General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Nelson Pharmacy, Nelson Local Care Centre, 220 Kingston Road, Wimbledon Chase, SW20 8DA

Pharmacy reference: 9010330

Type of pharmacy: Community

Date of inspection: 21/10/2019

Pharmacy context

This Healthy Living Pharmacy (HLP) is attached to a busy health centre located just off the main road between Raynes Park and Merton. 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, a travel health service and home deliveries for those who cannot get to the pharmacy themselves. It supplies some medicines in multicompartment compliance aids for those who may have difficulty managing their medicines.

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	1.2	Good practice	records of errors and near misses are regularly reviewed and records are kept showing what has been learnt and what has been done. There are also arrangements in place to make sure that learning is shared with the whole team.
2. Staff	Standards met	2.2	Good practice	New employees have a structured induction programme to prepare them for work in the pharmacy. They are also fully supported by more experienced members of the team.
3. Premises	Standards met	3.1	Good practice	The premises are of a notably high standard and bespoke design.
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 provides its services in a safe and effective manner. Its team members log the mistakes they make, and regularly review them together, so that they can learn from them and act to avoid problems being repeated. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They work to professional standards and identify and manage risks appropriately. They understand their role in protecting vulnerable people, and they keep people's private information safe. The pharmacy keeps most of the records it needs to, and it has appropriate insurance to protect people if things go wrong.

Inspector's evidence

There were standard operating procedures (SOPs) in place to underpin all professional standards. The SOPs were maintained online, although there were also hard copies for those members of staff who preferred to read them on paper. There were signature sheets in the front of each individual's staff folder to indicate that they had read and understood them. They had all been signed since February 2019 when the current owners acquired the pharmacy. 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. This was located on the wall of the dispensing robot at the rear of the dispensary, and easily accessible to all members of staff.

Errors and near misses were recorded using a paper form, showing what the error was, the members of staff involved, and the action taken. The forms were kept on a clipboard by the main labelling computer for easy access by all staff. The possible causes were recorded and there was evidence of reflection and learning. The pharmacist then collated the near misses and errors to produce the monthly patient safety report, which was filed by month in the clinical governance records folder. He explained that they held frequent staff meetings to ensure that all staff were involved, to discuss the previous months near misses and errors. Trends were identified and learnings noted. 'Look alike sound alike' (LASAs) medicines were discussed, but the pharmacist explained that the dispensing robot recognised the barcodes of each product which significantly reduced the risk of errors. He demonstrated how the robot automatically selected the correct item once the prescription had been processed. He pointed out that the robot also put the stock away when new deliveries arrived, which removed the possibility of human error at this stage of the process.

Roles and responsibilities of staff were not explicitly documented in one place, but each individual SOP referred to those who had the delegated authority to carry out specific tasks. The RP explained how each member of staff had a designated area to look after, including cleaning and date checking. 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 with only a couple of entries in the previous three months where the

time hadn’t been noted when RP’s responsibilities had ceased.

Results of the latest Community Pharmacy Patient Questionnaire (CPPQ) were displayed online at www.nhs.uk. The results were positive overall and areas for improvement included a need for more seating and for shorter waiting times. As a result of this feedback the pharmacy had highlighted the availability of additional seating in the consultation rooms. It had also tried to manage people’s expectations regarding waiting times by highlighting the dispensing robot which was more efficient and quicker, but also explaining that larger prescriptions will take a little longer. The pharmacy complaints procedure was set out in the SOP file and in the pharmacy practice booklet for people to take away.

A certificate of professional indemnity and public liability insurance from the National Pharmacy Association (NPA) valid until 31 July 2020 was on display in the dispensary. Private prescription records were maintained on the patient medication record (PMR) system and were mostly complete with all details correctly recorded. However, there were several entries where the prescriber had either been incorrectly entered or the details were incomplete. Dates of prescribing and of dispensing were all correctly recorded. The emergency supply records were completed on the PMR system with valid reasons recorded.

The electronic CD register was seen to be correctly maintained, with all running balances checked at regular weekly intervals. The RP demonstrated how the register worked and that it was integrated with their PMR software. He explained how he had trained all of his staff, and their regular locum pharmacists, to ensure that they selected the correct brand if there was a choice. This ensured that the entries were made in the correct sections of the register. Amendments were clearly documented showing details of the amendment and of the pharmacist making them. Running balances of two randomly selected CDs were checked and both found to be correct. The RP explained how he kept all CD prescriptions and invoices together by the CD cabinet until after he had completed a balance check, so that it would be easier to investigate and correct any discrepancies. Records of CDs returned by patients were seen to be registered upon receipt and subsequent destruction documented, although there were 7 entries made on the same day with no witness signature. The witness remembered the destruction and signed them as soon as it was pointed out, and upon reflection acknowledged that these records must be signed at the time of destruction. Records of unlicensed ‘specials’ were all complete with required patient and prescriber details.

