General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Macol Ltd., 696/702 Chigwell Road, Woodford Bridge, WOODFORD GREEN, Essex, IG8 8AL

Pharmacy reference: 1031455

Type of pharmacy: Community

Date of inspection: 19/06/2019

Pharmacy context

This pharmacy is in a parade of shops in a residential area. The signage at the front of the shop is for 'Hamlets' and the pharmacy is also known as Bridge pharmacy. A nail bar and chiropodist are situated in the pharmacy and a private GP practice and spa is situated upstairs. The pharmacy dispenses NHS prescriptions and offers a number of sexual health services including chlamydia testing and treatment. It supplies medicines in multi-compartment compliance packs to a number of people to help them take their medicines safely.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	3.4	Standard not met	People accessing the toilet to the rear of the dispensary can see other people's private information. This includes people using some of the pharmacy's services and non-pharmacy staff.
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's working practices are generally safe and effective. The pharmacy asks its customers for their views. It largely keeps the records it needs to so that medicines are supplied safely and legally.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which had been read and signed by most team members. The responsible pharmacist (RP) said that these had been put into place the previous year following a review. The dates of when the reviews had been carried out had not been annotated on the SOPs. This could make it harder for team members to know if the SOPs had been reviewed and were up to date. A roles and responsibilities matrix was available but this had not been completed. A folder containing the old version of SOPs was stored on the shelf with other folders. The RP agreed to move these away as it could cause confusion as to which SOPs were current.

In the event that a near miss was identified, the RP said that she would find out what had caused the mistake and brief the team including the person who had made the mistake. This would then be recorded in a near miss log book. Records made in the book showed that there had been no recorded entries made since February 2019. The RP said that there were two near misses identified in June which still needed to be recorded. As a result of past near misses warning notes had been attached to some of the shelves, reminding team members to be more vigilant when picking certain medicines such as amlodipine and amitriptyline. The RP had last carried out a review of near misses in January 2019, no action points had been recorded as part of this.

In the event that a dispensing incident was reported the RP said that she would investigate, check if the person had taken the incorrect medication, inform the team and report the incident on the National Reporting and Learning System website. In addition to this she would also notify the superintendent pharmacist (SI) and the person's GP. A pop-up prompt was also placed on the person's electronic patient medication record. As a result of a past incident the team had been briefed to take more care when dispensing escitalopram and enalapril.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP.

The pharmacy had current professional indemnity insurance.

The pharmacy had a complaint procedure and also completed an annual patient satisfaction survey. People were able to complain to the RP or to the SI. The RP said that there had not been any feedback which had required any changes to be made.

Records for private prescriptions, emergency supplies and unlicensed specials were well maintained. RP records were largely well maintained but the pharmacist had signed out ahead of time. Controlled drug (CD) registers were generally well maintained but some registers were loose. The RP said that she would ensure these were stapled together.

The RP said that CD balance checks were carried out monthly. But the last recorded check in a number of registers was in April 2019. One register had not been checked since October 2018. This means that

any error or discrepancies may not be picked up and investigated in a timely manner. A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received. There were a number of returns from 2018 which required destruction.

Assembled prescriptions were stored in the dispensary. The RP said that she thought there was an information governance policy in place, and colleagues had read and signed the SOP for confidentiality. Pharmacists had access to Summary Care Records and gained consent from people verbally to access these.

The RP had completed the level 2 safeguarding training and was aware of where to locate the contact details for the local safeguarding boards. The RP was unaware if the team had done any training. Team members said that they would speak to the RP if they had any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for its services. They have the appropriate skills, qualifications and training to deliver the pharmacy's services safely.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP, a trained dispenser and a pharmacy student. The pharmacy student's hours had been increased to help support the team. Other team members included two counter assistants, one of who was the manager and had qualified as part of the grandparenting scheme. The second counter assistant was responsible for the beauty side of the business and said that she did not sell any medicines or give any medical or healthcare advice, instead referring people to her colleagues.

The RP said that there were enough staff. She said that the pharmacy also had a pre-registration (pre-reg) trainee who was on study leave at the time of the inspection. The SI was the pre-reg tutor and worked at the pharmacy a couple of days a week. The RP said that at the beginning of some days she planned the workload in advance and arranged tasks that needed be done and prepare for the following day.

