General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Matson Pharmacy, 87 Matson Avenue, Matson, GLOUCESTER, Gloucestershire, GL4 6LL

Pharmacy reference: 1031566

Type of pharmacy: Community

Date of inspection: 19/11/2019

Pharmacy context

This is a community pharmacy in a shopping area in the southern suburbs of the city of Gloucester. A wide variety of people use the pharmacy but they are mostly middle-aged. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It also supplies medicines in multi-compartment compliance aids to help vulnerable people to take their medicines.

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	Good practice	2.1	Good practice	The pharmacy has proactively employed an additional team member to accommodate anticipated growth. It also has good procedures to cope with sickness, holidays and busy periods, such as, Christmas.
		2.4	Good practice	The team members are encouraged to keep their skills up to date. And, those members in training are well supported.
		2.5	Good practice	The team members feel comfortable about providing feedback to their manager to improve services and this is acted on.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy offers a good range of services and people can access the services.
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 keeps the up-to-date records that it must by law. And, it is appropriately insured to protect people if things go wrong. The team members keep people's private information safe and they know how to protect vulnerable people. But, they could learn more from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team identified and managed most risks. Dispensing errors and incidents were recorded, reviewed and appropriately managed. There had been an error on 25 July 2019 where Zomorph 10mg had been supplied, in error, against prescription calling for Zomorph 100mg. A possible reason for this was said to be that the most common strength of Zomorph, was 10mg. The prescription was checked by a locum and the staff were not sure if it had been checked with the patient on hand-out as required by the company's procedures. It was reported that any future prescriptions for Zomorph 100mg will be highlighted. Near misses were recorded but insufficient information was documented to allow any useful analysis, such as a recent mistake with losartan 100mg and levothyroxine 100mcg. It had been identified as a 'look alike, sound alike' error but no other information was recorded. Few near misses were documented in the log and there were no recorded actions to reduce the likelihood of similar recurrences. The log was said to be reviewed each quarter but this was not documented.

The dispensary was limited in size. There was a labelling area but, no clear separate assembly and checking areas. One small bench was done for both activities. A small separate bench was used for the preparation of multi-compartment compliance aids. The staff said that a full re-fit of the pharmacy was planned in the next few months. In the meantime, they said that they would look at utilising the small space better, such as, making a clear checking area and using shelves for baskets of prescriptions waiting to be checked in order to keep the work benches as clear as possible.

Coloured baskets were used and distinguished the prescriptions for patients who were waiting, those calling back, those for collection and those for delivery. There was a clear audit trail of the dispensing process and all the 'dispensed by' and 'checked by' boxes on the labels examined had been initialled. In addition, three independent people were usually involved in the dispensing process and this reduced the likelihood of errors.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were continually reviewed by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. The company's sales protocol was displayed and included questions to be asked of customers requesting to buy medicines and when customers should be referred to the pharmacist, such as specific patient groups and those requesting multiple sales. All codeine-containing potential sales were referred to the pharmacist. The medicine counter assistant said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. The staff were aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as chloramphenicol eye drops and Ella One and referred requests for these to the pharmacist.

The staff were clear about the complaints procedure and reported that feedback on all concerns was

encouraged. The pharmacy did an annual customer satisfaction survey. In the 2019 survey, 98% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback from 6% of people about having somewhere private to talk. The room was signposted but this was obscured by several other posters and so did not stand out. The pharmacist manger, newly appointed, said that he would move the signpost to a more prominent position.

Public liability and professional indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 31 October 2020 was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order.

There was an information governance procedure and the staff had also completed training on the new data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was shredded. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had read the SOP on safeguarding. The pharmacist and technicians had also completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers to escalate any concerns relating to both children and adults were available online. All the staff had completed ‘Dementia Friends’ training.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough staff to manage its workload. And, it has proactively employed an additional team member to accommodate anticipated growth. It also has good procedures to cope with sickness, holidays and busy periods, such as, Christmas. The team members are encouraged to keep their skills up to date. And, those members in training are well supported. The team members feel comfortable about providing feedback to their manager to improve services and this is acted on.

Inspector's evidence

The pharmacy was in a shopping area in the southern suburbs of the city of Gloucester. They mainly dispensed NHS prescriptions with the majority of these being repeats. The pharmacy also supplied medicines in multi-compartment compliance aids for domiciliary patients. Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, the manager (newly appointed), two part-time NVQ3 qualified technicians, one part-time NVQ2 qualified dispenser, one part-time NVQ2 trainee dispenser and one part-time medicine counter assistant. A trainee apprentice technician had just been appointed and it was hoped that she would become an accuracy checking technician. The pharmacist said that these staffing levels were not needed at present but that they were planning for anticipated growth. In addition, the pharmacy could call on the services of a previously employed dispenser, who had a zero hours contract and two pharmacy students. They had already secured extra cover for the busy Christmas period.

The staff were flexible and generally covered any unplanned absences. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix. A technician was always working.

