General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cubitt Town Pharmacy, 143 Manchester Road, Cubitt Town, LONDON, E14 3DN

Pharmacy reference: 1040179

Type of pharmacy: Community

Date of inspection: 16/05/2019

Pharmacy context

This is a community pharmacy situated on a busy main road. It serves a diverse local community. The pharmacy dispenses NHS prescriptions. It also supplies medicines in multi-compartment compliance trays. And offers other services including a delivery service, flu and travel vaccines and Medicines Use Reviews.

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. But it does not always record mistakes that occur during the dispensing process. This may mean that staff are not able to spot patterns in mistakes and they may not always understand how to prevent similar mistakes in future. The pharmacy generally protects people's personal information. But it could do more to make sure that its confidential waste is always destroyed properly. Team members are generally aware of how to protect vulnerable people.

Inspector's evidence

The majority of prescriptions were received electronically, and these were dispensed in advance of the person presenting at the pharmacy. This helped reduce waiting times and allowed the team to manage its workload more efficiently.

The dispensary was relatively small and there was limited work and storage space. A double-check was obtained, even when the pharmacist assembled prescriptions. A third check was also done when medicines were handed out to people.

A near-miss log was in place to record near misses, but it was not frequently filled in. Two near misses had been documented in 2019 and five in 2018. Team members accepted that there had been near misses made that had not been recorded. There was no formalised review of the log, but members of the team said they discussed near miss errors that had occurred at the pharmacy as well as at other pharmacies. For example, they had heard about an error where medication was handed out to the wife of a person at another pharmacy. The pharmacist had reminded the team to always confirm people's names and addresses when handing medicines out. The pharmacist had also highlighted an error where a person was supplied propranolol instead of prednisolone at another pharmacy. Some medicines had been separated on the shelves, for example, prochlorperazine and prednisolone tablets, to help reduce picking errors. The superintendent (SI) said that dispensing incidents would be reported on the National Reporting and Learning System. There had not been any incidents at the pharmacy for some time.

Standard operating procedures (SOPs) were in place but these had not been reviewed on their due review date (May 2018). Not all current members of the team had read and signed the relevant SOPs to confirm they had understood them. This could make it harder for them to know what the current procedures are.

Up-to-date indemnity and public liability insurance was in place. TThe correct responsible pharmacist (RP) sign was displayed in the retail area and the RP record was in order. The trainee medicine counter assistants (MCA) and dispensing assistant were aware of the tasks that could and couldn't be carried out in the absence of the RP.

All necessary records, including private prescription and emergency supply records, were kept. They were mostly in order but the date on which private prescriptions were written was not recorded for some entries in the private book. Emergency supplies provided to people who had not received their repeat prescriptions on time were recorded electronically but not in the book where other emergency supplies were documented. This meant that the pharmacy had two emergency supply registers which

could make it difficult to find a specific entry, in case of a query. Both sets of emergency supply records did not always include the nature of the emergency. Specials records were completed in line with MHRA requirements.

Controlled drug (CD) registers were in order. But, recorded balance audits were not conducted at regular or frequent intervals. The second pharmacist said that a balance audit had been conducted last year but this had not been documented. A random stock check of a CD agreed with the recorded balance. There was a large number of expired CDs in one cabinet; the pharmacist was advised to contact the CD Accountable Officer to arrange for their destruction.

The complaints procedure was outlined in the practice leaflet. Feedback was sought from people verbally or via annual community pharmacy patient questionnaires. Members of the team said that they tried to accommodate people’s requests for specific products or home deliveries.

Members of the team had been briefed on protecting people's personal information but had not completed any training on the General Data Protection Regulation (GDPR). This could mean that they may not know how to protect people’s personal information properly. They said that confidential waste was shredded at the pharmacy, but some repeat slips and labels were found in the normal waste bin. Members of the team said these should have been shredded. Computers were password protected and members of the team described signposting people to the consultation room for additional privacy.

Both pharmacists had completed a safeguarding module from the Centre of Pharmacy Postgraduate Education and had attended a training session with the Local Pharmaceutical Committee. The trainee MCA had been working at the pharmacy for just under one year. She had not received any training on safeguarding but said she would raise concerns to the pharmacist. She was able to describe signs of abuse but not of neglect. The dispensing assistant had not received any training either. This could make it harder for them to know how to respond to concerns properly.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services it provides, and they work in an open environment where they can make suggestions. But they do not always get time set aside to complete ongoing training. This may reduce the opportunities they have to help keep their skills and knowledge up to date.

Inspector's evidence

At the time of inspection there was the SI, a second pharmacist, two dispensing assistants, a pharmacy student and a trainee MCA. The pharmacy also employed another dispenser and another trainee MCA. The team managed its workload well throughout the inspection. Members of the team felt there was sufficient staffing for the services provided. Annual and emergency leave was covered internally by colleagues.

The trainee MCA, who was enrolled onto the medicines counter course several months ago, was involved in serving customers, selling pharmacy-only medicines (P-medicines), assembling mobility aids and handing out dispensed medicines. She was also involved in putting dispensary stock away. She said she confirmed with the dispensary team before handing medicines out and selling P-medicines. She asked the WWHAM questions before recommending a P-medicine and described referring back to the pharmacist if she was unsure of which product to recommend. But she could not name products which were liable to abuse. She said she would not sell P-medicines or hand out dispensed medicines in the absence of the RP. She completed her course modules at home and read booklets which the pharmacy received from wholesalers.

