General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Mattock Pharmacy, 163 Fosse Road North, LEICESTER, Leicestershire, LE3 5EZ

**Pharmacy reference:** 1034051

**Type of pharmacy:** Community

**Date of inspection:** 16/04/2019

## Pharmacy context

The pharmacy is situated in a residential suburb of Leicester. The pharmacy provides the standard NHS services. It dispenses NHS and private prescriptions, supplies medicines in multi-compartment compliance aids and sells over-the-counter medicines. The pharmacy was not completing quality payments. It was not a healthy living pharmacy and had not provided the flu vaccination service the previous year.

## 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 not all met | 1.2 | Standard not met | The pharmacy team doesn't record dispensing errors or near misses. So team members may not be aware of previous mistakes or understand how to stop the same errors happening again. |
| | | 1.7 | Standard not met | The pharmacy didn't have information governance procedures in place to keep people's personal information safely. |
| | | 1.8 | Standard not met | The pharmacy team members have not been trained in how to protect vulnerable people. The pharmacy didn't have contact details for organisations whose role it is to protect vulnerable people. |
| **2. Staff** | Standards not all met | 2.2 | Standard not met | The apprentice dispenser was not receiving appropriate support and training. Other staff don't have formal training plans or set aside times to keep their knowledge and skills up to date. This could affect how well the pharmacy cares for people and the advice that it gives. |
| | | 2.4 | Standard not met | The pharmacy didn't have a culture of openness, honesty and training. |
| **3. Premises** | Standards met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Standards not all met | 4.4 | Standard not met | The pharmacy doesn't keep records of the actions it takes in response to safety recalls. It was unable to show that it takes the right actions to protect people's health and wellbeing. |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance **Standards not all met**

### Summary findings

The pharmacy has not reviewed its written procedures since 2017 and not all the pharmacy team have read them. This increases the risks of tasks being undertaken in ways that are not good practice. The pharmacy team doesn't record dispensing errors or near misses. So team members may not be aware of previous mistakes or understand how to stop the same errors happening again. The pharmacy didn't have information governance procedures in place to keep people's personal information safely. The pharmacy team have not been trained in how to protect vulnerable people. The pharmacy didn't have contact details for organisations whose role it is to protect vulnerable people.

### Inspector's evidence

The current pharmacist had only been working at the pharmacy for two weeks and was only able to reflect on the practice he had introduced over that time.

The Responsible Pharmacist (RP) notice showing the pharmacist in charge of the pharmacy was displayed. It was a paper notice hanging at an angle which didn't present a professional image.

The Standard Operating Procedures (SOPs) had been due review in 2017. The pharmacist said that he had contacted the superintendent asking for the up-to-date SOPs. Not all staff had signed the SOPs to show that they had read them. The SOPs didn't cover some of the more recent changes in pharmacy practice with no SOP on accessing electronic patient summary care records or how to manage prescriptions sent electronically rather than on paper.

The dispensary apprentice had some understanding of the standard questions to be asked when selling an over-the-counter medicine and said that she referred to the pharmacist when people were taking other medicines. She had a very limited product knowledge. She knew that prescriptions for most medicines were valid for 6 months and that prescriptions for Controlled Drugs (CDs) were valid for 28 days. She was aware that tramadol and diazepam had a 28-day validity, she said these prescriptions were highlighted so that she could easily see them when she was giving out the medicine. She also knew that pregabalin had become a Schedule 3 CD. However, the pharmacy did not have a sufficiently robust way of making sure that CDs were only supplied within 28 days of the date of the prescription. A dispensed prescription waiting collection for testosterone was not highlighted and was dated January 2019. The prescription was now out of date and couldn't be given to a patient. Prescriptions for diazepam and gabapentin were seen that had not been marked to indicate that they had a 28-day validity.

An audit trail was created using dispensed by and checked by boxes. The final check was by the RP. The pharmacy had an SOP for managing errors/incidents and near misses. There were no records available for errors. The dispenser said that when the previous pharmacist had found a near miss it had been corrected but no other action was taken. The present pharmacist said he had found one near miss while working at the pharmacy. He had verbally discussed the near miss with the dispenser, but no record had been made.

The pharmacy had the appropriate records to support the safe delivery of pharmacy services. These included the RP log, private prescription records and the controlled drug register. CDs were stored in a

legally compliant CD cabinet. A random check of the recorded running balance of a CD matched the actual stock in the CD cabinet. Date expired stock were clearly separated and awaited destruction. CDs had been balance checked in April 2019 but prior to that audits were erratic with only two running balance audits seen in 2018. The SOP said that running balances should be audited at least every two months. Patient returns had been destroyed in April 2019.

There was a complaints procedure in place; staff resolved the matter if possible or referred to the pharmacist when required. The last patient satisfaction survey had taken place in April 2018. Over 90% of patients were satisfied with the service provided.

The public liability and professional indemnity insurance certificate on display had expired in April 2016. The pharmacist contacted the insurer and obtained an up-to-date certificate with an expiry of April 2019.

Computer terminals in the dispensary were positioned so that they couldn't be seen by people using the pharmacy. Access to the electronic patient medication record (PMR) was password protected. Confidential paper work was mainly stored securely. But some confidential paperwork was stored in drawers in the consultation room. This information might be accessible to people visiting the pharmacy. However, the consultation room was locked to prevent unauthorised access. Confidential waste was shredded.

The pharmacist said that he hadn't seen the standard NHS Information Governance toolkit or any confidentiality agreements with staff. The pharmacist was aware of safeguarding requirements; he had completed appropriate training. But there were no local contact details available if they needed to raise a concern and staff said they hadn't completed safeguarding training.

