General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Britannia Pharmacy, 13-15 Faircross Parade, Longbridge Road, Barking, IG11 8UN

Pharmacy reference: 9011854

Type of pharmacy: Community

Date of inspection: 23/08/2023

Pharmacy context

The pharmacy is on a parade of shops in a largely residential area. It provides NHS dispensing services, the New Medicine Service, flu vaccinations, blood pressure checks and weight monitoring. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medicines in multi-compartment compliance packs to a large 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. The pharmacy receives most of its prescriptions electronically.

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 adequately identifies and manages the risks associated with its services to help provide them safely. And it protects people's personal information well. People can provide feedback about the pharmacy's services. And team members understand how to protect vulnerable people. The pharmacy keeps the records it needs to and it largely keeps these accurate and up to date. Team members record and review their mistakes so that they can learn and make the services safer.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. 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. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Near misses were recorded and reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly during the team meetings. Learning points were also shared with other pharmacies in the group. The pharmacist said that he 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 he would make a record of any dispensing errors, undertake a root cause analysis and report on the National Reporting and Learning System.

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. And workspace in the dispensary was free from clutter. Team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. The accuracy checking dispenser (ACD) knew that she should not check items if she had been involved in the dispensing process for them. A quad stamp was added on prescriptions and dispensing tokens. Team members initialled next to the task they had carried out (dispensed, clinically checked, accuracy checked and handed out).

The pharmacist said that he would contact the pharmacy to let team members know if he was running late in the morning. And the dispensary manager would ensure that a notice was displayed so that people knew there was no responsible pharmacist (RP). Team members were aware of the tasks that they should and should not undertake if there was no RP or if the RP was not in the premises. Team members' roles and responsibilities were specified in the SOPs.

The right RP notice was clearly displayed, and the RP record was completed correctly. The pharmacy had current professional indemnity and public liability insurance. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were largely completed correctly, but the right prescriber details were not always recorded. This could make it harder for the pharmacy to find these details if

there was a future query.

People's personal information on bagged items awaiting collection could not be viewed by people using the pharmacy. Confidential waste was separated, and the delivery driver took it to the pharmacy's head office to be disposed of. Computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection.

The branch manager said that there had not been any recent complaints. The complaints procedure was available for team members to follow if needed and details about how people could complain were displayed in the shop area.

Team members had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The branch manager described potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. And he said that he would inform the pharmacy's head office. The branch manager said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can raise concerns to do with the pharmacy or other issues affecting people's safety. The team members can take professional decisions to ensure people taking medicines are safe. And they are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, four trained dispensers (one was also the dispensary manager) and four trained medicines counter assistants (MCA) (one was also the branch manager) working during the inspection. Team members wore smart uniforms with name badges displaying their role. They worked well together during the inspection. They communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The pharmacy was up to date with its dispensing and checking tasks.

The MCAs appeared confident when speaking with people. They were aware of the restrictions on sales of pseudoephedrine containing products. And would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Team members asked people questions before selling over-the-counter medicines to establish whether the medicines were suitable for the person they were intended for.

The pharmacist was aware of the continuing professional development requirement for professional revalidation. He said that he had recently completed the online refresher training for the flu vaccination service. Team members said that they could complete training in the pharmacy during quieter times. They had recently completed Dementia Friends training, and training for the Pharmacy Quality Scheme.

Team members explained that there was an informal meeting each morning to allow them to discuss any issues and prioritise tasks for the day. They said that the area manager regularly visited the pharmacy to ensure that the pharmacy was up to date with its dispensing and its managerial tasks. The pharmacist felt supported by the pharmacy's head office and said that he received prompt replies when he had contacted it. There were monthly staff meetings which allowed team members to discuss any patient safety issues and ensure that all team members were informed about any changes to processes in the pharmacy. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. And he felt able to take professional decisions.

Team members said that they had yearly performance reviews as well as ongoing informal ones. Team members felt comfortable about discussing any issues with the pharmacist or the pharmacy's head office. Targets were set for the New Medicine Service. The pharmacist said that the pharmacy usually reached the set target and he did not feel under pressure. He said that the pharmacy's computer highlighted when a person might be suitable for the service and this helped identify those people.

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 and not be overheard.

Inspector's evidence

The pharmacy was bright, clean, and tidy throughout and this presented a professional image. It was secured from unauthorised access. And pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines. Kitchen and toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available.

There were several chairs in the shop area. And these were positioned away from the medicines counter to help minimise the risk of conversations at the counter being overheard. The consultation rooms were accessible to wheelchair users and were in the shop area. They were suitably equipped but people could see into the room from the shop area. The pharmacist said that he would ensure that the windows were covered in future. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy provides its services safely and manages them well. And it highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with an external ramp and an automatic door. 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. The pharmacy could produce large-print labels for people who needed them.

Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And kept a record of blood test results on the pharmacy's computer. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were highlighted, and this helped to minimise the chance of these medicines being handed out if the prescription was no longer valid. 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 explained that the pharmacy did not supply split packs of these medicines. And team members ensured that the dispensing label did not cover up any of the warnings. The pharmacist said that he would refer people to their GP if they needed to be on the PPP and weren't on one.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. 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. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next six months were marked and items with less than three months shelf life remaining were removed from dispensing stock. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

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. One of the dispensers responsible for checking the fridge temperatures said that he would inform the pharmacist if the temperature was found to be out of range. CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and kept in a separate cabinet. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

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 monthly. Team members said that people usually collected their medicines after they had received a text message informing them that they were ready for collection. People were sent a follow-up text after around three months if they had still not collected their medicines. After this time, uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. 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. 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. Prescriptions for ‘when required’ medicines were not routinely requested. The pharmacist said that people usually contacted the pharmacy, or their GP if, they needed them when their packs were due. 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.

Deliveries were made by a delivery driver. The pharmacy obtained people’s signatures for deliveries where possible, and these were recorded in a way so that another person’s information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery. A list of items out for delivery was kept at the pharmacy so that team members could refer to it if there was a query.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had suitable equipment for measuring liquids and there were separate liquid measures marked for use with certain medicines only. Triangle tablet counters were available and clean and a separate counter was used for cytotoxic use only. This 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.

The pharmacy had up-to-date reference sources available in the pharmacy and online. The blood pressure monitor was replaced in line with the manufacturer's guidance and the weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.