General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Monarch Chemists Ltd, 318-326 Radford Road, COVENTRY, West Midlands, CV6 3AA

**Pharmacy reference:** 1038294

**Type of pharmacy:** Community

**Date of inspection:** 28/02/2024

## Pharmacy context

This is a community pharmacy located opposite a medical centre in Coventry, West Midlands. The pharmacy dispenses NHS and private prescriptions. It offers the New Medicine Service (NMS), seasonal flu vaccinations, blood pressure testing, the Pharmacy First Service, phlebotomy services and local deliveries. The pharmacy also supplies many 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

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 met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Standards met | 4.2 | Good practice | The pharmacy is good at providing its services in a safe way. |
| | | 4.3 | Good practice | The pharmacy actively ensures stock is stored and managed well. |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance ✔ Standards met

### Summary findings

The pharmacy suitably identifies and manages the risks associated with its services. Team members understand their role in protecting the welfare of vulnerable people. The pharmacy protects people's private information appropriately. And the pharmacy largely keeps the records it needs to by law. Members of the pharmacy team deal with their mistakes responsibly. But they are not always documenting and formally reviewing the necessary details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future.

### Inspector's evidence

The pharmacy had a range of documented standard operating procedures (SOPs) to provide guidance for the team to carry out tasks correctly. They had been read by the staff and this was work in progress for the very newest member of the team. Team members understood their roles and responsibilities. They knew which activities could take place in the absence of the responsible pharmacist (RP) and referred appropriately. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

The pharmacy had systems in place to identify and manage risks associated with its services. Team members described paying attention when dispensing and during the accuracy checking process. A three-way check of the details on the prescription, generated dispensing label and medicine took place before medicines were passed to the pharmacists for the final accuracy-check. Staff also concentrated on one task at a time, were observed to minimise conversations to prevent distractions and worked in designated areas. Multi-compartment compliance packs were assembled in a separate area which was to one side of the main dispensary activity. This helped minimise distractions. Team members also wore gloves when assembling compliance packs. The pharmacy had a complaints as well as an incident management policy.

The RP's process to handle dispensing errors which reached people was suitable and in line with the pharmacy's procedures. This involved appropriate handling of the situation, formal reporting, and investigation to identify the root cause. Staff routinely recorded mistakes that occurred during the dispensing process (near miss mistakes). The details were collated and regularly reviewed by the regular pharmacist which helped identify any trends or patterns. The findings were subsequently discussed with the team to raise awareness. However, some gaps were seen in the near miss records, the details were reviewed informally with no information seen recorded. This could make it harder to spot patterns and trends.

The pharmacy had processes to ensure people's confidential information was protected. Staff described ensuring that no confidential material was left on the front counter. Bagged items waiting collection could not be viewed by people using the pharmacy and the team separated confidential waste from normal waste. This was disposed of securely. The pharmacy's computer systems were password protected and staff used their own NHS smartcards to access electronic prescriptions. Pharmacists had been trained to level three to safeguard the welfare of vulnerable people. Members of the team could recognise signs of concern; they had been trained appropriately although a few newer members of the team required refresher training. The pharmacy had contact details available for the local safeguarding agencies so they could refer suitably in the event of a concern.

The pharmacy's records were largely compliant with legal and best practice requirements. This included a sample of registers seen for controlled drugs (CDs). On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Checks to verify the balance of CDs were made and recorded regularly. Records of CDs that had been returned by people and destroyed at the pharmacy were kept. The pharmacy had suitable professional indemnity insurance arrangements in place. The RP record, records about supplies of unlicensed medicines and emergency supplies had all been appropriately completed. However, on occasion, incomplete details about prescribers had been documented within the electronic private prescription register. The superintendent pharmacist (SI) was aware of this situation and had taken steps to help amend this.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has plenty of staff to manage its workload safely. Members of the pharmacy team are suitably qualified for their roles. They understand their roles and responsibilities well. And they can confidently make suggestions to improve the pharmacy's working practices. This has made internal processes more efficient. Team members have access to resources so that they can complete regular and ongoing training. But this is not always delivered in a structured way, which may make it harder for them to keep their skills and knowledge up to date.

### Inspector's evidence

The pharmacy team consisted of two regular pharmacists, eight trained dispensing assistants, a trained phlebotomist who only provided this service, two part-time delivery drivers and a very new member of staff who was imminently due to undertake an apprenticeship. The SI was also present at the inspection and worked alongside the pharmacists when needed. The team's certificates of qualifications obtained were seen and their competence was demonstrated. This was a very busy pharmacy. The pharmacy had plenty of staff to support the workload and the team was up to date with this. Staff wore uniforms and some were long-standing as well as experienced members of the team.

