General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Morland Pharmacy, 40 New Road, TADLEY, Hampshire, RG26 3AN

Pharmacy reference: 1085573

Type of pharmacy: Community

Date of inspection: 24/04/2019

Pharmacy context

This is a community pharmacy located within a GP surgery in Tadley in Hampshire. A range of people use the pharmacy's services. The pharmacy dispenses NHS and private prescriptions. It also offers a few services such as Medicines Use Reviews (MURs) and the New Medicines Service (NMS). And, it provides some people with their medicines inside multi-compartment compliance aids, if they find it difficult to take their medicines on time. These aids are assembled on another part of the company's premises and people can either collect them from the pharmacy or they are delivered to their homes.

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 identifies and manages most risks effectively. The pharmacy team record mistakes that occur during the dispensing process, they learn from these and act to prevent future mistakes occurring. Members of the pharmacy team understand how they can protect the welfare of vulnerable people. And, they protect people's private information well. The pharmacy generally keeps most records in accordance with the law. But, some details within its records of private prescriptions were incorrect or missing. This means that the team may not have all the information needed if problems or queries arise.

Inspector's evidence

The pharmacy's workload was mostly repeat prescriptions. This was manageable. The pharmacy was organised but some areas were cluttered (see principle 3).There was sufficient space for staff to carry out internal processes safely. Prescription assembly by staff and the final accuracy check by the Responsible Pharmacist (RP) occurred in segregated areas.

Near misses were recorded routinely by the team. These were reviewed collectively by the RP, details were recorded every month as part of the review and the information was faxed to the pharmacy's head office. Trends/patterns were analysed by the professional standards pharmacist who was based at the latter.

Staff described separating medicines with similar packaging or for example, any that had been involved in previous errors.This included moving prednisolone away from propranolol and olmesartan away from omeprazole. The team had also identified/highlighted look-alike and sound-alike (LASA) medicines on shelves. Caution stickers were placed in front of relevant stock as an additional visual alert.

There was information on display about the pharmacy's complaints procedure. This included the pharmacy's practice leaflet. The pharmacy informed people that an external contractor (NWOS) was being used to dispense some appliances. This was through a notice that was on display. However, there was no information to inform people that Monitored Dosage Systems (MDS) were being dispensed off-site (see Principle 4 regarding the process). Staff were unable to fully confirm how people's consent for this activity was obtained. They thought that people may have been verbally informed when the process was initially set up. Incidents were handled by the RP. A documented complaints process was present. The pharmacist's procedure was in line with this and included checking relevant details, investigating, explaining the process to people, checking the level of harm, informing the person's GP if any incorrect medicine was taken and documenting details. The latter was sent to the pharmacy's head office to ensure the superintendent pharmacist was informed.

There were a range of documented Standard Operating Procedures (SOPs) present to support the supply of services. These were prepared in 2019. Roles and responsibilities of staff were defined. Staff had signed to state that they had read SOPs. At the point of inspection, there was no SOP to provide the team with guidance about the off-site dispensing process. Team members could identify signs of concern to safeguard vulnerable people. In the event of a concern, the RP would be informed.

The pharmacist was trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE). Relevant local contact details were available. Information was on display to inform people about

how their privacy was maintained.There was no confidential material left within public facing areas. Confidential waste was shredded. Bagged prescriptions awaiting collection were stored in a way where surnames were visible from the retail area but no other sensitive information was displayed.

Staff had signed confidentiality agreements and were trained on the EU General Data Protection Regulation (GDPR). There were also a set of Information Governance SOPs as guidance for the team. The correct RP notice was on display.This provided details of the pharmacist in charge of operational activities.

Records relating to most pharmacy services were compliant with statutory requirements.This included records of unlicensed medicines, the RP record and a sample of registers for Controlled Drugs (CDs). Balances for CDs were checked and documented every four to six weeks.

There were incorrect prescriber details (name and address), incorrect types of prescribers or no prescriber details seen recorded within the electronic private prescription register. Professional indemnity insurance arrangements was provided through the National Pharmacy Association (NPA) and due for renewal after 30/06/19.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members generally have an appropriate level of understanding about their roles and responsibilities. They are provided with resources to complete necessary training.

Inspector's evidence

The pharmacy dispensed 9,000 prescription items every month and supplied around 40-45 people with MDS trays that were dispensed off-site, at the company's warehouse in Langley.

The pharmacy's staffing profile included the RP, two full-time dispensing assistants, one of whom was in training, two part-time trainee Medicine Counter Assistants (MCAs) who overlapped for a brief period every day and four part-time delivery drivers.

Staff in training were undertaking accredited training appropriate to their roles with 'Counter Intelligence'. The trained dispensing assistant's certificate to verify her qualification was seen.

Staff knew which activities were permissible in the absence of the RP, they used a range of questions to obtain relevant information before selling over-the-counter (OTC) medicines and if they were unsure, details were run past the RP.

Sufficient knowledge of OTC medicines was held. Sales of medicines prone to abuse or excess requests seen were monitored and brought to the RP's attention. Staff in training completed course material at home and at work as and when it was possible. They felt supported by the RP.

The team were relatively new to the branch except for the trained dispensing assistant who had worked for the past two years. The other staff's employment commenced within the last six to eight months. Communication was verbal with regular discussions occurring as they were a small team. Updates and emails were received from the company. The pharmacist described an expectation to achieve 400 MURs annually. This was described as manageable with no pressure applied to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are secure and provide a suitable space to deliver pharmacy services. But, the pharmacy stores some assembled prescriptions directly on the floor. This could damage medicines and may be a trip hazard.

