General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Munro Pharmacy, 303 Green Street, Upton Park, LONDON, E13 9AR

Pharmacy reference: 1040164

Type of pharmacy: Community

Date of inspection: 04/06/2019

Pharmacy context

This is a community pharmacy situated on a busy high street. It serves a diverse local community. The pharmacy dispenses NHS prescriptions. It also supplies medicines in multi-compartment compliance aids to help people take their medicines. And it offers other services including a delivery service, flu vaccinations, and an anticoagulant clinic.

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

The pharmacy generally manages risks well to make sure people are kept safe, for example, by carrying out risk reviews. But it does not always record mistakes that occur during the dispensing process. This may mean that staff are less able to spot patterns in mistakes and they may not always understand how to prevent similar mistakes in future. The pharmacy largely keeps the records it needs to by law. And it protects people's personal information.

Inspector's evidence

Apart from the medicine counter assistant (MCA), all other regular members of the team were away from the pharmacy at the time of inspection. Both locum pharmacists did not know where the pharmacy's standard operating procedures (SOPs) were and had not read them. One of the regular pharmacists joined the inspection at a later stage and found them. She said she would remind locum pharmacists to read them when they covered at the pharmacy. The pharmacist said that members of the team had read the SOPs, but none had been signed by the current members of the team. She said that another signed set was available, but it may have been taken by the superintendent pharmacist (SI) for review.

Baskets were used throughout the dispensing process. This helped prevent transfer between people's prescriptions. Workbenches were clean and generally tidy.

A communication diary was in place and some notes had been left for the locum pharmacists, such as the relevant passwords, location of certain items and a list of tasks to be completed. Notes had been made for any part-dispensed prescriptions so that the locum pharmacists were clear on what to do with them.

Both locum pharmacists did not know where they could record near misses. A near miss log was later found by the regular pharmacist. She accepted that not all near misses were captured as only one near miss had been recorded in 2019. The pharmacist said that near misses were discussed with the team and some changes had been made to reduce the likelihood of their reoccurrence. For example, shelf-edge labels were used to highlight some medicines, such as bisoprolol, Qvar inhalers, esomeprazole, lamotrigine and imipramine.

A risk review had recently been conducted and this had identified four risks: patient's medication bags placed on the pharmacy floor, locum pharmacists forgetting to leave the CD keys behind, Qvar Easi-breath inhaler picked instead of Qvar aerosol inhaler, and measuring cylinders not clearly marked for their uses. Action to be taken was documented and there was evidence it had been completed. This included making an 'end of day' list for locum pharmacists to remind them where to leave the CD keys, reviewing the storage of Qvar inhalers, keeping the dispensary floor clear and marking measures for their intended use.

A patient safety report had also been completed in January 2019. The regular pharmacists had reviewed work space, processes and task delegation. The pharmacists had redistributed responsibilities between the two dispensers to more evenly spread the workload The retrieval system had also been reviewed;

prescriptions were now filed in alphabetical order so that members of the team could find the medicines more efficiently. Owings were now being stored in a separate tub and this enabled the team to follow them up in a timely manner.

Dispensing errors were documented and reported on the National Reporting and Learning System. The team had separated two strengths of a medicine which had similar packaging following a dispensing error.

The indemnity insurance certificate displayed at the pharmacy had expired. The provider was contacted, and they confirmed that in-date indemnity insurance was in place. The correct responsible pharmacist (RP) sign was displayed in the retail area and samples of the RP register examined were generally in order.

Private prescriptions and emergency supplies were generally in order but the date on which the private prescription was written was not always documented in the private prescription record for some entries checked. The pharmacy had not dispensed unlicensed medicines for some time; previous records for these were completed in line with MHRA requirements.

Controlled drug (CD) balance audits were conducted at irregular intervals; the last check was done in March 2019 and in August 2018 prior to that. The regular pharmacist said that she would introduce more frequent balance checks. A random stock check of a CD agreed with the recorded balance. There was a large amount of expired stock; the pharmacist had contacted the CD Accountable Officer to arrange for their destruction.

