General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Well, 31A Danebury Avenue, Roehampton, London, SW15 4DG

**Pharmacy reference:** 9011362

**Type of pharmacy:** Community

**Date of inspection:** 23/04/2021

## Pharmacy context

This is a community pharmacy set on a parade of shops in Roehampton. The pharmacy opens six days a week. And most people who use it live or work nearby. The pharmacy sells a range of over-the-counter medicines. It dispenses NHS prescriptions, most of which it receives electronically. The pharmacy provides multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. And it delivers medicines to people who can't attend its premises in person. The pharmacy offers a needle exchange service. And it can dispense people's substance misuse treatments too. The pharmacy offers seasonal influenza vaccinations. It provides a stop smoking service. And its team can measure people's blood pressure. People can also collect coronavirus (COVID-19) home-testing kits from the pharmacy. This inspection took place during the COVID-19 pandemic.

## 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 adequately identifies and manages the risks associated with its services. Members of the pharmacy team review the mistakes they make and learn from them to try and stop them happening again. They can explain what they do, what they're responsible for and when they might seek help. They know how to protect vulnerable people. And they keep people's private information safe. People using the pharmacy can provide feedback to help improve the pharmacy's services. The pharmacy mostly keeps the records it needs to by law. And it has appropriate insurance to protect people if things do go wrong.

### Inspector's evidence

The pharmacy had completed a risk assessment of the impact of COVID-19 on the pharmacy and its services. And, as a result, it suspended or adapted some of its face-to-face services. The stop smoking service was provided at the counter. And it no longer used a monitor to measure the amount of carbon monoxide in a person's breath. The pharmacy offered to undertake an occupational COVID-19 risk assessment for each team member to help identify and protect those at increased risk. Members of the pharmacy team knew how they would report any work-related infections to the pharmacy's head office. They were self-testing for COVID-19 twice weekly. They wore fluid resistant face masks to help reduce the risks associated with the virus. And they washed their hands or used hand sanitisers regularly. The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. These were available electronically. And an electronic training record was kept for each team member to show they had read and understood the SOPs and would follow them. The pharmacy's head office team regularly reviewed the SOPs. The pharmacy team had received supplemental guidance to help it manage its services safely during the pandemic.

The pharmacy had a separate area to its main dispensary. This was used for the assembly of people's compliance packs. The team members responsible for making up people's prescriptions tried to keep each dispensing workstation tidy. The pharmacy kept an audit trail for each stage of the dispensing process from clinical screening by a pharmacist through to the final accuracy checking of the assembled prescription. Members of the pharmacy team used baskets to separate people's prescriptions and to help them prioritise the dispensing workload. They referred to prescriptions when labelling and picking products. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by an appropriately trained checker who also initialled the dispensing label. The pharmacy had systems to record and review dispensing errors and near misses. Members of the pharmacy team discussed individual learning points when they identified a mistake. They reviewed their mistakes periodically to help spot the cause of them. And they shared learning from these reviews with each other. So, they could try to stop the same types of mistakes happening again. The pharmacy team strengthened its dispensing process following mistakes involving the assembly of some people's compliance packs.

The pharmacy displayed a notice that told people who the responsible pharmacist (RP) was. Members of the pharmacy team wore name badges which identified their roles within the pharmacy. They knew what they could and couldn't do, what they were responsible for and when they might seek help. They explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products to a pharmacist. The

pharmacy had a complaints procedure. And a notice next to the consulting room told people how they could provide feedback about the pharmacy. The pharmacy team asked people for their views. People were generally asked to complete a satisfaction survey once a year. But a survey wasn't done last year due to the pandemic. The pharmacy team tried to keep people's preferred makes of prescription-medicines in stock when asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and when. The pharmacy had an electronic controlled drug (CD) register, which was kept in order. The pharmacy team regularly checked the stock levels recorded in the CD register. The pharmacy kept records for the supplies of unlicensed medicinal products it made. But it didn't routinely record when it had received the product nor who it was supplied to and when. The pharmacy recorded the emergency supplies it made electronically. But the reason for the supply, when requested by a patient, wasn't always recorded properly. The pharmacy recorded the private prescriptions it supplied electronically. But the prescriber's details didn't appear in these records despite the pharmacy team recording them.

People using the pharmacy couldn't see any other people's personal information. The pharmacy had arrangements in place to make sure confidential waste was collected and disposed of securely. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Members of the pharmacy team were required to complete training on information governance and data protection, as well as safeguarding vulnerable groups of people. The RP and the pharmacy technician confirmed that they had each completed a level 2 safeguarding training course. And they knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough team members to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. They work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

### Inspector's evidence

The pharmacy team consisted of a full-time pharmacist (the RP), a part-time pharmacist, a part-time pharmacy technician, a part-time pre-registration pharmacy technician, two part-time pharmacy assistants and a part-time trainee pharmacy assistant. The RP, the pharmacy technician, the pre-registration pharmacy technician trainee, one of the pharmacy assistants and the trainee pharmacy assistant were working at the time of the inspection. The pharmacy relied upon its team and team members from one of the company's other pharmacies to cover absences. Members of the pharmacy team worked well together. So, people were served promptly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by staff. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding, people who were old and people with long-term health conditions to a pharmacist.