Staff performance was managed by the SI who held an annual review with each team member. The pharmacists also provided team members with feedback.

The medicines counter assistant (MCA) counselled patients on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. He would always refer to the pharmacist if unsure and was aware of the maximum quantities of some medicines which could be sold over the counter. The MCA showed prescriptions to the dispensary team before handing them out.

Team members said that there was no formal procedure in place for ongoing training. The SI trained the team if there were any new changes and asked team members to attend external training courses. A team member was due to attend a training session about cancer. The team received training material from suppliers for new over-the-counter products which they read through and were given additional information about them by the pharmacists. The RP said that she provided the team with information when reviews were carried out for near misses and dispensing incidents.

As the team was small, there were no formal meetings and things were discussed as they came up. The RP communicated with the SI via telephone or when he came in. The RP said that previously there was a lot of backlog in terms of prescriptions needing to be dispensed and she had come in one day when the SI had been working to have a chat with him. Following this the team had changed the workflow which the RP said had an effect on the workload. Team members said that the SI was receptive to suggestions and feedback.

There were no numerical targets in place.

Principle 3 - Premises **Standards not all met**

Summary findings

The premises are clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services. But people accessing the toilet to the rear of the dispensary can see other people's private information. This includes people using some of the pharmacy's services and non-pharmacy staff.

Inspector's evidence

The pharmacy was modern, bright and spacious. The walk-in dispensary was clean at the time of inspection, work bench space was limited in the main dispensary area and an adjoining room was used to prepare multi-compartment compliance packs. This room had additional storage and bench space. Medicines were arranged on shelves in a tidy and organised manner. Some baskets with medicines that had been dispensed were stored on the floor next to the shelves that were used to store medicines. So, there could be a chance that medicines could fall in to the baskets from the shelves and be inadvertently supplied to people. There was a clean sink in the back room which was used for the preparation of medicines.

The consultation room was not signposted and was also used by a chiropodist a few days a week. The room contained a couch and stools. There was no confidential information or any medicines stored in the room. During the times when the chiropodist was providing services, people were brought into another room adjoining the dispensary for private conversations. People's private information was potentially visible within this room. The pharmacy also had an area on the shop floor used by nail technicians. As far as the RP was aware the nail technicians did not have access to the pharmacy when it was closed. The nail technicians used the staff toilets which were situated behind the dispensary. The RP said that they had not read or signed any confidentiality agreements. The technicians had to walk through the dispensary to access the toilets, and this was seen to happen twice during the inspection. This could mean that they could potentially see people's personal information. The pharmacy manager understood that the people using the pharmacy services used the toilet upstairs. But the RP confirmed that people who were required to provide a urine sample for some of the sexual health services also used the toilets behind the dispensary. The RP said that she would look through the service level agreement for the sexual health services to see if people could provide the sample for testing from home.

The premises were kept secure from unauthorised access when the pharmacy was closed.

The room temperature was appropriate for the for the provision of pharmacy services. And lighting was good throughout the pharmacy. Air conditioning was available to help regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are largely delivered in a safe and effective manner. The pharmacy obtains its medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use.

Inspector's evidence

The pharmacy was easily accessible and had a step-free, wide front entrance. There was easy access to the medicines counter. The team members said that there were a number of elderly people using the pharmacy and they would assist them if they needed help. There was a seating area at the front for people waiting for their prescriptions. The pharmacy had medicine packs with braille and had the ability to produce large print dispensing labels. The team were multilingual, speaking a range of South-Asian languages and Romanian. The team also used translation applications were necessary if people did not speak English. A private GP practice was situated upstairs and was accessible through the pharmacy or via a separate side entrance. The RP was unsure of what the arrangements to access upstairs were. The practice was registered with the Care Quality Commission.

A list of the services provided by the pharmacy was displayed in the window of the pharmacy. Team members were aware of the need to signpost people to other providers. Team members used the internet to find other services if they were not familiar with the details.

The RP said that the sexual health services had the most impact on the local population as there was a large uptake of these services and a lot of people were asking for this. The flu vaccination was also popular. The RP had attended a meeting recently for pharmacists in Redbridge for the chlamydia testing and treatment service.