Protected study times was generally not provided to members of the team. The dispensing assistant said she completed ongoing training at home, reading up about medicines using the Electronic Medicines Compendium website. She had also recently read emails on GDPR and was in the process of ensuring that the pharmacy was compliant with the regulation. Training records were not maintained for the team. This could make it harder for the team members to show what they had learned.

Targets were not set for the team. Performance was discussed informally. Members of the team said they were happy to raise concerns to the SI or second pharmacist. The dispensing assistant said she had discussed improving storage solutions and had requested to rearrange the dispensary soon, which the SI had agreed to.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally suitable for the pharmacy’s services. But the pharmacy could do more to make sure that it keeps the available space as organised as possible.

Inspector's evidence

The dispensary was located on a raised platform at the back of the store and it was small. There was limited work and storage space. Tubs of medicines were stored on the dispensary floor and workbenches were cluttered. P-medicines were stored behind the medicines counter, but the area behind the counter was messy. A consultation room was available for private conversations and services. The room was generally tidy.

A 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. A small storage room was also used as a staff room and it was located behind the dispensary. 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 provides its services safely. And it largely manages medicines well to make sure that they are safe for people to use. But it doesn't always make sure that all the stock medicines are labelled properly. This could make it harder for it to know if these medicines are still safe to use.

Inspector's evidence

Access into the pharmacy was step-free. A large 'please ask staff for assistance' sign was displayed on the window, near the door. Disabled parking spaces were near the pharmacy. Team members were multilingual and translated for people when possible. They also used online translating applications when necessary. Services were advertised on the NHS website and on the window.

The SI trained GP registrars offsite and at the pharmacy. The training covered medicines, legalities of prescriptions and how to handle referrals. The SI had referred a person whose doctor had sent him to the pharmacy back to their doctor. And the person was subsequently diagnosed with skin cancer.

Dispensing audit trails were generally not maintained to help identify team members involved in dispensing and checking prescriptions. Part dispensed prescriptions had labels attached for the owed items, and were filed away with completed medicines awaiting collection. One prescription was seen where the stock had been received but it had not been dispensed for the person and the stock had been put away instead. This could increase the chance that owed items are not dispensed in a timely manner. Members of the team said they checked and cleared the retrieval system every two weeks. People were contacted to remind them to collect their medicine.

The second pharmacist said that people taking warfarin were asked for their yellow books; copies of their INR levels were taken and filed for reference. These levels were checked on a regular basis. She also checked if people taking other higher-risk medicines, such as methotrexate and lithium, were being monitored. The pharmacist had read the valproate guidance and said she printed it out for women in the at-risk group. The dispenser had also read the guidance and pointed out the location of the information cards, which she said she would supply to women taking valproate.

Designated members of the team oversaw the preparation of multi-compartment compliance trays for particular people. The pharmacy managed the prescriptions for people receiving these trays. Requests were normally sent by email to the surgery and there was a follow-up process to help ensure prescriptions were received on time. Once received, prescriptions were checked against the patient medication record (PMR); any changes were first confirmed with the prescriber and then documented on the PMR. Drug descriptions were not provided to help people, or their carers, identify the medicines. Patient information leaflets (PILs) were not always supplied. This might mean that people don't get all the information they need to take their medicines safely. Several people's trays were seen stored together in boxes; some had packs of medicines attached to the trays with elastic bands. This could increase the chance of mixing people's medication or misplacing medicines which were not supplied inside the trays.

The second pharmacist was an independent prescriber specialising in contraception and asthma

treatment. She said she rarely prescribed medicines. Two private prescriptions were seen. And one included a range of medicines including an antibiotic. The pharmacist had not made records of information she had obtained from the person to explain why she had prescribed these medicines. This could make it harder for her to show if the medicines were prescribed safely.

Stock was obtained from licensed wholesalers. The second pharmacist said that expiry date checks were conducted approximately once a year. A list of short-dated medicines was maintained but date checking records were not maintained to help the team identify when each section had been checked.

Medicines removed from their foil blister were not always stored in amber medicines bottle but were sometimes put back loose in their outer carton. A medicine which had expired in March 2019 and another expiring in May 2019 were found still in the fridge and on the shelf respectively. This could increase the chance that people get a medicine which is past its 'use-by' date. A medicine had been removed from its original pack and kept in an amber medicine bottle. It was not labelled with any information, including the name of the medicine.

Fridge temperatures were checked and recorded daily; these were kept within the recommended range of 2 to 8 degrees Celsius. The pharmacist said that drug alerts and recalls were received via email from the MHRA. Audit trails of action taken in response to these alerts were not maintained. This may make it harder for the pharmacy to show that the stock is safe and fit for purpose. The pharmacist was aware of the recent alert for co-amoxiclav powder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment and facilities it needs to provide its services safely. But it does not always keep its equipment as clean as it could.

Inspector's evidence

There were several glass measures available, but they were not all clean. Measures used for methadone liquid were not clearly marked to help prevent the chance of cross-contamination. Clean counting triangles were also available, including a separate one for cytotoxic medicine.

The pharmacist said that the blood pressure monitor was calibrated every 6 months. 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.