Inspector's evidence

The pharmacy was open from 8am to 8pm Monday to Friday, and from 8am to 2pm on the weekends. Details about the pharmacy's services as well as its opening times were clearly advertised, and the pharmacy had some leaflets on display to provide information about various health matters. People could enter the pharmacy from two entrances, one of which was from inside the health centre and the other was from the street. The latter had powered doors and was step-free. The pharmacy's retail area consisted of clear, open space which further assisted people with restricted mobility or using wheelchairs to easily enter and access the pharmacy's services. Team members were multilingual. This assisted people whose first language was not English. Staff described making reasonable adjustments for some people with different needs if this was required. This included providing people with written details or communicating verbally to people who were visually impaired.

The workflow in the dispensary involved staff preparing each individual prescription in designated areas, people waiting for their prescriptions took priority and medicines were checked for accuracy by the RP from another section. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer. Once staff generated the dispensing labels, there was a facility on them to help identify who had been involved in the dispensing process. Team members routinely used these as an audit trail.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Most of the pharmacy's medicines were stored within an automated dispensing system (robot). Medicines with bar codes were scanned into the robot's software system, this ensured the robot stored details about batch numbers and expiry dates. Stock reports could subsequently then be produced to assist the team to monitor expiry dates and the staff checked medicines for expiry regularly. Short-dated medicines were identified. There were no date-expired medicines seen. CDs were stored securely and medicines requiring refrigeration were stored in a suitable way. Fridge temperatures were checked daily. Records verifying this and that the temperature had remained within the required range had been appropriately completed. Medicines returned for disposal, were accepted by staff, and stored within designated containers. However, the designated containers were stored within the staff toilet which could make it easier for medicines to be diverted. People who brought sharps back for disposal were redirected accordingly. Drug alerts were received electronically via email. Staff explained the action the pharmacy took in response and relevant records were kept verifying this.

Dispensing staff were aware of the additional guidance when supplying sodium valproate and the associated Pregnancy Prevention Programme (PPP). The pharmacy had identified people at risk, who had been supplied this medicine and educational material was available to provide upon supply of this

medicine. However, people prescribed other higher-risk medicines or medicines that required ongoing monitoring were not routinely identified. The team did not ask relevant questions or details about their treatment nor was this information regularly recorded.

Services such as vaccinations and the NMS were said to be offered by the regular pharmacist who was not present during the inspection. The pharmacy was registered with the National Travel Health Network and Centre (NaTHNaC) to offer yellow fever vaccinations, People's medicines were delivered to them, and the team kept specific records about this service. This helped verify and trace who had received their medicines in this way. CDs and fridge lines were highlighted. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended.

The pharmacy provided people who lived in their own homes with their medicines inside compliance packs. This was in conjunction with the person's GP and once a need for this had been identified. Staff prepared compliance packs in a separate location and maintained individual records for people who received their medicines in this way. Any queries were checked with the prescriber and the records were updated accordingly. All medicines were removed from their packaging before being placed inside the compliance packs. The packs were not left unsealed overnight. However, descriptions of the medicines inside the packs were not always provided and patient information leaflets (PILs) were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate range of equipment and facilities it needs to provide its services safely. Its team members keep the equipment clean and use it in a way which helps keep people's private information safe.

Inspector's evidence

The pharmacy's equipment included a robot which was serviced annually, current reference sources, standardised conical measures for liquid medicines, an appropriately operating pharmacy fridge and a legally compliant CD cabinet. Triangle tablet counters were available including a separate one marked for cytotoxic use only. This helped avoid any cross-contamination. The pharmacy's equipment was very clean. Computer terminals were password protected and their screens faced away from people using the pharmacy. This helped prevent unauthorised access. The pharmacy also had portable telephones which meant that conversations could take place in private if required.

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.