General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Meraj Pharmacy, 694 High Road Leyton, LONDON, E10 6JP

Pharmacy reference: 1087389

Type of pharmacy: Community

Date of inspection: 24/04/2019

Pharmacy context

A busy branch of a small group of independent pharmacies. The pharmacy is situated on a busy main road opposite a health centre. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance trays. And offers the minor ailments and emergency hormonal contraception services. It is a Healthy Living Pharmacy.

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 identifies and manages the risks associated with its services. The pharmacy keeps people's private information safe. The pharmacy asks its customers and staff for their views. Team members use the procedures in place to safeguard vulnerable people. The pharmacy generally maintains the records that it must keep by law. But some records are incomplete. So, it may not always be able to show exactly what happened if any problems arise.

Inspector's evidence

Standard Operating Procedures (SOPs) were in place and were up-to-date. Members of the team had read SOPs relevant to their roles, with the exception of the new joiners who had started working earlier that week. Team roles were defined within the SOPs. A roles and responsibilities matrix was available but this was incomplete. The responsible pharmacist (RP) confirmed following the inspection that he had completed this.

Near misses were recorded on a log. These were then reviewed informally every three months by the RP and an annual review was also carried out in April 2019. Annual reviews were recorded with findings discussed at the group meeting. A completed review was seen for 2016-2017. The RP was unable to locate the latest completed review sheet as he was in the process of sorting out the paperwork. Quarterly reviews were not recorded. With the shop refit, different strengths of some medicines were separated as near misses were repeatedly occurring. Different packs of medicines that had a similar appearance were also separated on the shelves.

Dispensing incidents were recorded on an incident report form. If the error was picked up by the pharmacy the RP would contact the person. Due to a past incident the team had been asked to show all prescriptions for unlicensed medicines to the pharmacist before dispensing the prescription. As a result of another incident atenolol and allopurinol were moved to ensure that they were not on the same shelf.

The correct RP notice was displayed but this was not clearly visible from the medicines counter. The RP assured that this would be moved following the inspection. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The new team member was unsure of activities that could not be carried out but said that she would confirm with colleagues before doing anything or go and speak to the pharmacist at the sister branch situated a few doors away. Following the inspection, the RP confirmed that he had gone over the SOP for activities that could not be carried out in the absence of the pharmacist with the new join.

Professional Indemnity insurance was in place.

The pharmacy had a complaints procedure in place. Following an inspection at another branch the RP said that he had left space for the complaints notice to be displayed. The pharmacy also completed an annual patient satisfaction survey. The RP was due to upload details of this on to the NHS website; results obtained were compared against other branches. Past feedback had been in relation to the waiting area which had been addressed with the refit. Since then the pharmacy had received positive feedback from people. In the latest survey the pharmacy had received a lesser percentage of satisfaction compared to other branches for waiting times. To help with the waiting times the RP had

reviewed team training, organised the pharmacy and a new counter assistant had started; the RP said that as she became more experienced it would help reduce waiting times.

Records for unlicensed specials and controlled drug (CD) registers were well maintained. Private prescription records had not been made for prescriptions dispensed in April 2019; however, records for these were available on the electronic register. But the details of the prescriber was not always accurate on these. Emergency supply records were generally well maintained. But supplies made under the NHS Urgent Medicine Supply Advanced Service were not processed as emergency supplies on the patient medication record (PMR). And so, records were not accurately made and labels were not annotated with the words 'emergency supply.' Responsible pharmacist records were well maintained but pharmacists were not always recording absences.

CD balance checks were carried out monthly. A random check of a CD medicine complied with the balance recorded in the register. CD patient returns were recorded in a register as they were received.

Assembled prescriptions were stored away from the view of people. An information governance policy was in place which had been recently reviewed. When the General Data Protection Regulation had come into place pharmacists and managers had worked through a booklet. After this, team members had been briefed. The team had been asked to ensure that people collecting dispensed medicines repeated the address back to them. The dispensary team members had their own smartcards. And the regular RP and superintendent pharmacist (SI) both had access to summary care records. Consent for accessing these was gained verbally from the person and a record was made in the folder.

