General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Mansons Pharmacy, 108 High Road, South Tottenham, LONDON, N15 6DS

Pharmacy reference: 1040440

Type of pharmacy: Community

Date of inspection: 22/05/2019

Pharmacy context

This is a branch of a group of pharmacies. It is situated on a main road in a parade of shops close to a health centre. It dispenses NHS prescriptions and offers a number of sexual health services including HIV testing. It supplies medicines in multi-compartment compliance packs to a number of people to help them take their medicines safely.

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 met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.2	Standard not met	The confidentiality of people who receive pharmacy services is not fully maintained.
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’s working practices are generally safe and effective. The pharmacy asks its customers for their views. It largely keeps the records it needs to so that medicines are supplied safely and legally.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which were available electronically. Members of the team had read SOPs relevant to their roles. Team roles were defined within the SOPs. There were an additional two sets of SOPs available in the dispensary which could cause confusion as to which SOPs were current. The SOP for the changeover for the responsible pharmacist (RP) was missing and some of the information in the SOPs was outdated; some referred to the Royal Pharmaceutical Society of Great Britain (RPSGB). The RP said that he would notify the superintendent pharmacist of this.

Near misses were recorded and reviewed at the end of each month. The RP said that based on the trends found, action points would be generated. In the past medicines with similar names were either separated or a warning label was attached on the shelf/drawer. An example of medicines which had been separated using dividers included amlodipine and amitriptyline. Previously, near misses were recorded electronically and there was one entry made in 2017. The RP had highlighted the lack of recording near misses to the team and as a result a decision had been made to record them on paper. However, at the time of the inspection there were no records or review notes available to see including any records made in May 2019.

In the event that a dispensing incident was reported the RP said that he would report the incident on the National Reporting and Learning System website, although he had not had to do so. Records seen for previous incidents on the computer system were very brief and there was no information relating to the person who had been supplied the medicines, details of the prescriber, who was involved, timings and actions taken. The RP said that learning from incidents was shared with other branches.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaint procedure. And details of this were displayed on a poster. The pharmacy also completed an annual patient satisfaction survey. Due to feedback the RP had asked counter staff to check with the dispensary team before letting people know of waiting times.

Records for private prescriptions, emergency supplies, unlicensed specials and RP records were well maintained. Controlled drug (CD) registers were generally well maintained but some entries had the address of the wholesalers missing. CD balance checks were not frequently carried out. The last recorded checks in some registers was in June 2018. The liquid balance was done more frequently. This means, that any error or discrepancies may not be picked up and investigated in a timely manner.

A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received. The computer in the dispensary was password protected and the screen was out of view of the public. Confidential waste was collected by a company and sent for incineration. The team were using the superintendent pharmacist’s (SI) smartcard despite her not being present. The RP said that his replacement smartcard was in the post as

he had misplaced his. The dispenser's smartcard did not have the authorisation to nominate people. The SI was responsible for reviewing the information governance policy. The team had read through reference material on the General Data Protection Regulation and completed multiple choice questions to check their understanding. Both pharmacists had access to Summary Care Records, consent was gained verbally.

The RP had completed level 2 safeguarding training and knew where to access information for safeguarding contacts and said that he would print out a copy to display in the pharmacy. Team members had some awareness, but the RP said he would look into enrolling them on a course.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services provided. They have the appropriate skills, qualifications and training to deliver the pharmacy's services safely.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP, a trained dispenser who was completing the course to become a technician, and a pharmacy student who had just started working at the pharmacy. Other team members who were not present included a medicines counter assistant (MCA). The RP said that two part-time MCAs were on long-term leave, and the pharmacy student had been employed to cover them. The RP had worked at the pharmacy for a year and half and also worked at the group's other branches. The superintendent pharmacist also worked at the pharmacy.

The RP said that there were enough staff for the services provided. Staff performance was informally managed. A one-to-one chat was held with team members to appraise how they were doing and feedback was given on the spot if the pharmacists identified anything. The RP said that he would intervene when needed. This was done verbally and not documented. During the one-to-one session a discussion was held as to how things were going, what was going well, setting targets, and what needed to be achieved.

The pharmacy student counselled patients on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She would always refer to the pharmacist if unsure or for any requests for multiple sales. The RP said that he had briefed her on the types of questions to ask people when they wanted to buy over-the-counter medicines and as she was a pharmacy student he highlighted things to her which he thought were useful.