All staff were able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. They had all signed confidentiality agreements and were able to provide examples of how they protect patient confidentiality, for example inviting them into the consulting room when discussing sensitive information. Completed prescriptions in the prescription retrieval system were arranged so that people waiting at the counter couldn’t read details. Confidential waste was kept separate from general waste and shredded onsite. There was a privacy notice on display for people to read.

There were safeguarding procedures in place and contact details of local referring agencies were seen on the noticeboard for all staff to access, and in the clinical governance records folder. The RP and second pharmacist had both completed level 2 safeguarding training, and most of the team had been trained so that they could recognise potential safeguarding risks. All staff were dementia friends.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely, and they work well together as a team. Pharmacy team members are well-trained and support those who have recently joined the team. They have a good understanding of their roles and responsibilities and can make suggestions to improve safety and workflows where appropriate.

Inspector's evidence

There were two medicines counter assistants (MCA), one dispensing assistant, one pre-registration pharmacy graduate (Pre-Reg), the RP and a second pharmacist on duty during the inspection. This appeared to be appropriate for the workload and everyone was working well together. In the event of staff shortages, part-time staff could adjust their working hours to provide additional cover, and the pharmacy could call upon other local branches of the company for help.

Training records were seen confirming that all staff had completed the required training, and there were some certificates to be seen in individual staff folders. One of the dispensing assistants was newly employed and his folder contained evidence of progress through the company's induction programme. 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.

All staff were seen to serve customers when the MCA was busy, and all asking appropriate questions when responding to requests or selling medicines. There was no pressure to achieve specific targets. They appeared to have open discussions about all aspects of the pharmacy, and team members were involved in discussions about their mistakes and learning from them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a very modern and professional environment for people to receive its services. The pharmacy keeps its premises clean and well maintained. Team members make regular use of their private consultation room for some of the pharmacy's services and for sensitive conversations

Inspector's evidence

The pharmacy premises were very modern looking, clean, tidy and in a good state of repair with step-free access via a single automatic door to the street, and automatic double doors from the GP surgery next door. The pharmacy was very open with plenty of space for people with wheelchairs. The dispensary was large and well laid out with two PMR workstations in the front section, and two more in the area behind the dispensing robot, which separated the two areas. There was 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 available.

There were two consultation rooms available for confidential conversations, consultations and the provision of services. The doors to the consultation rooms were kept secure with digital combination locks when not in use. There were closed cupboards for paperwork and no confidential information was visible. There was a password-protected PMR terminal in the first consultation room but the second room was mainly used for storage.

Staff have access to toilet facilities in the surgery and were seen to be clean and well maintained. Room temperatures were appropriately maintained by a combined air-conditioning and heating 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. It responds well to drug alerts or product recalls so that people only get medicines or devices which are safe. Team members identify people supplied with high-risk medicines so that they can be given extra information they may need to take their medicines safely. But they don't always record all of those checks, which may make it harder for them to show what they have done if a query should arise in future.

Inspector's evidence

A list of pharmacy services was displayed on the doors leading in from the medical centre. The pharmacy provided a range of services including seasonal flu vaccinations during the autumn and winter, and a travel health service.

Controls were seen to be in place to reduce the risk of picking errors, such as the use of baskets to keep individual prescriptions separate. The baskets were colour coded to prioritise those for people waiting over those calling back later. Prescription labels were initialled to show who had dispensed and checked them. Owings tickets were used and the prescription was kept in the owings box until the stock arrived. In the event of being unable to obtain any items, they used a Watsapp group to see if the stock was available in any of their other branches. If they couldn't obtain the stock the RP contacted the GP to suggest an alternative.

There were valid patient group directions (PGDs) in place to enable the pharmacist to supply a number of prescription-only medicines as part of the travel health service. The PGDs were all held electronically using the SONAR online platform. The signature pages had all been printed off, signed and filed in the private PGD folder, together with certificates of competence and other evidence of appropriate training. These included malaria prophylaxis PGD valid until November 2020, combined hepatitis A and Hepatitis B vaccine, meningococcal ACW135Y vaccine, typhoid, cholera and Japanese encephalitis PGDs all valid until January 2021. Patient consent forms and other paperwork relating to supplies covered by the PGDs were seen and were stored in a PGD file. There were two adrenaline autopen injectors kept in the consultation room for use in emergencies.

