General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hollytree Pharmacy, 2-3 Hollytree Parade, Sidcup Hill, Footscray, Sidcup, DA14 6JR

Pharmacy reference: 9011938

Type of pharmacy: Community

Date of inspection: 22/02/2023

Pharmacy context

The pharmacy is on a parade of shops in a largely residential area. It provides a range of services, including the New Medicine Service, blood pressure checks and the flu vaccination service. The pharmacy supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And people can feedback about the pharmacy's services. Team members understand their role in protecting vulnerable people. And the pharmacy largely keeps its records up to date and accurate.

Inspector's evidence

The pharmacy had electronic copies of standard operating procedures (SOPs) and the superintendent (SI) pharmacist was in the process of printing them. Team members had been reading them and signing to show that they had read and understood 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. Near misses were recorded but not reviewed for any patterns. The dispenser said that she would review the near miss records in future. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacist said that there had not been any recent dispensing errors, where a dispensing mistake had reached a person. He explained that he would record any dispensing errors and undertake a root cause analysis. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The SI said that the pharmacy had not received any recent complaints.

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

Team members' roles and responsibilities were specified in the SOPs. The dispenser said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. And she knew which tasks should not be undertaken if there was no responsible pharmacist (RP). And she knew that he should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was clearly displayed, and the RP record was completed correctly. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The private prescription records were largely completed correctly, but the prescriber's address was not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. Controlled drug (CD) registers examined were filled in correctly and any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was not the same as the physical amount of stock available. The SI was unable to reconcile the balance during the inspection. He said that he would investigate this and undertake a balance check for all CDs, ensuring that any unresolved discrepancies were reported to the Controlled Drugs Accountable Officer. And he confirmed that he would undertake more regular balance checks.

Confidential waste was shredded, 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. Bagged items waiting collection could not be viewed by people using the pharmacy. And team members had completed training about how to protect people's personal information.

The SI had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. And other team members had undertaken training about how to protect vulnerable people. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. The team members gave examples of action they had taken in response to safeguarding concerns. 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 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. They can raise any concerns or make suggestions and have informal meetings to discuss any issues. And team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There were two pharmacists (one was the SI), one trained dispenser, one apprentice, two trainee dispensers and one trainee medicines counter assistant (MCA) working during the inspection. Some team members had completed an accredited course for their role, and some were enrolled on a suitable course. Several team members were still in their probationary period and the SI said that he would ensure that team members were enrolled on courses within the required timeframe. The team worked well together during the inspection and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

The apprentice appeared confident when speaking with people. She said that she would check with the pharmacist if a person asked to purchase more than one packet of an over-the-counter medicine. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The SI was aware of the continuing professional development requirement for the professional revalidation process. He said that he had recently done some training about medicinal cannabis and probiotics. The dispenser said that she had access to online training modules and completed these at home. The SI checked which training team members had completed and ensured that all necessary training modules had been done. The SI said that he felt able to take professional decisions. And he said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members said that they had informal huddles to discuss any issues and allocate tasks. And they felt comfortable about discussing any issues with the SI. Targets were not set for team members. The SI said that the services were provided for the benefit of the people using the pharmacy. And the New Medicine Service was managed by the second pharmacist.

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 from unauthorised access. It was bright, clean, and tidy throughout which this presented a professional image. Air conditioning was available, and the room temperature was suitable for storing medicines. Pharmacy-only medicines were kept behind the counter or behind screens in the shop area. 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.

There were a few chairs in the shop area for people to use while waiting. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped, well-screened and kept secured when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. And people with a range of needs can access the pharmacy's services. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to 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. The pharmacy could produce large-print labels for those who needed them.

Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The SI said that people would only be given a prescription from their GP if they had in-date blood test results. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The SI said that he would ensure that prescriptions for higher-risk medicines and CDs would be highlighted in future. The dispenser 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 SI said that people would be referred to their GP if they were not on a PPP and needed to be on one. The pharmacy had the relevant patient information leaflets and warning cards available. But it did not have the warning stickers for use with split packs. The dispenser said that she would order these from the medicine manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and some short-dated items were marked. There were no date-expired items found in with dispensing stock. Several medicines were found which were not kept in their original packaging. And some of the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. The SI said that he would ensure that all medicines were kept in appropriately labelled packaging in future. 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 segregated. The SI said that returned CDs were recorded in a register at the time of destruction. And these were destroyed with a witness, and two signatures were recorded. The SI could not locate the destruction register during the inspection. The SI said that he would record the returned CDs at the time of receipt in future so that there is a full audit trail. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. And the fridge was suitable for storing medicines and was not overstocked.

Team members said that part-dispensed prescriptions were checked frequently. And 'owings' notes were provided when a prescription could not be dispensed in full. People were kept informed about supply issues and prescriptions for alternate medicines were requested from prescribers where needed. The SI said that the pharmacy dispensed owings from the electronic prescription on the PMR and used

this copy of the prescription to carry out the final accuracy check. Non-electronic prescriptions were kept at the pharmacy until the remainder was dispensed. The pharmacist said that uncollected prescriptions were checked every two or three months. Items remaining uncollected after this time were returned to dispensing stock where possible. And the prescriptions were returned to the NHS electronic system or to the prescriber. Dispensing tokens were not kept with dispensed items until collected. The pharmacist said that team members checked the prescription on the PMR to ensure it was in date before items were handed out. He said that he would review this system as it often caused delays if a computer was not readily available.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. The prescriptions for these packs were ordered in advance so that any issues could be addressed before people needed their medicines. And prescriptions for 'when required' medicines were not routinely requested. The dispenser said that the pharmacy contacted people to ask if they needed these medicines when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and they 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. And medication descriptions were put on the packs to help people and their carers identify the medicines. But the patient information leaflets were not routinely supplied. The dispenser said that she would ensure that these were supplied in future. So that people had up-to-date information about how to take their medicines safely. Team members wore gloves when handling medicines that were placed in these packs.

Deliveries were made by a delivery driver and the pharmacy kept a list of items out for delivery. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. 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.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The SI explained the action the pharmacy took in response to any alerts or recalls. But the pharmacy did not keep a record of any action taken. The SI said that he would keep a record so that the pharmacy could show what it had done in response.

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. Separate liquid measures were used to measure marked for certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked 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.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was replaced in line with the manufacturer’s guidance. 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.