The trainee technician said that she was well supported with her training and would speak to the pharmacists if she needed help. She had a day off during the week to study. The trainee technician said that she often had discussions with the pharmacist. Recently they had discussed the licensing of selling Emla cream over-the-counter for use prior to tattooing. As part of this she had contacted Numark and the manufacturers. The learning had been shared with other branches.

To keep up-to-date team members were encouraged to look through 'Counterskills' workbooks sent by Alliance Healthcare. Previously the team had also received books from Numark. The RP said he highlighted relevant information from alerts to the team and gave the example of briefing the team on the use of topical lidocaine preparations in children. Campaigns and audits were also used as a means of learning. The team attended seminars or the RP would brief them on any training that he had attended. Recent training attended by the RP had included training on arterial fibrillation and inhaler use. The team also held peer discussions and were informed of changes in legislation, alerts, and any material which was sent to the pharmacy.

Things were generally discussed as they came up. If the RP wanted to discuss something in relation to what he had seen he said that he waited for the shop to be empty and would then have a chat with the team. He also said he used case-based scenarios and gave an example of a discussion held around of confirming the address with people when prescriptions were handed out. The RP worked at the other branches and met the owners regularly. The owners also visited the pharmacy and were contactable by

telephone. No numerical targets were set for the services provided.

Principle 3 - Premises Standards not all met

Summary findings

The premises are generally suitable for the pharmacy’s services and they are kept secure. Some areas of the pharmacy are untidy or require cleaning. This detracts somewhat from the overall appearance of the pharmacy. Due to the layout of the pharmacy people’s private information is visible to other people using the pharmacy.

Inspector's evidence

The pharmacy was reasonably clean and maintained to a level of hygiene appropriate for the provision of healthcare. Although there was a considerable amount of dust in some areas. There was limited workbench space in the dispensary but there were pull out benches available which increased the workspace available. These were used to prepare multi-compartment compliance packs. A sink was available in the dispensary, this was old and heavily stained. Medicines were arranged on shelves and in drawers in a tidy and organised manner. However, some baskets with assembled prescriptions were stored on the floor near the shelves holding stock; this could increase the possibility of items falling into the baskets from the shelves. Cleaning was done by the team.

The pharmacist used the stock room as a consultation room. Curtains had been used to close off the stock room from the area that was used as the consultation area, the whole area had concrete flooring. The room was accessed from behind the medicines counter and required walking past the dispensary and assembled prescriptions stored on shelves. People’s personal details were clearly visible on them The consultation room had cobwebs and ceilings tiles were missing and stained. The premises were kept secure from unauthorised access. The ambient temperature and lighting were adequate for the provision of pharmacy services. Air conditioning was available to help regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are generally delivered in a safe and effective manner. The pharmacy obtains its medicines from reputable sources. And it generally manages them appropriately so that they are safe for people to use. But it does not always use some of the safety materials (such as warning stickers) when it supplies valproate. This means that people may not always have all the information they need to take their medicines safely.

Inspector's evidence

The pharmacy was easily accessible and had a ‘push through’ door and slight ramp at the entrance. Team members would help people who required assistance. There was easy access to the medicines counter. The consultation room was easily accessible and the pharmacist said that he would move wholesalers’ containers before escorting people through to the room. The pharmacy had the facilities to produce large print labels.

The pharmacy's services were advertised and there was a wide range of leaflets throughout the pharmacy. Team members were aware of the need to signpost people to other providers. People were supplied with leaflets or team members used the internet. Signposting and referrals were documented. Team members were multilingual and the team also used translation applications. The pharmacist gave an example of using this for people who spoke Spanish in the past.

The RP thought that the emergency hormonal contraception (EHC)service had the most impact on the local community, along with the minor ailments scheme as it was not always easy to get a GP appointment. There was a large uptake of the sexual health services as the pharmacist could supply EHC under a patient group direction. He said that he was able to use the consultation to advise people of additional services offered as well as supply condoms.

Since the RP had joined the pharmacy he had spoken to the owners about offering the HIV testing service as he had previously offered it at another pharmacy. This had been launched. At the time of the inspection the RP was the only accredited pharmacist to provide the service. He said that he had attended training sessions to learn how to carry out the test and also had training on how to manage results. People who received a reactive test result were referred to a clinic in Archway. The RP would make contact whilst the person was still there, and they would then need to go for further tests.

As the pharmacy was a Healthy Living Pharmacy (HLP) they tried to update their stand with different health promotion campaigns each month. The RP said that the week prior to the inspection had been mental health awareness week and the campaign had been tied in with this. The team had displayed leaflets and posters and had a chat with anyone who approached them about the topic. The RP said that a few people talked to the team about mental health and were taken into the consultation room for a chat to assure them that they were not isolated.