The staff were well qualified and clearly worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal where any learning needs could be identified. Review dates would be set to achieve this. The staff were encouraged with learning and development and completed regular e-Learning, such as recently on ear infections and sepsis. They mainly completed this in their own time because there was no computer terminal for them to use in the consultation room and the ones in the dispensary were needed for dispensing duties. Staff enrolled on accredited courses were allocated dedicated time for learning. All the dispensary staff reported that they were supported to learn from errors. The GPhC registrants reported that all learning was documented on their continuing professional development (CPD) records. The pharmacist was studying towards the clinical diploma from Keele University.

The staff knew how to raise a concern and reported that this was encouraged and acted on. A qualified dispenser had recently raised issues with the procedures for assembled medicines. Because of this, the pharmacy now operated a numbered retrieval system. There were weekly staff meetings. All the staff were aware of the company’s whistle-blowing policy.

The pharmacist said that he was not set any formal targets. He did as many advanced NHS services as he could for the benefit of the community.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally looks professional. The work areas are small but mainly tidy and organised. The pharmacy signposts its consultation room but the sign is not prominent. So, some people may not realise that there is somewhere private for them to talk.

Inspector's evidence

The retail area of the pharmacy was spacious but the dispensing areas were limited in size. The manager said that a full re-fit of the pharmacy was planned in the next few months. In the meantime, they intended to try to make better use of the available space in order to keep the limited bench space as clear as possible. The premises were clean and well maintained.

The consultation room was small but the door opened outwards and the table could be folded and so access by the emergency services, if necessary, should not be impeded. The door contained clear glass panels and whilst these were mainly obscured by posters, it was still possible to see into the room. In addition, whilst there was a signpost to the room, this did not stand out from the other posters that were displayed on the door. The pharmacist said that he would move the sign to a more prominent position and make sure that all the clear glass was obscured. The consultation room had no sink or computer. The lack of a computer made regular e-Learning difficult in work-time (see under principle 2). Conversations in the consultation room could not be overheard. The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

The temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a good range of services. People can access the services it offers. The pharmacy services are effectively managed to make sure that they are provided safely. The pharmacy team members make sure that people have the information they need to use their medicines properly. They intervene if they are worried about anyone. The pharmacy gets its medicines from appropriate sources. The medicines are stored and disposed of safely. The team members make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was no independent wheelchair access to the pharmacy and the consultation room because of a step up. But, there was a bell to alert the staff to anyone who may need assistance entering the pharmacy. However, the pharmacy did not have a portable ramp and the staff said that lifted anyone using a wheelchair into the pharmacy. They had access to a translation application on the pharmacy computers for use by non-English speakers. The pharmacy could print large labels for sight-impaired patients.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), Community Pharmacy Consultation Service (CPCS), smoking cessation (nicotine replacement), Gloucestershire urgent repeat medicine service, Gloucestershire minor ailment service, 'just in case' boxes, needle exchange, supervised consumption of methadone and buprenorphine and seasonal flu vaccinations. The latter was also provided under a private scheme. The services were well displayed and the staff were aware of the services offered.

The pharmacist had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. He had also completed training for the new CPCS scheme and the minor ailment service. He often referred to the National Institute for Health and Care Excellence (NICE) clinical knowledge summaries (CKS) for evidence-based advice on minor ailments. The pharmacist had good clinical skills and was studying towards the clinical diploma.

Several substance misuse patients had their medicines supervised and others took their medicines home. There was a dedicated folder for all these patients where any relevant information was kept. The pharmacist recorded any concerns about these clients in the daily diary and he called the service provider every day to share any relevant information. The supervised patients were offered water or engaged in conversation to reduce the likelihood of diversion.

A number of domiciliary patients received their medicines in compliance aids. These were assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There were dedicated folders for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. These were referred to at the checking stage. The assembled compliance aids were stored tidily. Procedures were in place to ensure that all patients who had their medicines in compliance aids and were prescribed high-risk drugs, were having the required blood tests.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. Interventions were seen to be recorded on the patient's prescription medication record. Green 'see the pharmacist' stickers were used. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were asked about. The pharmacist also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. Assembled CDs were seen to have dedicated stickers which included the expiry date of the prescription. All the staff were aware of the new sodium valproate guidance. Two patients, who may become pregnant, had been identified and counselled. Information cards were included with each prescription for these people.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Potential non-adherence or other issues were identified at labelling, ordering and hand-out. Any patients giving rise to concerns were targeted for counselling. The pharmacist said that he often gave lifestyle advice to people during MURs, such as, on diet and exercise.

Medicines and medical devices were mainly obtained from AAH and Alliance Healthcare. Specials were obtained from Quantum Specials. Invoices for all these suppliers were available. Two scanners were available to check for falsified medicines as required by the Falsified Medicines Directive (FMD). They were not aligned to labelling at present but the pharmacist hoped that they would be when the system was upgraded. CDs were stored tidily in accordance with the regulations and access to the cabinets was appropriate. But, the space in the cabinets was small for the storage of all the assembled methadone prescriptions. There were several patient-returned CDs. These were clearly labelled and separated from usable stock but were occupying valuable space in the cabinet. The pharmacist said that he would destroy these as soon as possible. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 18 November 2019 about folic acid 5mg tablets. The pharmacy had none in stock and this was recorded. The also completed a concise audit sheet for all alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment for the services it provides. And, the team members make sure that it is clean and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 100ml) and ISO stamped straight measures (10 – 100ml). There were three tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was shredded. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.