The apprentice asked relevant questions before selling medicines. She was aware of medicines which could be abused or had legal restrictions and sales of these medicines were monitored. Staff knew when to refer to the pharmacist appropriately. Their performance reviews were said to be an informal process and discussions took place regularly. Team members communicated verbally and via an electronic messaging application. They had access to resources for ongoing training through pharmacy support organisations. This helped members of the pharmacy team to keep their knowledge up to date, but the training was not delivered or monitored in a structured way.

Staff were also able to feedback and improve on the pharmacy's internal processes, suggestions were incorporated and helped improve the pharmacy's internal processes. Examples included changes to the delivery process. Previously, a spreadsheet had been used to keep records of this service. Team members suggested that this needed updating. In response, a specific electronic application was implemented which generated and used QR codes, provided the driver with lists and optimal routes as well as giving 'live' information to the pharmacy team. This meant that staff could now track and verify deliveries at the point at which they occurred.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy's premises provide a suitable environment to deliver services from. The pharmacy is professionally presented and secure. And people can have a conversation with a team member in a private area.

### Inspector's evidence

The pharmacy’s premises were presented professionally. The pharmacy was clean and tidy with modern fixtures and fittings. The retail area was spacious. 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 inspector was informed that the pharmacy was due to be re-fitted imminently. The dispensary had enough space for staff to carry out dispensing tasks safely and dispensing benches were kept clear of clutter. There was a clean sink in the dispensary for preparing medicines which had hot and cold running water. The pharmacy had two separate consultation rooms in the shop area which were used to hold private conversations and provide services. One room was used only for phlebotomy services. The rooms were of an appropriate size and clearly signposted. They were also accessible for people using wheelchairs. Conversations at a normal level of volume could take place inside without being overheard.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides its services safely and effectively. Members of the pharmacy team can show that the pharmacy's services result in positive outcomes for the local community. People with undiagnosed high blood pressure, prescribed new medicines or recently discharged from hospital are identified, monitored, and suitably counselled. This makes them better informed about their medicines. Team members help ensure that people with a range of needs can easily access the pharmacy's services. The pharmacy obtains its medicines from reputable sources, and it stores as well as manages them well.

### Inspector's evidence

The pharmacy had been providing services to the local community for the past 40 years and was a family-run business. The RP had also worked at the pharmacy for over 20 years. Team members therefore knew the people who used their services well and the SI described effective communication as well as useful links with the local GP surgeries and integrated care services. This ensured they provided a consistent service. The pharmacy was open Monday to Friday and the pharmacy's services as well as its opening times were clearly advertised. The pharmacy had information and leaflets on display to promote health. People could enter the pharmacy through the front door which was powered and step-free. The retail area consisted of clear, open space. This helped people with restricted mobility or using wheelchairs to easily access the pharmacy's services. Team members explained that they served people with different needs. The team said that speaking clearly helped people to lip read and written communication was used for people who struggled to hear easily. Staff were also multilingual and used Google translate if needed.

The workflow involved prescriptions being prepared by staff in one area before the pharmacists checked medicines for accuracy from another section. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. The baskets were also colour coded which helped identify priority. After the staff had generated the dispensing labels, there was a facility on them which helped identify who had been involved in the dispensing process.

Once prescriptions had been assembled, checked for accuracy, and bagged, they were stored in a separate sections and drawers. When people arrived to collect them, their location was accessed using the pharmacy's system. Dispensed CDs and temperature-sensitive medicines were stored within clear bags. This helped to easily identify the contents upon hand-out. Staff used stickers to identify certain medicines or specific situations. This included fridge lines, CDs, if pharmacist intervention was required and for prescriptions with higher-risk medicines such as methotrexate, warfarin, and lithium. 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 identified people in the at-risk group who had been supplied this medicine.

People's medicines were delivered to them, and the team kept records about this service through a specific application. 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.

The pharmacy supplied medicines inside compliance packs to many people who lived in their own homes, after this was considered necessary and an assessment had taken place. This helped people to manage their medicines more effectively. The team ordered prescriptions on behalf of people. They identified any changes that may have been made, maintained individual records to reflect this and queried details if required. The compliance packs were sealed as soon as they had been prepared. Descriptions of the medicines inside the packs were provided and patient information leaflets (PILs) were routinely supplied. Medicines were de-blistered into the compliance packs except for finasteride which was supplied within its outer packaging. The pharmacy team could justify this practice and had taken reasonable steps to help mitigate the risks associated with this. This included documenting relevant details.

