General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Frank Mays Pharmacy, 30 Barking Road, East Ham, LONDON, E6 3BP

Pharmacy reference: 1040051

Type of pharmacy: Community

Date of inspection: 09/01/2020

Pharmacy context

The pharmacy a family-run business which is located on a busy road near to East Ham town centre and it is in a largely residential area with many shops. The people who use the pharmacy are mainly older people and younger families. The pharmacy receives around 90% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service, travel vaccinations, influenza vaccinations and emergency hormonal contraception. It also provides medicines as part of the Community Pharmacist Consultation Service. And it supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. It also provides substance misuse medications to a small number of people.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. It mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people. They record and review their mistakes so that they can learn and make the services safer.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. The superintendent (SI) pharmacist could not find all the required SOPs during the inspection. Following the inspection, the SI sent copies of them to the inspector. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The superintendent (SI) pharmacist explained that the pharmacy had previously highlighted where certain medicines were kept, but with the refit these stickers had been removed. He said that this system would be re-implemented once the near miss log had been reviewed. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. The SI said that there had not been any recent dispensing incidents reported to the pharmacy.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The pharmacy technician said that only her and the SI had keys to the pharmacy. She said the pharmacy would not open without the pharmacist being present. She knew that she should not carry out any dispensing tasks, sell medicines or hand out dispensed items if there was no responsible pharmacist (RP). The trainee medicines counter assistant (MCA) said that she would not hand out any dispensed items or sell pharmacy-only medicines if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed medicine was made. And the private prescription records were completed correctly. There were signed in-date Patient Group Directions available for the relevant services offered. And the RP log was completed correctly and the right RP notice was clearly displayed. Controlled drug (CD) registers examined were filled in correctly. The CD running balances were checked at regular intervals and liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The SI said that not all emergency supplies had been recorded in the book.

This could make it harder for the pharmacy to show who a medicine was supplied to or the reason it was supplied if there was a query. He said that he would ensure that all emergency supplies were recorded in the future.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could be viewed by people using the pharmacy, but people's personal information was protected. Team members had completed training about the General Data Protection Regulation

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website. Results were positive and over 98% of respondents were satisfied with the pharmacy overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The SI said that there had not been any recent complaints.

The pharmacist and pharmacy technician had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The trainee MCA said that she had undertaken some safeguarding training, but she was not confident with who might be classed as vulnerable. She said that she would refer any concerns to the pharmacist. The SI said that there had not been any safeguarding concerns at the pharmacy. He confirmed that he would ensure that team members knew how to identify vulnerable people. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. And they can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist, one pharmacy technician and two trainee MCAs working during the inspection. The trainee MCAs had been enrolled on an accredited course for their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The SI and pharmacy technician were aware of the continuing professional development requirement for the professional revalidation process. Recent training included; risk management, sepsis, safeguarding vulnerable people and 'look alike and sound alike' medicines. The pharmacist said that once the trainee MCAs had completed their course, they would be enrolled on a dispenser course. He said that they were also provided with booklets about over-the-counter medicines. The SI kept training records for team members and he monitored this. And team members had regular reviews of any dispensing mistakes and discussed these openly in the team. The SI said that he felt able to take professional decisions. He had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members underwent yearly appraisals and performance reviews and these were documented. Team members felt comfortable about discussing any issues with the SI or making any suggestions. The SI explained that there were no formalised team meetings, but any issues were discussed as a team as and when they happened. Information was passed on informally during the working day. Targets were not set for team members. The SI said that he carried out the services for the people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. The pharmacy had recently undergone a refit to increase the size of the dispensary and this created more workspace for dispensing. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available; the room temperature was suitable for storing medicines.

There were three chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. There was a finned section at the medicines counter which was designated for ‘prescriptions and collections’. This helped the counter staff to serve people who wanted to purchase medicines over the counter while others waited to collect prescription items.

A large consultation room had been built during the refit. The SI explained that this was so that the pharmacy had a room suitable for providing enhanced services. The room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services and the languages spoken by team members helps some of the local population. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. The SI and pharmacy technician could speak other languages. This helped people in the local community access the services. Services and opening times were clearly advertised and a variety of health information leaflets was available. Prescriptions waiting to be dispensed were kept in alphabetical order, this helped team members locate the prescriptions when people came to collect their medicines.

The SI said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin where possible. He explained that he discussed any side effects with people and checked whether they were taking any medicines which they had bought over the counter. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacy had recently carried out an audit for people taking methotrexate. The SI said that he had identified people who had been supplied methotrexate and he had not had to refer any of them to their GP. He explained that if a person requested to a prescription for warfarin, then the pharmacy would make a copy of their monitoring record book and give this to the surgery when the request was submitted. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The SI said that he would ensure that prescriptions for higher-risk medicines and Schedule 3 and 4 CDs were highlighted in the future. The SI said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had some valproate patient information leaflets available, but these were not the updated version. The SI said that he would order replacements from the manufacturer. Most of the medicine boxes for valproate had the warning cards attached.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked frequently and this activity was recorded. Stock due to expire within the next few months was marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions

were kept at the pharmacy until the remainder was dispensed but not collected. The SI said that he would ensure that prescriptions were kept at the pharmacy until all items had been supplied in the future. The pharmacy technician said that uncollected prescriptions were checked monthly. Items remaining uncollected were returned to dispensing stock where possible and uncollected prescriptions were returned to the NHS electronic system or kept at the pharmacy. The pharmacy kept a record of all uncollected items so that people could be informed about what had happened to their medicines.

The SI said that the pharmacy would refer people to their GP if they requested to have their medicines in multi-compartment compliance packs. He said that the GPs would carry out assessments to show that the packs were needed. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacy technician said that people had been asked to contact the pharmacy one week before their medicines were due, to let the pharmacy know which medicines they required. She explained that the pharmacy would contact the person to check before ordering any of their medicines. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had checked each pack. But the pharmacy technician had not initialled the packs checked by the inspector. This could make it harder for the pharmacy to identify who had done these tasks and limit the opportunities to learn from any mistakes. The backing sheets were not attached to the trays. This could increase the chance of them being misplaced. Detailed medication descriptions were put on the packs to help people and their carers identify the medicines, but patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The pharmacy technician said that she would initial the packs she had assembled in the future and she would ensure that the backing sheets were attached. She would also ensure that the relevant patient information leaflets were supplied.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by one of the team members. This service was only offered to those people who could not access the pharmacy themselves. The pharmacy did not obtain people's signatures for deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. The SI said that deliveries were usually made during the working day, but he would check that the person was in before attempting a delivery after the pharmacy was closed so that items would not have to be returned to the pharmacy.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The pharmacist and pharmacy technician had undertaken some training on how the system worked, but the dispenser had not yet done the training.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Separate liquid measures were marked for methadone use only. Triangle tablet counters were available and clean; a separate counter was marked for methotrexate/cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The SI said blood pressure monitor had been in use for around two years. He said that this would be replaced in line with the manufacturer's recommendations. The shredder was in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked. The thermometer in the small fridge in the dispensary was not a digital type so it would be difficult for the pharmacy to exactly know the temperature if it was over 8 degrees Celsius, and the maximum would not reset. The pharmacy technician said that she would order a digital thermometer. The temperatures showing on the thermometer on the day of the inspection were within the recommended range.

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.