General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Royal Docks Pharmacy, 14 Royal Crest Avenue, West Silverton, London, E16 2TQ

**Pharmacy reference:** 9011100

**Type of pharmacy:** Community

**Date of inspection:** 04/12/2024

## Pharmacy context

The pharmacy is a shopping precinct in a largely residential area. It provides NHS dispensing services, the New Medicine Service, the NHS Pharmacy First service and flu and travel vaccinations. The pharmacy supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people. This is the pharmacy's first inspection since it opened around five years ago.

## 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. But it does not always record things that go wrong, so some learning opportunities may be missed. It protects people's personal information. And it keeps the records it needs to keep by law. But some of the records are incomplete which means the pharmacy may not always be able to show that its medicines have been supplied safely and legally. Team members understand their role in protecting vulnerable people.

### Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). And team members had signed to show that they had read, understood, and agreed to follow them. Team members' roles and responsibilities were specified in the SOPs. They knew which tasks should only be undertaken if there was a responsible pharmacist (RP) signed in. And they knew that they should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy technician said that he was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. He explained that if any happened, they would be recorded on a designated form and a root cause analysis would be undertaken. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses had not been recorded recently but the pharmacy technician said that he would ensure that they were recorded in future so that they could be reviewed to identify any patterns. Medicines with similar packaging or similar names had been separated on shelves where possible to help minimise the chance of the wrong medicine being selected.

The pharmacy had current professional indemnity insurance. The correct RP notice was clearly displayed, and the RP record was completed correctly. Team members said that people would usually be signposted people to NHS 111 or their GP if they needed a prescription-only medicine in an emergency without a prescription. The pharmacy did not routinely record the nature of emergency when it supplied a prescription-only medicine without a prescription. Team members said that they would ensure that this was recorded in future. The private prescription records were largely completed correctly, but the correct prescriber details were not always recorded. The importance of maintaining complete records about private prescriptions and emergency supplies was discussed with the team. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not routinely recorded. The recorded quantity of a CD item checked at random was the same as the physical amount of stock available.

Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Confidential waste was removed by a specialist waste contractor, computers were password protected and people using the pharmacy could not see information on the computer screens. People's personal information on dispensed medicines awaiting collection could not be seen by people using the pharmacy.

The complaints procedure was available for team members to follow if needed and details about how people could complain was available in the pharmacy. Team members said that there had not been any recent complaints. They explained that they would attempt to deal with any complaints, and they would inform the superintendent pharmacist if they could not resolve it.

The pharmacy had contact details available for agencies that dealt with safeguarding vulnerable people. And team members had completed training about protecting vulnerable people. The trainee dispenser described potential signs that might indicate a safeguarding concern and said that he would refer any concerns to the pharmacist. The pharmacy technician said that there had not been any safeguarding concerns at the pharmacy.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough team members to provide its services safely. They have regular meetings and can raise any concerns or make suggestions. The team members can take professional decisions to help ensure people are taking medicines safely. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills.

### Inspector's evidence

There was one pharmacist, one pharmacy technician, two trainee dispensers and one trained medicines counter assistant (MCA) working during the inspection. There were contingency arrangements for pharmacist cover if needed and holidays were staggered to ensure that there were enough staff to provide cover. Team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The pharmacy was be up to date with its dispensing.

Team members appeared confident when speaking with people. And they asked people relevant questions to establish whether the medicines they sold were suitable for the person they were intended for. The trainee MCA was aware of the restrictions on sales of medicines containing pseudoephedrine. And explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care.

The pharmacist and pharmacy technician were aware of the continuing professional development requirement for professional revalidation. The pharmacist had completed declarations of competence and consultation skills for the services offered and had done the associated training. And he had recently completed training for the NHS Pharmacy First service, and the flu and travel vaccination services. Trained team members were not provided with ongoing training on a regular basis, but they did receive some on an ad hoc basis. Team members mentioned that information about current issues was passed on to them when needed.

Team members explained that there were regular team meetings and they felt comfortable about discussing any issues with the pharmacist as they arose. And they said that they had ongoing informal performance reviews. The pharmacist felt able to make professional decisions. No performance targets were set for team members.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

### Inspector's evidence

The pharmacy was secured against unauthorised access and pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. The pharmacy was bright, clean, and tidy throughout which presented a professional image. Air conditioning was available, and the room temperature was suitable for storing medicines.

The consultation room was accessible to wheelchair users and conversations at a normal level of volume in the consultation room could not be heard from the shop area. It was suitably equipped, well-screened, and kept secure when not in use.

Toilet facilities were clean and there were separate hand washing facilities available. Some waste medicines were stored in the toilet area which was accessible from the shop area. So there was a risk of unauthorised access to them. The pharmacy technician said that this area would not be used to store medicines in future.

## Principle 4 - Services ✔ Standards met

### Summary findings

Overall, the pharmacy provides its services safely and manages them well. And people with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from licensed wholesalers and largely stores them properly. It responds appropriately to drug alerts and product recalls. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. So the team may miss opportunities to give advice to people when they collect these medicines to make sure they are using them correctly. People who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

### Inspector's evidence

There was step-free access into the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised, and a variety of health information leaflets was available.

Workspace in the dispensary was largely free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. Team members initialled dispensing labels when they dispensed and checked each item to show who had completed these tasks.

There were signed in-date patient group directions available for the relevant services offered. Prescriptions for higher-risk medicines such as warfarin were not highlighted. So, opportunities to counsel these people when they collected these medicines might be missed. The pharmacy technician said that people usually attended the pharmacy with their monitoring record books when they collected their medicines. He said that the pharmacist checked the books, but the pharmacy did not keep a record, so they could not show when checks had been carried out. Prescriptions for Schedule 3 and 4 CDs were not highlighted which could increase the chance of these medicines being supplied when the prescription was no longer valid. Team members knew how long these prescriptions were valid for and said that they checked the validity of prescriptions when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist said that he would speak with patients when valproate was supplied and refer people to their GP if necessary. The pharmacy dispensed valproate medicines in their original packaging.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacy technician explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response. Dispensing stock was stored in an organised manner in the dispensary. The pharmacy technician said expiry dates were checked regularly and short-dated items were highlighted. But there were a few expired and short-dated medicines found in with dispensing stock during a random spot check and these medicines were not marked. The pharmacy technician said that the pharmacy would implement a more robust date checking routine in future to help minimise the chance of these expired medicines being supplied.

Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked. And an alarm sounded when the fridge door was opened. CDs were stored in accordance with legal requirements and denaturing kits were available for the safe destruction of CDs. Expired CDs were clearly marked and separated. The pharmacy technician was not sure where returned CDs would be recorded and thought it might be in the CD registers as a footnote. He said that he would check with the SI and record these in a separate register in future.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked regularly. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacy supplied medicines in multi-compartment compliance packs to some people. Team members explained that a suitability assessment was completed by the person's GP to identify which medicines were needed to be dispensed into the packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacy technician said that people contacted the pharmacy if they needed their 'when required' medicines. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. This meant people had up-to-date information about their medicines. Team members wore gloves when handling medicines that were placed in these packs.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

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

### Inspector's evidence

Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only which helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for around two months, and the pharmacy technician said that it was replaced regularly. The phone in the dispensary was portable so it could be taken to a more private area when needed. The pharmacy technician explained that the otoscope and thermometer were cleaned after each use and disposable tips were used.

## 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. |