Inspector's evidence

The premises consisted of a medium sized retail area and dispensary at the rear. Areas that faced the public were well presented. The pharmacy was suitably lit and well-ventilated.

Pharmacy only (P) medicines were stored behind the front counter. Staff were always within the vicinity. There was also a gate here as a barrier.This helped restrict P medicines from being self-selected.

Most areas were clean although the sink in the staff WC could have been cleaner and the carpet in the dispensary required vacuuming. This took place a few times a week according to staff.

Most of the available bench space in the dispensary was taken up with baskets of assembled prescriptions. This was observed to be work in progress. The RP’s designated area to accuracy check prescriptions was kept clear of clutter. Some baskets of assembled prescriptions were being stored directly on the floor in the dispensary.

A signposted consultation room was available to provide services and private conversations. There were two entrances, one entry point was from behind the front counter and the door from the retail space was kept locked. The space was of an adequate size for the services provided. There was no confidential information accessible from within the room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy tries to ensure its services are accessible to everyone. It obtains its medicines from reputable sources and mostly stores them appropriately. Team members generally ensure pharmacy services are provided safely.

Inspector's evidence

There were two entrances into the pharmacy; one was from within the doctor's surgery and the other from a wide front door, with a very slight step from the street. This was not sufficient to prevent access for people with mobility issues and staff explained that they physically attended people at the door if they noticed any issues. There were three seats available for people waiting for prescriptions and some car parking spaces at the rear of the premises.

The team described coming out from around the front counter to face people with different requirements. They would use written communication to assist people who were partially deaf or use the consultation room to help minimise background noise. Staff provided verbal information and checked understanding for people who were visually impaired.

There were some leaflets available for people to access information about other local services. The pharmacist explained that MURs and NMS had made the most impact as these services had provided opportunities to meet people, discuss concerns, identify side effects and provide relevant information as needed.

The pharmacy team used baskets to hold each prescription and associated medicines. This prevented any inadvertent transfer.Staff used a dispensing audit trail to verify their involvement in processes. This was through a facility on generated labels.

People prescribed higher risk medicines were identified and counselled when required. According to the RP, relevant parameters were checked during MURs. People prescribed warfarin in the area had been changed to other medicines such as apixaban. Staff were aware of risks associated with valproate. This was stored in a separate area. Dispensing staff explained that the pharmacist would be made aware if prescriptions for females that may become pregnant were seen. The RP had not seen any prescriptions since his employment commenced (November 2018).

Prescriptions for MDS trays were processed through the pharmacy system and relevant paperwork for each individual person filled in. This was then taken by the driver to the company's warehouse for assembly. There were records in place to demonstrate which person's record had been taken up as well as when assembled trays were received back into the pharmacy. Staff checked that trays received matched details on these records upon receipt.

Medicines were delivered. There were audit trails in place to demonstrate when and where medicines were delivered. CDs and fridge items were identified and people's signatures were routinely obtained, once they were in receipt. Failed deliveries were brought back to the pharmacy with notes left to inform people. Medicines were not left unattended.

Medicines and medical devices were obtained from licensed wholesalers such as Alliance Healthcare,

OTC Direct, Colorama and Doncaster. Unlicensed medicines were obtained through Alliance Healthcare.

Staff were generally aware of the process involved for the European Falsified Medicines Directive (FMD). Relevant equipment was in place but not set up, to enable use at the point of inspection. The team were provided with guidance from their head office on how to ensure compliance once the pharmacy was fully set up for this.

Most medicines were stored in an organised manner in the dispensary. Date-checking of medicines to identify expiry dates occurred every two months. Short dated medicines were identified using a highlighter pen and black dots. A schedule was in place to demonstrate when medicines were last checked for expiry. There were no date expired medicines or mixed batches seen. Liquid medicines were marked with the date they were opened. Odd medicines that were stored outside of their original containers held full and relevant details. There were a few of these seen that only included the expiry date and not the batch number of the medicine. Ensuring all medicines were appropriately labelled was discussed at the time.

CDs were generally stored under safe custody. Assembled medicines awaiting collection were stored with prescriptions held within an alphabetical retrieval system. Fridge items and CDs (Schedules 2-3) were identified and details marked on prescriptions to highlight. There was a list available to assist staff in identifying Schedule 4 CDs. Prescriptions for these were not marked in any way to assist with identifying their 28-day prescription expiry. Counter staff were also unable to identify some of these.

Uncollected medicines were checked and removed every month. Once accepted, the team stored returned medicines requiring disposal within appropriate receptacles. People bringing back sharps for disposal were referred to the local council. Returned CDs were brought to the attention of the RP with relevant details entered into a CD returns register. The audit trail of receipt and destruction was complete. Drug alerts were received by email. The process involved checking for stock and acting as necessary. An audit trail was available to verify.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was equipped with current versions of reference sources. Staff could also use online reference sources and could call the NPA if additional advice or information was required. Computer terminals were positioned in a way that prevented unauthorised access. A shredder disposed of confidential waste. The team used their own NHS smart cards to access electronic prescriptions. These were stored securely overnight.

Clean, crown stamped conical measures were present for liquid medicines. Counting triangles were also available. This included a separate one for cytotoxic medicines.

The dispensary sink used to reconstitute medicines was relatively clean. There was hot and cold running water available as well as hand wash present. The fridge was maintained at appropriate temperatures for the storage of medicines. Daily temperature records kept verified this. The CD cabinet was secured in line with legal requirements.

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.