General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jamaica Road Pharmacy, 182C Jamaica Road, London, SE16 4RT

Pharmacy reference: 9010908

Type of pharmacy: Community

Date of inspection: 20/05/2019

Pharmacy context

This is a community pharmacy situated on a main road. It serves a diverse local community. The pharmacy dispenses NHS prescriptions. It also supplies medicines in multi-compartment compliance trays and offers other services including a delivery service, flu and travel vaccines and Medicines Use Reviews.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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

The pharmacy generally manages the risks associated with its services. The pharmacy records any mistakes it makes during the dispensing process. But not all members of the team are told when these are reviewed. This may mean that they are missing out on opportunities to learn and improve the pharmacy's services. The pharmacy largely keeps the records it needs to by law. And it protects people's personal information. Team members know how to protect vulnerable people.

Inspector's evidence

Baskets were used throughout the dispensing process. This helped prevent transfer between people's prescriptions. There was ample work space and workbenches were clean and generally tidy. Members of the team were observed screening prescriptions that were handed in by people. Most prescriptions were received electronically, and these were dispensed in advance of the person presenting. This helped the team manage its workload.

A near miss record was seen to be frequently used to record near miss errors. The pharmacist said this was discussed with the team at the end of the month to identify common errors and action needed to minimise errors. He said a formalised review of the record was not done but members of the team shared important messages on a telephone messaging application. After joining the inspection at a later stage, the owner showed some monthly reviews which had been conducted by the second regular pharmacist (who was not in during the inspection). To help reduce errors, amiloride and amlodipine tablets had been separated on the shelf and methotrexate 2.5mg and 10mg were kept in separate boxes. Following a change to the patient medication record (PMR) system, members of the team had one-to-one training sessions with the pharmacist or pre-registration student to ensure they were all up-to-date on the system. They were also briefed to confirm people's details and look out for duplicate records. Incidents were documented on the PMR system though not in detail. For example, details of staff involved and action taken by the pharmacy team were not documented following an incident in 2018 where the incorrect strength of citalopram was supplied.

When asked for their standard operating procedures (SOPs), members of the team showed a folder containing a set of procedures which had not been reviewed since November 2015. It then transpired that an updated version was held electronically but it was evident that the team was still referring to the outdated SOPs in the folder. There was no evidence that current members of the team had read the most up-to-date version of the SOPs to confirm they had read and understood them. The pharmacist contacted the owner and she explained that she had taken the signed paper copies of the updated SOPs home with her. The owner confirmed that she would brief the team on how to find the new SOPs.

An out-of-date indemnity and public liability insurance certificate was displayed in the dispensary. The provider was contacted, and they confirmed the pharmacy had in-date indemnity insurance. An in-date certificate was shown by one of the owners, who joined the inspection at a later stage.

The correct responsible pharmacist (RP) sign was displayed and was visible to people. The RP log was generally complete. Private prescriptions and emergency supplies were documented electronically. These were generally in order, but prescriber details and the date on which the prescription was written

were not always accurate in the private prescription record. Specials records were completed in line with MHRA requirements. Controlled drug (CD) balance audits were conducted at irregular intervals (sometimes monthly but at other times every few months). A random stock check of a CD agreed with the recorded balance. Expired stock was kept in a clear plastic bag, but a liquid CD which had been opened in January 2018 (and to be used within 3 months of opening) was stored with in-date stock. This was segregated from in-date stock during the inspection.

Feedback was sought from people verbally or annual community pharmacy patient questionnaires. Some members of the team had not been informed of the results of these questionnaires.

Computers were password protected and the screens timed out automatically. Access to the PMR system was via NHS smartcards but one was seen left on a workbench when not in use. Confidential waste was collected in a basket and shredded on site. Medicines awaiting collection were stored inside large tubs on the shelves to prevent the sharing of information. Members of the team said they had received online training and had completed an assessment on the General Data Protection Regulation. They said they had also signed material on data protection, but the owner had taken the folder containing this home.

The pharmacist had completed a module on safeguarding children and vulnerable adults through the Centre of Pharmacy Postgraduate Education. The dispenser had completed safeguarding training several years ago. The trainee medicine counter assistant (MCA) had been briefed on the subject and could describe signs of neglect and abuse. Both said they would raise concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to provide the pharmacy services safely. But they do not always get time set aside for training time or receive feedback and coaching from a tutor. This may make it harder for them to keep their knowledge and skills up-to-date.

Inspector's evidence

At the time of inspection, there was a regular pharmacist, a pre-registration student, a dispenser and a trainee MCA. The owner, who was also a pharmacist, arrived later during the inspection. The pharmacy also employed a full-time trainee MCA and a part-time dispenser.

This was a busy pharmacy with a constant flow of people. Members of the team had good rapport with people and knew most of them on a first-name basis. One member of the team was observed offering water to a person who was coughing. Some people had to wait for some to time to be served. One person was observed requesting an over-the-counter medicine, but a member of the team forgot about her request and left her waiting while she was distracted by another task.

Some members of the team were not entirely sure of processes or where to locate certain documents, such as date checking records or records for drug alerts and recalls. The trainee MCA had been working at the pharmacy for two years but had only been enrolled onto the medicine counter course in November 2018. She was involved in selling Pharmacy-only medicines (P-medicines) since starting at the pharmacy. This meant she had not been enrolled onto a suitable course in a timely manner and in line with the General Pharmaceutical council's policy on minimum training requirements. But she was now registered on an accredited course. She was observed asking the WWHAM questions before selling P-medicines. Set study time was not provided so she completed her training modules at home. The pharmacists checked her progress every few months. The trainee MCA said she did not have access to any other training material. The owner added that members of the team received booklets from a wholesaler which they were asked to read every month and complete the corresponding questionnaire.

