General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Mayberry Pharmacy, 15 Main Street, The Square, Crumlin, NEWPORT, Gwent, NP11 4PT

Pharmacy reference: 1043429

Type of pharmacy: Community

Date of inspection: 21/01/2020

Pharmacy context

This is a pharmacy in a small town. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. Some NHS prescriptions are assembled off-site at another pharmacy owned by the company. It offers a wide range of services including smoking cessation, treatment for minor ailments and a seasonal 'flu vaccination service for NHS and private patients.

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	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures to help make sure the team works safely. Its team members record and review their mistakes so they can learn from them. And they take action to help stop mistakes from happening again. The pharmacy keeps the records it needs to by law. It asks people to give their views about the services it provides. And it keeps people's private information safe. The pharmacy's team members understand how to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

The pharmacy had systems in place to identify and manage risk, including the recording of dispensing errors and near misses. There was evidence that monthly near miss reviews had been conducted between July and September 2019. The pharmacist said that she reviewed near misses regularly to try to spot any patterns or trends but had not documented this recently. Some action had been taken to reduce risks that had been identified. For example, the 'Look-Alike, Sound-Alike' or 'LASA' drugs allopurinol, amlodipine and amitriptyline had been separated on dispensary shelves following a series of picking errors, as had pravastatin and pantoprazole tablets.

A range of standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Staff had yet to read and sign the most recent versions. The responsible pharmacist (RP) procedures had not been signed by two trainee pharmacy technicians. However, they understood the procedures and could describe activities that could and could not take place in the absence of the RP. An appendix of the Staff Roles and Responsibilities SOP showing the tasks that each staff member was expected to perform had not been completed. However, staff were able to clearly describe their roles and responsibilities when questioned.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed at the medicines counter showed that this was mostly positive. During the inspection a customer who came into the pharmacy was very complimentary about the standard of service he received from the pharmacy team. A formal complaints procedure was in place although this was not advertised in the retail area.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and were generally properly maintained, including responsible pharmacist (RP), private prescription, unlicensed specials and controlled drug (CD) records. However, there were occasions on which the pharmacist had not signed out of the RP register to show the time at which she had relinquished responsibility for the safe and effective running of the pharmacy. There was a risk that there might not be enough information available for queries or errors to be dealt with effectively. There were no records of emergency supplies available, but the pharmacist said that she did not remember the last time she had made such a supply. CD running balances were typically checked at the time of dispensing, although some items that were not frequently dispensed had not been subject to a balance check for several months. This increased the risk that concerns such as dispensing errors or diversion might be missed.

Staff had signed confidentiality agreements. They were aware of the need to protect confidential

information, for example by being able to identify confidential waste and dispose of it appropriately. A privacy notice displayed at the medicines counter explained the way in which data was used by the pharmacy and gave details of the pharmacy's Data Protection Officer.

The pharmacist and trainee pharmacy technicians had undertaken level two safeguarding training and had access to guidance and local contact details that were available in the dispensary. Other staff had undertaken level one safeguarding training. They were able to identify different types of safeguarding concerns and said that they would refer these to the pharmacist, who confirmed that she would report concerns via the appropriate channels where necessary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. They are properly trained for the jobs they do. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The regular pharmacist manager worked at the pharmacy on most days. The support team consisted of two trainee pharmacy technicians and a dispensing assistant. The pharmacist said that an accuracy checking technician had left the team at the end of the previous year and one of the trainee pharmacy technicians had been recruited to replace her. A pre-registration pharmacist and another dispensing assistant were absent. There were enough suitably qualified and skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. Staff members had the necessary training and qualifications for their roles. The dispensing assistants had been declared competent under the grandparent clause. The pre-registration pharmacist and the trainee pharmacy technicians worked under the pharmacist's supervision.

Targets were set for MURs. The pharmacist said that she managed these appropriately. She said that there was some pressure to achieve targets but she felt that this did not affect her professional judgement or compromise patient care. Staff worked well together. The pharmacy served a small and close-knit community and staff had an obvious rapport with customers. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist, superintendent pharmacist and head office staff. A whistleblowing policy that included a confidential helpline for reporting concerns outside the organisation was available in the dispensary. It had been read and signed by all staff.

Staff had access to informal training materials such as counter skills modules, articles in trade magazines and information about new products from manufacturers. They had also recently completed training provided by the superintendent's office on the Falsified Medicines Directive. However, the lack of a structured training programme might restrict the ability of individuals to keep up to date with current pharmacy practice. All staff were subject to annual performance and development reviews. They could informally discuss issues with the pharmacist whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and secure. It has enough space to allow safe working and its layout protects people’s privacy.

Inspector's evidence

The pharmacy was clean, tidy and well-organised, with enough space to allow safe working. Some stock and dispensed prescriptions awaiting collection were temporarily stored on the floor but did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. A consultation room was available for private consultations and counselling. A sign above the door identified the consultation room as a ‘Healthcare Centre’, but it was not clearly advertised as a space for confidential conversations. The lighting and temperature in the pharmacy were generally appropriate. Parts of the dispensary were a little cold, but it was a very cold day.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes the services it provides so that people know about them and can access them easily. If it can't provide a service, it directs people to somewhere that can help. The pharmacy's working practices are generally safe and effective. It supports people taking higher-risk medicines by making extra checks and providing counselling where necessary. It stores medicines appropriately and carries out some checks to make sure they are in good condition and suitable to supply. But it doesn't always keep prescription forms with dispensed medicines. This means that the pharmacy's team members may not always have all the information they need when they hand out the medicines.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. Access to the pharmacy was slightly uneven but staff said that the team would go out to people in wheelchairs and help them into the pharmacy if necessary. There was wheelchair access into the consultation room. A hearing aid loop was available. Staff said that they would signpost people requesting services they could not provide to nearby pharmacies or other providers such as the local health board, which offered a sharps collection service. Some health promotional material and information about local health services was on display in the retail area. The pharmacist explained that she had recently visited local surgeries to discuss and promote services as part of a health board funded collaborative working initiative. Visits had involved discussions around the repeat dispensing service, compliance aid dispensing and the common ailments service.