## Principle 2 - Staffing **Standards not all met**

### Summary findings

The pharmacy team adequately manages the workload within the pharmacy. The apprentice dispenser was not receiving appropriate support and training. Other staff don't have formal training plans or set aside times to keep their knowledge and skills up to date. This could affect how well the pharmacy cares for people and the advice that it gives. The pharmacy didn't have a culture of openness, honesty and training.

### Inspector's evidence

The pharmacy displayed who the RP in charge of the pharmacy was. The RP record showed who the RP in charge of the pharmacy had been. The pharmacy had enough staff to manage its workload safely. During the inspection there was one pharmacist, one dispensing assistant and an apprentice dispenser.

The apprentice dispenser said that she had been at the pharmacy since August 2018. She had received informal training from the superintendent who visited regularly and other team members. But she hadn't received any training or training booklets from the training provider. The current pharmacist was making arrangements for her to change to another provider so that she would receive appropriate training and support.

The second dispenser said that she had received some informal training from the pharmacist but hadn't had any more formal or structured training. She said that she hadn't had an appraisal for around three years.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy keeps its premises safe, secure and maintained appropriately. The pharmacy design protects people's privacy. The premises are secure from unauthorised access during working hours and when closed.

### Inspector's evidence

The dispensary was a reasonable size for the services provided, with an adequate dispensing bench available for the assembly of medicines and reasonable space for the storing of medicines. On arrival the bench was cluttered and a little messy. This reduced the work space available and made dispensing less safe. The dispensary shelves were a little dusty; there was a sink with hot and cold water.

The pharmacy was an appropriate temperature for the storage of medicines; lighting was sufficient. There were boxes on the floor which created a trip hazard.

A good size sound-proofed secure consultation room was available to ensure patients could have confidential conversations with pharmacy staff. But the room was very untidy; at the time of inspection it was being used to store boxes of medicines. This gave it an unprofessional look and made it unsuitable for consultations. The consultation room was locked during the inspection.

Computer screens were set back from and face away from the counter. Access to the electronic patient record (PMR) was password protected. Unauthorised access to the pharmacy was prevented during working hours and at night.

## Principle 4 - Services **Standards not all met**

### Summary findings

The pharmacy generally provides its services safely and effectively. Its team members are helpful and give appropriate advice to people. The pharmacy obtains its medicines and medical devices from reputable sources. It generally stores them safely. The pharmacy doesn't keep records of the actions it takes in response to safety recalls. It was unable to show that it takes the right actions to protect people's health and wellbeing.

### Inspector's evidence

The pharmacy was within a row of shops. There was a push pull door and flat access to provide reasonable access for a wheelchair or those with physical disability. There was a clear route to the dispensary counter. The opening hours and services were displayed on the window but there was no patient information leaflet available. The pharmacist understood the signposting process and used local knowledge to direct people to the correct service.

The pharmacist said that he gave advice to people on a range of issues. This included new medicines and changes in dose. He was giving advice on high risk medicines such as warfarin and recording people's INRs in their electronic records. He understood the risks with sodium valproate and knew most of the advice that should be given to people in the at-risk group. Patient information and leaflets for sodium valproate were available.

The pharmacy used a dispensing audit trail which included use of dispensed by/checked by boxes. The pharmacy also used baskets during the dispensing process to reduce the risk of error.

There were separate areas for the assembling and checking of prescriptions. Work was prioritised based on whether the prescription was for a person who was waiting or calling back.

The pharmacy didn't record the date of opening on all liquid medicines to make sure that they were still safe to be used. The date of opening should be recorded to make sure that medicines are suitable to be supplied.

People with a multi-compartment compliance aid had their medicines recorded on a chart so that medicines could be put in the correct time of day. Any changes in the prescription were checked with the surgery before supply. Medicines seen on the record were crossed through which made the chart harder to read. But the date of any changes was recorded which was good practice. The compliance aid seen didn't have the colours and shape of the medicine which meant that they were less easily identifiable.

The pharmacy provided a delivery service. People signed to say they had received the medicine to create an audit trail. Records showed that medicines that required cold storage were stored correctly between 2-8 degrees Celsius. The current temperature on the thermometer was within the required range but the maximum/minimum figures weren't working. The pharmacist said that he had problems with the thermometer and would get a new one.

Stock medicines were stored in their original containers on the shelf, fridge or CD cabinet as

appropriate. Medicines on the shelves were stored tidily. The dispenser explained that date checking had been carried out informally with a check on dispensing. The pharmacy had just completed a date check and had found a substantial quantity of out of date stock on the shelves. The pharmacist said he was introducing routine date checking. A short check of stock medicines didn't show any out-of-date medicines.

CDs were stored in a cupboard that complied with legal requirements. Only recognised wholesalers were used for the supply of medicines. The pharmacist was aware of the procedure for drug alerts. But the newest record in the alert folder dated back to November 2017. There was no evidence that appropriate action had been taken so the pharmacist said he would review the alerts after this date to make sure there was no stock on the shelves.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has access to the appropriate equipment and facilities to provide the services it offers. It generally adequately maintains the equipment and facilities that it uses.

### Inspector's evidence

The pharmacy used crown marked measures for measuring liquids. Separate measures were used for methadone. There were a couple of measures that were not stamped; the pharmacist said he would stop using these. The pharmacy had an up-to-date reference sources.

Waste medicines were separated appropriately. The fridge was in working order with the current temperature within the required range; temperatures were recorded daily. CDs were stored in accordance with legal requirements.

The pharmacy said that it had Falsified Medicine Directive compliant scanners in place but had not started using them. There was no evidence that the pharmacy carried out any safety testing for its electrical equipment.

## 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. |