General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Morgan; S.E., 16 Dunstable Road, LUTON, Bedfordshire, LU1 1DY

Pharmacy reference: 1028860

Type of pharmacy: Community

Date of inspection: 21/08/2024

Pharmacy context

This is a community pharmacy on a busy main road close to the centre of Luton in Bedfordshire. The pharmacy dispenses NHS and private prescriptions. It offers the New Medicine Service (NMS), local deliveries and Pharmacy First. And it provides people's medicines inside multi-compartment compliance packs if they find it difficult to manage their medicines at home.

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 identifies and manages the risks associated with its services in a satisfactory way. Members of the pharmacy team manage their mistakes responsibly. But they are not always documenting or formally reviewing the necessary details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. Team members understand their role in protecting the welfare of vulnerable people. And the pharmacy generally keeps appropriate records that it needs to by law.

Inspector's evidence

The pharmacy's standard operating procedures (SOPs) were in the process of being updated and signed by staff. They provided the team with guidance on how to complete tasks appropriately. Team members were clear on their roles and responsibilities, and they knew what their tasks involved. Staff understood which activities could take place in the absence of the responsible pharmacist (RP) and the correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

Staff explained that the workflow involved downloading electronic prescriptions, ordering medicines, and processing them first through the pharmacy system. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. There was a facility on the dispensing labels to help identify who had been involved in the dispensing process and team members routinely used these as an audit trail. From the layout of the dispensary, a circular workflow was in place where staff worked in separate areas to the pharmacist. They ensured dispensing benches were kept clear of clutter and with larger prescriptions which spanned over two baskets, they ensured people's bag labels were appropriately highlighted to indicate this. This helped ensure people's prescriptions were not separated at the accuracy-checking stage.

The pharmacy's displayed details about how to make a complaint or provide feedback and the RP described handling dispensing incidents which reached people as well as complaints in a suitable way. The relevant details were always brought to the attention of the superintendent pharmacist and investigated appropriately. But details about them were not always recorded. Errors that occurred during the dispensing process (near miss mistakes) were also routinely passed back to staff for them to identify. The team described separating some medicines in response. This included those that looked-alike or sounded-alike and different forms (such as tablets and capsules) for the same medicine. But the pharmacy team was not regularly recording nor formally reviewing these kinds of mistakes. This could make it harder to spot patterns and trends.

Members of the pharmacy team had been trained to protect people's confidential information. The pharmacy displayed details on how it did this, and team members ensured confidential information was protected. They stored and disposed of confidential information appropriately. No sensitive details could be seen from the retail space. Staff used their own NHS smartcards to access electronic prescriptions. The RP had been trained to level two to safeguard the welfare of vulnerable people. Team members could recognise signs of concern; they had been trained appropriately. The pharmacy had contact details available for the local safeguarding agencies so they could refer suitably in the event of a concern.

The pharmacy had current professional indemnity and public liability insurance. A sample of registers seen for controlled drugs (CDs) and records of supplies made against private prescriptions had been maintained in accordance with legal requirements. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of CDs that had been returned by people and destroyed at the pharmacy as well as records verifying that fridge temperatures had remained within the required range were also maintained appropriately. The RP record was mostly complete, but some details of when the pharmacist's responsibility had ceased were missing. And electronic records about the nature of the emergency when a supply of a prescription-only medicine was made, in an emergency without a prescription were also sometimes incomplete. This could make it harder for the pharmacy to justify the supplies made. These points were discussed at the time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the appropriate skills to deliver the pharmacy’s services. Members of the pharmacy team have a range of skills and experience. The pharmacy provides them with resources so that they can complete regular and ongoing training. This helps keep their skills and knowledge up to date.

Inspector's evidence

During the inspection, the pharmacy team consisted of the regular RP, a part-time, trained dispensing assistant and a pharmacy student (MCA). There was also another part-time dispensing assistant and delivery driver. Team members were observed to work efficiently. Staff asked appropriate questions before selling medicines, they were aware of medicines which could be abused and knew when to refer to the pharmacist appropriately. As they were a small team, verbal discussions took place regularly. Staff performance was said to be an informal process with concerns or issues addressed directly. Members of the pharmacy team had access to resources for ongoing training. This was through organisations which provided support for pharmacies.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an appropriate environment to deliver services from. The pharmacy is suitably presented. And people can have a conversation with a team member in a private area.