The pre-registration student was not provided with set study time and mostly completed ongoing training at home. She attended webinar sessions with a training provider, researched online and read material which her university sent. She was also part of a group of students who shared information on a telephone messaging application. She said she reviewed her progress with her tutor 'occasionally' but was able to call, text or email her tutor when needed. She worked with her tutor only occasionally and could not describe how many hours or over how many days they worked together. She did not have a plan in place with regards to her training and had to ask for next tasks to complete. She was not entirely sure how she would be able to fulfil her competencies.

Following the inspection, the superintedent pharmacist (SI) added: 'The pre-registration student is enrolled on an external Buttercups training programme. This comprises of full day face-to-face training sessions, webinars, online training modules, assessments and a mock exam. Each student is assigned a tutor for additional support. The webinar sessions take place during working hours as part of her study time. Additionally the student has half a day off each week as study time. There is a training plan in place and regular meetings with the tutor take place'.

The owner was the tutor to the pre-registration student. And said that she frequently worked alongside the student. It was unclear how much time the pre-registration student was spending with her tutor; this information was provided to the pre-registration team in the GPhC.

Formal performance reviews were conducted annually. Members of the team said they could raise concerns with the owner or regular pharmacist. Targets were not set for the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is maintained and secured properly. And it provides an environment that is suitable for its services.

Inspector's evidence

This was a large, bright pharmacy with ample work and storage space. Fittings were modern, clean and well-maintained. The retail area was well laid-out and organised. There were several chairs in the area for people wanting to wait for a service. P-medicines were stored behind the medicines counter. There were some ceiling tiles missing in the dispensary. The pharmacist said these were removed following a leak in the flat above the pharmacy and would be replaced soon.

Two clearly signposted consultation rooms were available for private conversations and services. The rooms were clean and tidy. The room temperature and lighting were suitable for the provision of pharmacy services. A clean sink, with hot and cold running water, was used for the preparation of medicines. Another sink was fitted at the back of the dispensary for staff use. The premises were secure.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy generally provides its services safely. But team members are not all aware of what advice to give people taking some higher-risk medicines. This could mean that people might not get all the information they need to take their medicines safely. The pharmacy generally manages medicines well to make sure that they are safe for people to use. But it does not always remove expired medications from shelves promptly. This could increase the chance that people get medicines that are past their 'use-by' date.

Inspector's evidence

Access into the pharmacy was step-free and via a wide automatic door. Services were listed in the practice leaflet. Information leaflets were displayed on a table in the retail area and some posters were displayed on the front window.

Members of the team did not always confirm people's names and addresses at hand out. The owner said this was not the normal practice and that she would be reminding them to follow the pharmacy's procedure on handing out dispensed medicines. Dispensing audit trails were generally maintained through the use of the 'dispensed by' and 'checked by' boxes on medicine labels. This helped identify members of the team involved in dispensing and checking prescriptions.

Dispensing audit trails were not maintained for these to help identify who had dispensed and checked them. The pharmacist said instalments were measured out by the pre-registration student and checked by the pharmacist. CD instalments were prepared in advance for the week and stored in boxes according to collection day. Prescriptions for Schedule 3 and 4 CDs were not always flagged up once they were dispensed. A prescription for a schedule 3 CD, dated January 2019, was found still in the retrieval system.

The dispenser had read the valproate guidance but could not remember what information to provide women in the at-risk group. The pharmacy didn't have information cards for valproate. The dispenser didn't know how she should label valproate which was removed from its original pack.

The pharmacist said that people on higher-risk medicines were asked for their blood test results and these were recorded on the PMR system where possible. He said he would provide advice on side-effects and signs of toxicity but not necessarily give dietary advice. The pharmacist said that prescriptions for higher-risk medicines were flagged up so that people were referred to the pharmacists when collecting their medicines.

A part-time dispenser had started at the pharmacy one month ago. She managed multicompartment compliance trays. The only other member of staff training on the system was the pre-registration student. They said that the second regular pharmacist ordered the repeat prescriptions for people receiving these trays. Clear audit trails were maintained of repeat prescriptions ordered, number of trays, and the date on which they were supplied. Prescriptions were cross-checked against the PMR system and the person's individual record card. Any changes were noted on the PMR and the cards. Trays were assembled by the pre-registration student or dispenser. Medicine descriptions were put on the trays and patient information leaflets (PILs) were generally supplied. Individual cards were annotated with the date on which the person collected their trays. Prescriptions were not retained with

the trays awaiting collection which meant that team members relied on bag labels generated at the pharmacy to confirm people's details when handing these out.

The patient group direction (PGD) for the smoking cessation service was due for review in July 2014 (it had been prepared in 2012). The dispenser who provided the service said she referred to the 'updated version of the PGD' although she could not find this in the relevant folder. She was then told the updated version was held electronically. An in-date PGD for the emergency hormonal contraception service was seen. Online questionnaires were completed with people to ascertain if they were suitable for the service.

Stock was received from licensed wholesalers. The pharmacist said that expiry date checks were conducted on sections of the dispensary every month. Date-checking records were not very clear and it was difficult to work out when each section had been checked. Three packs of expired medicines were found still on the shelves.

Fridge temperatures were checked and recorded daily; these were kept within the recommended range of 2 to 8 degrees Celsius. CDs were stored securely. Drug alerts and recalls were received electronically, printed out and annotated with the action taken.

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

One glass measure and three plastic measures were in use. The owner had ordered two new glass measures, and these were removed from their packaging at the time of inspection for the pharmacy team to use. Clean counting triangles were available, including a separate one for cytotoxic medicines.

The fridge was clean and suitable for the storage of medicines. The CD cabinet was fitted securely. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Members of the team had access to the internet and several reference sources.

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.