The RP had done a lot of reading around mindfulness and anxiety and was able to talk to people about techniques they could try to use. The RP said that in the summer he planned to run campaigns on skin protection and travel. The HLP champion was on long-term leave and the dispenser was completing her training so that she could take over. The RP had done research on oral health and had looked at ordering posters and charts which children could use to track progress. The RP said that he had also

collected some leaflets when he had attended the HIV training to ensure there was a wide range of leaflets available.

The pharmacy had an established workflow in place with majority of prescriptions received electronically. Most people were also part of the repeat service which was managed via the repeat management system (RMS; an electronic system). People needed to call the pharmacy between five to seven days before their prescription was due to run out, in some cases the pharmacy team called the person to check what they needed. The system allowed the team to keep track of what had been ordered and received so missing items could be chased up. People were informed that if the pharmacy was unable to contact them they would not automatically reorder a prescription. An audit was kept of attempts made to contact people. Prescriptions were processed, labelled and dispensed by either the dispenser or RP. And then they were checked. In the event that the RP was working alone he would have to self-check and said he would take a mental break in between dispensing and checking.

Dispensed and checked by boxes were available on labels; these were initialled by team members when they were dispensing or checking. The pharmacy team used baskets to ensure that people's prescriptions were separated, to reduce the risk of errors.The RP was familiar with the change in guidance for dispensing sodium valproate. He was unsure if the pharmacy had received the 'Prevent pack.' Although he was aware of the warning stickers he was unsure of when they needed to be used.

Prescriptions for all high-risk medicines were processed as owings, so that it was highlighted to the pharmacist that they need to query monitoring with the person. The team were aware of the need to ask for the yellow book for warfarin. The RP checked this for monitoring and the INR was entered on the computer system, together with the date of the appointment and next one, dosage and INR). The RP annotated the top of the prescription to prompt the team with what needed to be done.

Prescriptions for CDs including Schedule 4 were processed as an owing. This was done to act as a prompt for the pharmacist to check before the medication was handed out. For people who were supplied their medicines in multi-compartment compliance packs, the pharmacy checked that the person was not in hospital and for any changes before placing an order for the repeat prescription. When the prescription was received it was checked against the system for any changes and omissions, processed, backing sheets were prepared, stock collected and checked before the packs were prepared. The pharmacy retained a spare copy of the backing sheet. A record was made when trays were collected and a list of when people were due was also made. If someone was in hospital it was recorded on the system and prescriptions were not ordered. The team ensured a discharge summary was received by the pharmacy and doctors, and any changes actioned. Packs were prepared and sealed by the dispenser.

Assembled packs observed were labelled with product descriptions and mandatory warnings. Patient information leaflets were handed out monthly. An audit trail was in place to show who had prepared and checked the packs.The pharmacy only offered deliveries in exceptional circumstances.A signed and in-date patient group direction was in place for the supply of EHC.

Medicines were obtained from licensed wholesalers and stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of medicines. CDs were kept securely. A number of bottles containing liquid controlled drugs were found stored securely. However, these had not been labelled. The RP said that he had pre-packed them earlier that day and agreed to ensure that these were stored with labels in the future.

Date checking was done by the dispenser or pharmacists every three months. But this had not been done for a while due to staff shortages. This could increase the chance that someone received a

medicine which was past its use-by-date. A date-checking matrix was in place. To avoid date-expired medicines being handed out, the team were checking dates when stock was received, and the date was checked at the point of dispensing and checking. Short dated stock was highlighted. Two date-expired medicines were found on the shelves sampled.

The pharmacy had the equipment fitted for the Falsified Medicines Directive (FMD) but were waiting for their computer system to be updated so that they could start using it. The RP and team had watched the relevant PSNC webinars to prepare for this. Out-of-date and other waste medicines were segregated at the back away from stock and then collected by licensed waste collectors.

Drug recalls were received through the NHS email and recorded on the PMR system. The last recorded alert was for atropine. Alerts could be checked by both pharmacists and dispenser. The RP had been away when the alert for co-amoxiclav had come out. He said that he would check with the other pharmacist if it had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had all the necessary facilities and equipment for the services offered. Equipment was clean and in good order. Measuring cylinders, tablet and capsule counting equipment were clean and ready for use. A separate triangle was available and used for cytotoxic medication and a separately labelled measure was available for methadone to avoid contamination. Up-to-date reference sources were available including access to the internet. A fridge of adequate size was available.

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.