The pharmacy had an induction training programme for its team. Members of the pharmacy team needed to complete mandatory training during their employment. And they were required to undertake accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with their line manager when they could. They were encouraged to ask questions and familiarise themselves with new products. They were also asked to complete online training to make sure their knowledge was up to date. And they could train while they were at work when the pharmacy wasn't busy. The pharmacy held meetings and one-to-one discussions to update its team and share learning from mistakes or concerns.

The pharmacy team had some targets. But its team didn't feel under pressure to achieve them. The RP and the pharmacy technician felt able to make professional decisions to ensure people were kept safe. Members of the pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And their feedback led to changes in the way people's compliance packs were dispensed.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy provides a suitable and secure environment for people to receive healthcare. And its premises are clean and tidy. The pharmacy has a room where people can have private conversations with members of the pharmacy team.

### Inspector's evidence

The pharmacy had a small retail area, a consulting room, a counter, a dispensary, a toilet and a stockroom with a kitchenette area. It was air-conditioned, bright, modern, secure and appropriately presented. It had the workbench and storage space it needed for its current workload. And its dispensary was of an adequate size. This meant that its team members could generally keep their distance from one another. The consulting room was suitable for the services it offered and if people needed to speak to a team member in private. It was locked when it wasn't being used. So, its contents were kept secure. The pharmacy had some sinks. And it had a supply of hot and cold water. Members of the pharmacy team were responsible for keeping the pharmacy's premises clean and tidy. They cleaned the pharmacy on most days it was open. And they regularly wiped and disinfected the surfaces they and other people touched.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides services that people can access. Its working practices are safe and effective. And its team is helpful. The pharmacy delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources and it stores them appropriately and securely. Members of the pharmacy team carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose. And they generally dispose of people's waste medicines properly too.

### Inspector's evidence

The pharmacy had an automated door and its entrance was level with the outside pavement. This meant that people who may have difficulty climbing stairs, such as wheelchair users, could access its premises easily. The pharmacy offered a text messaging service to tell people when their medicines were ready. The pharmacy had a notice that told people when it was open. And leaflets describing some of the pharmacy's other services were available in-store. A seating area was available for people who wanted to wait in the pharmacy. And this was set away from the counter and the entrance to help people keep apart. Members of the pharmacy team were helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy sent some people's prescriptions to an offsite dispensing hub. The hub assembled these prescriptions and returned the medicines to the pharmacy for its team to hand out or deliver to the person. The pharmacy team used a handheld device to find out where people's prescriptions were. And the device was also used to keep an audit trail of the process. People were told that their medicines would be dispensed at a different location to the pharmacy before being asked if they wanted to use the service. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked whether a medicine was suitable to be re-packaged. The pharmacy kept an audit trail of the person who had assembled and checked each compliance pack. And patient information leaflets were routinely supplied. But sometimes the compliance pack didn't include the date it was dispensed on. And a brief description of each medicine contained within a compliance pack wasn't always provided. The pharmacy used clear bags for some dispensed items, such as insulin, to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. The pharmacy team marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting, such as a high-risk medicine, or if other items, such as a CD and a refrigerated product, needed to be added. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The pharmacy had some valproate educational materials available. The pharmacy offered a delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery to show that the right medicine was delivered to the right person. But it had adapted its delivery process because of the pandemic. And people no longer needed to sign an electronic or paper delivery record to say they had received their medicines. This meant that the delivery person and the people they were delivering to could keep their distance from each other.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices tidily on the shelves within their original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines at regular intervals. It recorded when it had done these checks. And it marked products which were soon to expire to reduce the chances of it giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy kept its out-of-date, and patient-returned, CDs separate from in-date stock. And its team needed to keep a record of the destruction of patient-returned CDs. But it hadn't recorded the receipt of some of these as required by the pharmacy's SOPs. And some intact patient-returned tramadol capsules were found in a pharmaceutical waste bin. The pharmacy had procedures for handling the unwanted medicines people returned to it. These medicines were kept separate from stock and were placed in a pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they took and the records they made when they received a drug alert.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is clean.

### Inspector's evidence

The pharmacy had some plastic screens on its counter. It had markings on its floor to help people keep apart. And its team could restrict the number of people it allowed in the premises at a time if needed. The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had a range of clean glass measures for use with liquids, and some were marked for use only with certain liquids. It had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the superintendent pharmacist's office to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of each refrigerator. The pharmacy team occasionally needed to take people's blood pressure. And the monitor it used to do this was replaced a few weeks ago. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. The pharmacy had a cordless telephone system. So, its team could have confidential conversations with people when necessary. Most of the team members responsible for the dispensing process had their own NHS smartcard. And they each made sure their card was stored securely when they weren't working.

## 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. |