Pharmacists had attended safeguarding training as part of the emergency hormonal contraception service. And in addition to that they had also completed the level 2 training. The team had been briefed by the RP during the staff meeting. All team members had been asked to download the safeguarding mobile application which had information as well as details of local safeguarding contacts. The RP had also printed these out.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members manage the workload within the pharmacy well. And they work well together. They are comfortable about providing feedback to the pharmacist and they are involved in improving the pharmacy's services.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the SI (who left partway through the inspection), the regular RP (came in partway through to cover the afternoon shift), two trained dispensers, and a trainee technician. There was also a new counter assistant who the SI said would be enrolled on the counter assistant course after her probation period.

The SI said that there were enough staff for the services provided. He said that usually at any given time there were four team members plus the RP.

Staff performance had been managed informally by the SI who usually had verbal reviews with all team members. This was due to be formalised with records to be kept. The RP said that he gave feedback to team members. And he said that current team members were comfortable and felt able to approach him if they needed help. This was reinforced by team members.

Team members on formal training courses were given study time during working hours. The RP was the trainee technician's supervisor. She described that she was able to go to him if she needed help or had questions. If the RP was working at another branch, he came in when they closed earlier to help her with her training. The RP said that he briefed the team if he came across information in the trainee technicians' course which he felt others would benefit from.

Team members were encouraged to attend external training sessions and accompanied the group's pharmacists if they were allowed. The latest training session had covered cancer awareness which some members of the team had attended with the pharmacist. If team members were not able to attend the pharmacist would arrange in house training. The SI usually printed out and gave the teams handouts which they could read and talk to him about. The team had been recently briefed on changes in Schedule of pregabalin and gabapentin and electronic CD prescriptions.

The RP was looking into arranging formalised ongoing training for all the group's staff. Other training such as when medicines moved from prescription only to over-the-counter medicines was usually done informally in house. The RP described how he had trained the team on Viagra Connect including questions to ask people. This was supplemented by representatives from manufacturer's and promotional leaflets received.

Meetings were held at least once a month with additional meetings held if there was an incident or staff issues. A meeting had been held to discuss how the workload would be managed prior to the bank holidays. The group's pharmacists were also part of electronic messaging group.

Team members felt able to make suggestions and give new ideas, the trainee technician was new to the company and described how she had suggested pre-printing nomination forms and using an owings book which had been taken on board.

There were no numerical targets set for pharmacists. The RP was aware of the maximum numbers of medicine use reviews (MURs) that he could provide in a year and said that due to the footfall the pharmacy was able to provide this many. He said that the pharmacy also provided many new medicine service (NMS) consultations due to the volume of walk-in prescriptions received.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services.

Inspector's evidence

The pharmacy had undergone a refit since the last inspection and was bright and airy. The dispensary was large with ample workbench space available which was roughly allocated for certain tasks. Cleaning was done by the team with a rota in place. A sink was available, and medicines were arranged on shelves in a tidy and organised manner. There had been a leak into the dispensary from the flat upstairs; this had been temporarily fixed as the upstairs was being refurbished

The consultation room had a wide door suitable for wheelchair users and was clean and tidy. The door leading in from the shop floor was locked and entry was gained via keypad entry. Access to the basement was from the shop floor. This area was undergoing refurbishment. The premises were kept secure from unauthorised access.

The room temperature and lighting were adequate for the provision of healthcare. Air conditioning was available to regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy. Pharmacy services are generally well managed. But team members sometimes leave medicines in unsealed multi-compartment compliance trays overnight. This could increase the chances of mistakes being made. And it could affect the quality of the medicines.

Inspector's evidence

There was step free access into the pharmacy with power assisted double doors. These had been fitted during the refit along with a slight ramp. The middle gondolas had been removed to allow easy access to the medicines counter. Team members would also provide assistance when required. Services were advertised. The team were multilingual and spoke a range of South Asian languages which were spoken locally. Online translation applications were also used when needed.