The complaints procedure was displayed in the retail area. Feedback was sought from people via annual Community Pharmacy Patient Questionnaires (CPPQ). The pharmacist said that the patient medication record (PMR) system and a book were now being used to keep track of repeat orders. This allowed members of the team to chase up repeat requests which had not been received back in time, following some feedback about missing items.

The MCA could not remember if she had completed training on the General Data Protection Regulation (GDPR). The regular pharmacist said that members of the team had been verbally briefed about GDPR but had not completed any formal training on protecting people's personal information. A folder which contained information governance policies and guidance on GDPR was later found but only one of the regular pharmacists had signed these to confirm they had read them. The pharmacist said she would ask all members of the team to read and sign the guidance and policies. Confidential waste was shredded at the pharmacy. The MCA was observed handing medication out whilst it was still in the basket; the medication was visible to people waiting near the medicines counter. The regular pharmacist said she would review the procedure for handing out dispensed medicines and brief the team. Computers were password-protected and access to the PMR system was via NHS Smartcards, but these were shared.

The pharmacist said that all dispensary team members had completed the safeguarding module from the Centre of Pharmacy Postgraduate Education (CPPE). The medicine counter assistant (MCA) had not received any training on safeguarding and could not describe signs of neglect. So, she may not know how to respond to concerns properly. The pharmacist said she would be providing training for all counter assistants.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff and the team members are trained for the jobs they do. Members of the team are provided with training resources and have time set aside to complete them. This helps them keep their skills and knowledge up to date.

Inspector's evidence

During the inspection there were two locum pharmacists and an MCA. The two regular pharmacists, two dispensers and the trainee technician were all off. One of the regular pharmacists was contacted and joined the inspection at a later stage. All members of the team had completed accredited training.

One of the locum pharmacists had worked twice at the pharmacy, in the last year. The second locum pharmacist had not worked at the pharmacy before. The MCA was the only regular member of staff present and she was not involved in dispensary tasks. The regular pharmacist who arrived at a later time said that one regular dispenser had been planned in to work on the day, but he had been unable to come in.

The locum pharmacists were not entirely sure of the services available at the pharmacy or the location of certain documents, such as the SOPs and near-miss log. Clear notes had been left for the locum pharmacists and they appeared to be managing the workload well.

The MCA was observed asking a number of questions before selling pharmacy only medicines (P medicines). She had good knowledge of products which were liable to abuse and had refused to sell these to some people in the past. She said she was extra vigilant when selling certain products such as sleeping tablets and laxatives.

The regular pharmacist said that she provided the team with material from CPPE and discussed one module a month, during the quieter periods at work. The team had recently read material on and discussed oral health and conjunctivitis. The regular pharmacist assessed their understanding on each topic. She said she also observed members of the team whilst they were serving people and asked them to elaborate on why they had provided certain advice. Members of the team had access to pharmacy magazines and training modules from manufacturers. The trainee MCA was provided with set study time to complete her training modules.

The team used a telephone messaging application to communicate with each other and with the SI. A communication book was also in use. Formal performance reviews were conducted every six months. The MCA said she was happy to raise concerns with the regular pharmacists or the SI. Targets were not set for the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is maintained and secured properly. And it provides an environment that is suitable for its services.

Inspector's evidence

This was a large, spacious pharmacy. There was sufficient work and storage space in the dispensary and it was generally clean and organised. A clearly signposted consultation room was available. The room was clean and tidy.

A storage room was used to keep excess P medicines and waste medicine bins. The door to the room had been kept unlocked (although a keycode lock was fitted). The security guard said that members of the team regularly used the door to access the staff room and WC. The regular pharmacist said she would ask the team to keep the door locked when not in use.