Dispensing staff used a colour-coded basket system to help ensure that medicines did not get mixed up during dispensing and to differentiate between different prescriptions. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Controlled drugs requiring safe custody and fridge lines were dispensed in clear bags to allow staff members to check these items at all points of the dispensing process and reduce the risk of a patient receiving the wrong medicine. Stickers were used on dispensed items awaiting collection to identify patients eligible for an MUR and to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding, or that the pharmacist wished to speak to the patient or their representative at the point of handout. Stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was invalid and could no longer be supplied.

The pharmacy team used 'Therapy Check' stickers and pre-printed forms to routinely identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate so that they could be counselled. The forms included prompt questions to ensure that the member of staff handing out the medicines obtained all necessary information from the recipient. This was then added to their patient medication record (PMR). The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that any patients prescribed valproate who met the risk criteria would be counselled and provided with appropriate information. A valproate information pack was available in the dispensary. The pharmacy carried out regular high-risk medicines audits commissioned by the local health board. These audits were used to collect data about the prescribing, supply and record-keeping associated with high-risk medicines to flag up areas where risk reduction could be improved within primary care. Information about insulin prescribing provided by the local health board was displayed in the dispensary. It categorised insulins by type and reminded the pharmacy team not to

supply more than one type of insulin from each category without contacting the prescriber. Insulin passport cards, steroid cards and warfarin, lithium and methotrexate monitoring booklets were available for provision to patients.

Prescriptions were not always retained for dispensed items awaiting collection. This meant that prescriptions for some Schedule 3 CDs might not be marked with the date of supply at the time the supply was made, as required by legislation. A prescription was not available for a bag of dispensed tramadol capsules awaiting collection, but a CD sticker had been used to show that the prescription would be invalid after 28/11/19. The pharmacist said that the failure to remove the medicines from the retrieval area was an oversight and remedied this immediately. She said that she would ensure that prescriptions for Schedule 3 and 4 CDs were retained at the branch until supply in future. Most prescriptions were scanned, and the image remained available for reference. However, this was not the case for all prescriptions.

The delivery service was usually managed using the Prodelivery Manager application. Each prescription was scanned into a smartphone and patients or their representatives signed the smartphone to acknowledge receipt of the delivery as an audit trail. However, the smartphone was currently broken, and the branch was awaiting a replacement. A delivery driver demonstrated that in the meantime signatures were being obtained on paper forms. Separate signatures were obtained for controlled drugs. In the event of a missed delivery, a notification card was put though the door and the prescription was returned to the pharmacy.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a number of patients. Any new patients requesting the service were assessed for suitability. All compliance aid prescriptions were clinically checked at the branch. The pharmacist explained that most were then assembled at the company's hub pharmacy, although a few were dispensed at the branch. Compliance aids assembled off-site were marked with details of the hub pharmacy, but not with the details of the supplying branch, contrary to legal requirements. The pharmacist said that if any compliance aid patients contacted the hub pharmacy with a query or complaint, they were directed back to the branch and the pharmacy team dealt with it appropriately. Compliance aids were labelled with descriptions to enable identification of individual medicines. The pharmacist said that patient information leaflets were routinely supplied. Each patient whose compliance aid was assembled at the hub pharmacy had a section in one of four dedicated files. This included their personal and medication details, collection or delivery arrangements, details of any messages or changes and any relevant documentation, such as repeat order forms and completed assessment forms. Each patient whose compliance aid was dispensed at the branch had a labelled basket that contained their stock medicines. It also contained their current prescription, their repeat order form and details of their collection or delivery arrangements.

Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were stored in a large, well-organised drug fridge. Maximum and minimum temperatures were usually recorded daily, and recorded temperatures were consistently within the required range. However, there were some gaps in the records for the previous few days, making it difficult for the pharmacy to be assured that fridge items were consistently stored appropriately. The pharmacist said that the team had been unable to record temperatures as the fridge thermometer had broken. She demonstrated that a new thermometer was now in place. CDs were stored appropriately in a well-organised CD cabinet and obsolete CDs were segregated from usable stock.

There was some evidence to show that regular expiry date checks were carried out, although the frequency and scope of these checks was not always documented. This created a risk that out-of-date

medicines might be supplied. An out-of-date adrenaline injection for use in the influenza vaccination service was found in the consultation room. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. Two unsealed sharps bins containing used sharps were situated in the unlocked consultation room, which could be accessed from the retail area. The pharmacist moved these as soon as this was pointed out. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist was able to describe how she had dealt with a recent drug recall for ranitidine tablets by quarantining affected stock and returning it to the supplier. The pharmacy had the necessary equipment to work in accordance with the Falsified Medicines Directive (FMD) but was not yet compliant.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It makes sure these are always safe and suitable for use. The pharmacy's team members use equipment and facilities in a way that protects people's privacy.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Triangles were used to count tablets and a separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the pharmacy software system was protected with a password and the consultation room was used for private consultations and counselling. Dispensed prescriptions could be seen from the retail area but no confidential information was visible.

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.