The pharmacy offered a range of useful services. This included a very busy phlebotomy service, the Discharge Medicines Service (DMS), free blood pressure (BP) checks, the New Medicines Service (NMS) and Pharmacy First. The RP explained that the pharmacy had identified errors from the hospital through the DMS, when people had been discharged and that the person's GP often did not receive the relevant information. Staff therefore tended to contact people and the GP to ensure the right medicine(s) were subsequently prescribed as well as waiting for the repeat prescription to confirm changes.

People could have their BP checked and their ambulatory BP could be monitored and checked over a 24-hour period through the pharmacy. The results were then sent to the GP surgery. The second pharmacist explained that this service was appreciated as it had identified people with undiagnosed BP and people often returned with prescriptions for prescribed medicine(s). However, the pharmacy team was not always informed about the outcome if people were referred to them directly through the GP.

The RP explained that the NMS was beneficial to people. This service had helped identify side effects associated with certain medicines where specific organs (such as the liver or kidneys) had been independently affected. This resulted in the medicine being changed. The RP had successfully advised, face-to-face, on inhaler technique for people with asthma. The service had also highlighted that people had not been taken their medicines correctly, dosages for new as well as existing medicines were therefore routinely reinforced.

The pharmacy had also begun providing the recently commissioned Advanced NHS service, Pharmacy First Service. The service specification and Patient Group Directions (PGDs) to authorise this were readily accessible and had been signed by the pharmacists. Suitable equipment was present which helped ensure that the service was provided safely and effectively (see Principle 5). The pharmacists had also been trained on how to use them. People had received medication for certain conditions under this service and referrals from GP practices were now being seen. The pharmacy had experienced some initial challenges when the service first started and had actively reached out to the NHS and the local GP surgery to help resolve them.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. It had considered how best to store its stock and this involved planning ahead and regularly reviewing how the stock was stored. The pharmacy stored its medicines in a very organised way. The pharmacy used an automated system (robot) to store and dispense medicines. The SI explained that because this was an older model, the robot only stored packs of medicines which were of a specific size. The pharmacy's stock was therefore stored in specific ways. The owners had created a mini but spacious warehouse to one side of the dispensary. This contained separate sections of excess stock, each medicine was clearly labelled and very well arranged so that stock could be easily located. Split packs of medicines were stored in

designated drawers near the dispensing area which were used by staff when needed and other stock such as liquids and bulky items were also kept in clearly defined and labelled areas. There was also an 'overflow' section. Staff explained that orders were checked before being sent to the wholesalers to help manage stock levels.

The team checked medicines for expiry regularly and kept records of when this had taken place. Short-dated medicines were routinely identified and on randomly selecting some of the pharmacy's stock, there were no medicines seen which were past their expiry date. Liquid medicines, when opened were marked with the date they were opened. This helped to determine stability when dispensing them in the future. CDs were stored securely and the keys to the cabinet were maintained in a way which prevented unauthorised access. Fridge temperatures were checked daily. Records verifying this and that the temperature had remained within the required range had been appropriately completed. Out-of-date and other waste medicines were separated before being collected by licensed waste collectors. Medicines which were returned to the pharmacy by people for disposal, were accepted by staff, and stored within designated containers in a specific, designated area. This was a secure area and included sharps or needles provided they were within sealed bins. Lists identifying hazardous and cytotoxic medicines were also on display in this area. This helped staff to clearly separate these medicines. Drug alerts were received electronically. 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 necessary equipment and facilities it needs to provide its services safely. Its equipment is suitably clean. And team members use them appropriately to keep people's private information safe.

### Inspector's evidence

The pharmacy's equipment was suitable and kept very clean. This included standardised conical measures for liquid medicines, triangle tablet and capsule counters. Staff wore gloves when preparing compliance packs. The pharmacy had an appropriately operating pharmacy fridge, legally compliant CD cabinets, a shredder and access to current reference sources. Additional equipment for the pharmacy's services included an otoscope, tongue depressors, a torch and BP machines, including ones to measure ambulatory BP. The latter were new. Portable telephones and headsets helped conversations to take place in private if required. The pharmacy's computer terminals were password protected and their screens faced away from people using the pharmacy. This helped prevent unauthorised access.

## 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. |