Completed prescriptions for CDs were highlighted with a CD sticker or annotated by hand so that staff would know that they needed to look for a bag in the CD cupboard. Schedule 3 CDs were also highlighted, but Schedule 4 CDs such as zopiclone or diazepam were not routinely highlighted. The RP explained that everyone was aware of the 28-day expiry for CD prescriptions, but upon reflection accepted that it would be better to include the expiry date when highlighting all CDs. The RP explained that the retrieval shelves were cleared every 28 days, and that any prescriptions from the previous month were removed and stored separately for a further two weeks. They would attempt to contact the patients by text or phone to remind them that they had a prescription awaiting collection. Any left uncollected after six weeks would be returned to stock and the tokens amended accordingly. The Fridge lines in retrieval awaiting collection were also stickered so that staff would know that there were items to be collected from the fridge.

Compliance aids were dispensed offsite at another branch within the company. The pharmacy used a calendar with each week of the four-week cycle lettered A to D in order to ensure that prescriptions were ordered at the appropriate time. They also kept a folder for each week of the cycle, containing each individual patient's details, any known allergies and hospital discharge summaries together with details of their medication times. Changes were recorded on the individual PMR. Medication times were checked, and any discrepancies were followed up before labelling. A backing sheet containing the dosage instructions for each item in the compliance aid was sent to the assembly hub, together with a copy of the MAR chart. The compliance aids were assembled by machine at the hub and then returned to the pharmacy, where any additional items were added before being placed in retrieval awaiting either collection of delivery. Compliance aids were seen to include product descriptions and photos of the medicines on the backing sheet but patient information leaflets (PILs) were not always supplied. There were a number of compliance aids ready for supply to individual patients which were also seen to have product descriptions but no PILs. Upon reflection the RP agreed to contact the assembly hub to ensure that the PILs were included in future. Warfarin and alendronic acid were supplied separately.

Staff were aware of the risks involved in dispensing valproates to women in the at-risk group, and all such patients were counselled regarding the importance of having effective contraception. Records of the initial intervention were kept on their PMR but not subsequent interventions. Upon reflection, the RP agreed that they would do so in future. Patients on warfarin were asked if they knew their current dosage, and whether their INR levels had been recently checked. These interventions and the INR results were recorded on the PMR. Patients taking methotrexate and lithium were also asked about blood tests, but these interventions were not recorded. Upon reflection, the RP agreed to start recording them in future. There were steroid cards, lithium record cards and methotrexate record cards available to offer patients who needed them.

The pharmacy had recently started offering diabetic foot and eye checks to those who might benefit from this service. Patients were identified as their prescriptions were labelled, and the results were recorded on the PMR and shared with their GP.

There was a health promotion area and a leaflet display on the prescription reception counter. Recent health promotion events included Stoptober and an antimicrobial resistance campaign. The pharmacy had also recently installed TV screen, which currently only displayed contact details and opening hours of the pharmacy. The RP explained that the plan was for it to be used for health promotion in future.

Deliveries to people's homes were tracked live using the 'ProDelivery' software on a mobile device, which also maintained people's confidentiality when signing for their deliveries. This was particularly useful when people phoned the pharmacy to ask about their delivery. Staff were able to let them know exactly where their delivery was and when they could expect to receive it.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance, Day Lewis and. Unlicensed 'specials' were obtained from Smartways. The pharmacy had the scanners and software necessary to comply with the Falsified Medicines Directive (FMD) but was not using it at present to decommission stock. The RP agreed to contact the SI for guidance on how to proceed with decommissioning.

Routine date checks were seen to be in place, record sheets were seen to have been completed, and no out-of-date stock was found. The RP explained how the robot also carried out its own date checks and would move stock around by itself 24-hours a day to continually ensure that the oldest packs were used first, and to make the best use of the available space within itself. Opened bottles of liquid medicine

were annotated with the date of opening. There were no plain cartons of stock seen on the shelves and 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 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.

The MCA described how patient-returned medicines were screened to ensure that any CDs were appropriately recorded, and that there were no sharps present. Patients with sharps were signposted to the local council for disposal. There was no list of hazardous medicines present and no separate purple-lidded container designated for the disposal of hazardous waste medicines. The RP agreed to obtain both. 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 the clinical governance records folder. 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.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for the range of services it provides. It uses its facilities and equipment appropriately to keep people’s private information safe.

Inspector's evidence

The pharmacy has the necessary resources required for the services provided, including the consulting rooms themselves, 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 monitor had been replaced earlier in the year and would be replaced every two years.

Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Computer screens were positioned so they were not visible to the public. 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 left in a secure location within 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.