There were several chairs in the retail area for people wanting to wait for a service. A clean sink, with hot and cold running water, was used for the preparation of medicines. The room temperature and lighting were suitable for the provision of pharmacy services. The premises were secure.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy generally organises its services well and provides them safely. But people taking some higher-risk medicines might not always get all the information they need to take their medicines safely. The pharmacy manages its medicines well to make sure that they are safe for people to use.

Inspector's evidence

There were two entrances to the pharmacy; both were step-free. The pharmacy was spacious and there was ample space for people in wheelchairs or those with pushchairs. The table in the consultation room could be folded so that there was enough space for people in wheelchairs. The MCA was observed translating for a customer who did not speak English well. The pharmacist said that one MCA was able to communicate effectively with a person using hand signs.

Services were advertised on the NHS website and on the window. Members of the team were observed confirming people's names and addresses and checking if they had any allergies when handing out dispensed medicines. Dispensing audit trails were maintained to help identify team members involved in dispensing and checking prescriptions.

The pharmacist had briefed the MCAs on how to identify CD prescriptions, for example, looking out for the quantity prescribed in both numbers and words.

The pharmacist said that prescriptions for higher-risk medicines were flagged up with coloured stickers. People taking these medicines were asked for their latest blood test results. INR levels were recorded on an online system which was used for the anticoagulant service, but this could only be accessed by one of the regular pharmacists. INR levels were not recorded on the PMR system so could not be reviewed by other members of the team. The pharmacist described contacting the prescriber to raise concerns about a person's poor compliance with warfarin. The doctor had subsequently prescribed an alternative anticoagulant.

The pharmacist said that the team had read the valproate guidance. She was able to describe checks she would make when supplying valproate to patients in the 'at-risk' group'. Information cards were not available to hand and the pharmacist did not know how she would need to label valproate removed from its original pack and supplied to patients in the at-risk group.

People receiving multi-compartment compliance aids were mainly referred to this service by their GP. The pharmacist said she assessed whether a person required the compliance aids and if they would benefit from the service. She spoke to people regularly and checked how they were getting along with the compliance aids. As a result of some of these discussions changes had been made to some compliance aids, for example the time of administration. She checked people's compliance during Medicines Use Reviews and anticoagulant clinic appointments. Clear audit trails were maintained of when prescriptions were due and when repeat requests had been ordered. These records were retained at the pharmacy for one year in case of a query. People receiving compliance aids were organised over a four week cycle. Prescriptions were cross-checked against the PMR system and

individual record cards when they were received. Any changes were noted on the PMR and record sheets. Drug descriptions were not provided on the compliance aids, but patient information leaflets (PILs) were routinely supplied. Label inserts were loose inside the compliance aids which may increase the chance of them being misplaced.

Audit trails were maintained for the delivery service. People were asked to sign a delivery log to confirm receipt of their medication, but several bag labels were placed on one sheet. These labels were at times annotated with additional information, such as the presence of a CD, which could lead to the sharing of people's personal information. The pharmacist said she would review the delivery record to ensure that people's personal information was protected,

Stock was obtained from licensed wholesalers. Expiry date checks were conducted on sections of the dispensary every week and these checks were documented to help keep track. Medicines with short expiry dates were highlighted with coloured stickers. No out-of-date medicines were found at the time of inspection.

Fridge temperatures were checked and recorded daily; these were kept within the recommended range of 2 to 8 degrees Celsius. Drug alerts and recalls were received from the MHRA, printed out and annotated with action taken. Recent alerts were seen to have been actioned by the team.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

There were several clean glass measures available. Measures used for CD liquids were clearly marked to help prevent the chance of cross-contamination. The medical fridge was clean and suitable for the storage of medicines. The blood pressure monitor was replaced every six months.

Clean counting triangles were also available, including a separate one for cytotoxic medicine. This helped avoid cross-contamination. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Members of the team had access to the internet and several reference sources.

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.