Services were offered on a walk-in basis. For the chlamydia testing service, the person needed to meet the criteria and complete a form. A urine sample had to be provided which was taken at the pharmacy and then sent off for testing. People needed to walk through the dispensary to access the toilet and there were a number of boxes near the toilets which could present a trip hazard. Test results were sent directly to the person. The RP said that they service had not been offered for very long, and there had not been anyone present to the pharmacy for the treatment.

Most prescriptions were received by the pharmacy electronically and were part of a repeat prescription service. The team had a reminder list of whose prescriptions need to be ordered. A log was used to audit when prescriptions were due back and received. When the prescription was received electronically it was labelled on the same day and the stock was ordered. The RP said that on the days that she worked there everything was labelled and dispensed in the morning, after which she completed all the checking by lunchtime. The cycle was repeated in the afternoon. On some occasions the RP self-checked, she said that she would leave the basket aside and go back to check this after a while.

Dispensed and checked by boxes were available on labels; these were not always initialled by team members when they were dispensing or checking. This could make it harder for the pharmacy to show who had done these tasks if there was a query. The pharmacy team used baskets to ensure that people’s prescriptions were separated, to reduce the risk of errors.

When the pharmacy received a prescription for high-risk medicines such as warfarin the RP said that she would check the strength and dispense what was on the prescriptions. For people on warfarin she said that she would only check the INR if she was carrying out a review.

The RP was aware of the change in guidance for dispensing sodium valproate and the pregnancy prevention programme. However, she was not aware of the need to use the warning stickers. The inspector reminded her of the requirements. She said that there were one or two people who fell in the at-risk group of who she had spoken to one.

People who were supplied their medicines in compliance packs were organised into weeks. The pharmacy ordered prescriptions a week in advance from the surgery. Each person on the service had an individual record which listed all the medicines they were taking. This was used to compare against the prescription when it was received. The dispenser called the surgery if there were any missing or new items after which a record was made on the person's electronic record and on the individual record sheet. Packs were prepared by the dispenser after the pharmacist had checked the medicines which had been picked. The dispenser said she sealed the trays if there were a small number of tablets in each compartment. In the event that someone was admitted into hospital the pharmacy team were called by the hospital and waited until the person's discharge information was received before new packs were prepared.

Assembled packs observed were labelled with mandatory warnings and product descriptions. There was no audit trail to show who had prepared and checked the packs. And this could make it harder for the pharmacy to show who had done these tasks if there was a query. Patient information leaflets were supplied on a monthly basis. Backing sheets were placed loosely in the packs. The dispenser said that she would ensure these were securely attached to ensure that there was no risk of these becoming misplaced.

Deliveries were carried out by a designated driver two days a week. The team member was unsure if the driver obtained signatures from people when their medication was successfully delivered. In the event that someone was unavailable, medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of medicines. CDs were kept securely.

A small number of medicines were seen to be stored on shelves in loose blisters out of their original packs. In the area used to prepare compliance packs, medicines were found stored in brown bottles. One of these had no labels and another had no indication of batch number or expiry date. This could make it harder for the pharmacy to date-check these medicines or respond to safety alerts appropriately. This was removed from the shelf during the inspection.

Date checking was completed every six months. Short dated stock was logged and marked with a black dot. No date-expired medicines were observed on the shelves checked.

The pharmacy had the equipment and software in place for the Falsified Medicines Directive (FMD). But they had not yet started using this.

Out-of-date and other waste medicines were segregated at the back of the pharmacy away from stock and then collected by licensed waste collectors.

Drug recalls were received via emails, these could be accessed by all team members. Alerts were printed and stored in a folder in the dispensary.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services.

Inspector's evidence

Several calibrated glass measures were available and clearly marked for use with methadone or antibiotics. Tablet triangles were available. A separate counter for use with cytotoxic medicines was available to avoid cross-contamination.

A fridge of adequate size was available.

Up-to-date reference sources were available including access to the internet.

The computers were password protected and most members of staff had individual smartcards to access the PMR system. Confidential waste was shredded.

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.