Inspector's evidence

The premises consisted of a small retail area, a raised dispensary to one side, a basement, and staff areas. There were three flights of stairs at the back of the premises which led to staff areas. Some of these rooms were quite cluttered with vast amounts of paperwork. Prescription only medicines were also stored on shelves in some sections of the stairwells. The lighting and ambient temperature within the pharmacy was appropriate for storing medicines and safe working. The premises were also secure from unauthorised access. The dispensary was smaller than the retail area and only had a limited amount of space for staff to carry out dispensing tasks safely. The team made best use of this space by clearing tasks as they worked. The pharmacy had hot and cold water. The pharmacy was presented appropriately but some areas could have been cleaner. The pharmacy also had a separate consultation room which was used to hold private conversations and provide services. There was a sign in the retail space to advise people that a consultation room was available. The room had two entrances, one of which led behind the front counter. The room was small but adequate for its intended purpose. The team ensured any confidential information stored here was protected and inaccessible.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services appropriately. The pharmacy sources its medicines from reputable suppliers and stores its medicines suitably. The pharmacy has some checks in place to ensure that medicines are not supplied beyond their expiry date. But records to help verify this are missing. And the pharmacy's team members are not always identifying people who receive higher-risk medicines or making the relevant checks. This makes it difficult for them to show that people are provided with appropriate advice when these medicines are supplied.

Inspector's evidence

People could enter the pharmacy from a single, front door, although the pharmacy's front entrance was not level with the outside pavement. This made it harder for someone who used a wheelchair, to enter the building. But the pharmacy team assisted people at the door if needed. The pharmacy's services as well as its opening times were clearly advertised. There were also a wide range of leaflets and posters on display to provide information about various health matters and a few seats for people if they wanted to wait. Team members could make suitable adjustments if they served people with different needs; this included providing people with written details, communicating verbally or physically assisting if required. Some of the staff were also multilingual which assisted people whose first language was not English; representatives and Google translate could also be used.

The pharmacy provided people who lived in their own homes with their medicines inside multi-compartment compliance packs. This was in conjunction with the person's GP and once a need for this had been identified. Staff maintained individual records for people who received their medicines in this way. They also cross-checked details on patient medication records (PMR) after ordering and receiving people's prescriptions for this service. Any queries were checked with the prescriber and the records were updated accordingly. All medicines were removed from their packaging before being placed inside the compliance packs. The packs were not left unsealed overnight. Higher-risk medicines including sodium valproate and CDs were provided separately. Descriptions of the medicines inside the packs were always provided and patient information leaflets (PILs) were routinely supplied.

People's medicines could be delivered to them, and the team kept specific records about this service. This helped verify and trace who had received their medicines in this way. CDs and fridge lines were highlighted. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended.

Staff were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). They ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them and had previously identified people in the at-risk group who had been supplied this medicine. However, the team did not routinely identify people prescribed medicines which required ongoing monitoring. They did not always ask details about relevant parameters, such as blood test results for people prescribed these medicines or keep any records about this.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Short-dated medicines were identified. The team checked medicines for expiry but could not locate up-to-date

records of when this had taken place. There were no date-expired medicines seen. CDs were stored securely and medicines requiring refrigeration were stored in a suitable way. Medicines returned for disposal, were accepted by staff, and stored within designated containers. People who brought sharps back for disposal were redirected accordingly. Drug alerts were received electronically via email. Staff explained the action the pharmacy took in response and relevant records were kept verifying this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate range of equipment and facilities it needs to provide its services safely. Its team members keep the equipment clean and use them in a way which helps keep people's confidential information safe.

Inspector's evidence

The pharmacy's equipment included access to current reference sources, standardised conical measures for liquid medicines, an appropriately operating pharmacy fridge and a legally compliant CD cabinet. There were also triangle tablet counters including a separate one marked for cytotoxic use only. This helped avoid any cross-contamination. The pharmacy's equipment was clean. Computer terminals were password protected and their screens faced away from people using the pharmacy. This helped prevent unauthorised access. The pharmacy also had portable telephones which meant that conversations could take place in private if required.

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.