The SI felt that the delivery service helped people who were elderly receive their medication. He also said the MURs and NMS had an impact as the local area had a diverse ethnic mix. And many people were not fully aware of what medicines had been prescribed for them or the message that they had received from the GP may have not been clear. The pharmacists would try and reinforce the message in the patient's own language as both regular pharmacists spoke a couple of languages each. The RP said that he had attended a training session arranged by the Clinical Commissioning Group on making the most of MURs. Particularly in people with respiratory conditions and with inhaler use as there were a number of new inhalers available. The RP said that following this training he had carried out a number of intervention MURs and used placebo inhalers to help people understand how to use their inhaler correctly.

The pharmacy had been part of a local pilot scheme testing for atrial fibrillation. They had worked in conjunction with the Local Pharmaceutical Committee to find any abnormalities. Results of these were forwarded to a cardiologist at Whipps Cross hospital. The pharmacy had monitored between 30-40 people of who three had been referred.

As part of a Healthy Living campaign the pharmacy had taken part in an event held at a local park. Where they had carried out blood pressure and cholesterol testing and given advice on smoking cessation. Some team members had also attended meeting on cancer awareness and the pharmacy planned to run a campaign on this. The RP said that blood sugar testing was done in store as there was a large south Asian community locally and had a higher prevalence of diabetes. The team advised on diet and exercise and said they were able to relate as they had family members who had the condition.

The pharmacy had an established workflow in place. They received a large volume of walk in prescriptions from the surgery across the road who still supplied people with paper prescription forms. Prescriptions were dispensed by the dispensers and checked by the RP. Completed prescriptions were handed out by the RP or the team. The RP said he had to self-check very rarely as there were support staff available. On the occasions that he had to self-check he said that he would take a mental break.

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 said that learning had been shared from an inspection carried out at another branch. The RP explained that he would speak to the person and ensure that they were aware of the change in guidance. Warning labels had been printed out which were attached to the pack when sodium valproate was not dispensed in its original pack. When a prescription was received the RP would check the person's sex and age and see if they needed to be advised. He had looked through patients who were supplied valproate regularly from the pharmacy and only one person had required counselling.

For patients bringing in prescriptions for warfarin the RP would check the yellow book for INR readings. The pharmacy had a policy in place that a copy of the book needed to be taken before repeat prescriptions could be ordered. A copy of this was sent to the surgery. This was shredded once the prescription was received. For people on methotrexate, results of blood tests were confirmed verbally.

The pharmacy had a folder with individual records for each person who was supplied their medicines in a multi-compartment compliance tray. Prescriptions for these were ordered by the pharmacy in advance and any missing items and changes were queried with the surgery. The person was informed of the change and a note was made on the system. Trays were prepared by a dispenser and then checked and sealed by the pharmacist. Trays prepared the previous day for eight people had not been sealed. In the event that a person was admitted into hospital either the family member informed the team or the hospital did. The dispenser waited for the discharge summary before preparing the next tray and notes were filed with the person's record.

Assembled trays observed were labelled with product descriptions and mandatory warnings. There was no audit trail in place to show who had prepared and checked the pack. This could make it harder to know who did each task if there was a query. Patient information leaflets were handed out monthly.

Some medicines were found in a basket on a workbench. These had been deblistered into brown bottles or back into the original packs. The brown bottles did not have any indication of expiry dates or batch numbers. These were discarded by the dispenser during the inspection.

Deliveries were carried out by a designated driver and signatures were obtained for most people except those who were elderly or unable to sign. The sheet was folded to maintain patient confidentiality. In the event that no-one was home, medication was returned to the pharmacy.

The pharmacy was reusing a bottle for a person on the supervised consumption service. The RP said that they would stop doing this and use a fresh bottle each time.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and recorded; these were observed to be within the required range. CDs were held securely.

Date checking was carried out by the team every three months. A date checking matrix was in place and short dated stock was highlighted; however, the matrix was not always updated. No date expired medicines were found on the shelves sampled.

The pharmacy was compliant with the Falsified Medicines Directive (FMD). The SI was in the process of updating the relevant SOPs.

Out of date and other waste medicines were segregated at the back of the pharmacy and then collected by licensed waste collectors.

Drug alerts and recalls were received via emails and from wholesalers. The last actioned alert had been for losartan. Alerts could be checked by the RP and dispensers.

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

Several calibrated glass measures were available with a separate measure used for methadone. Some of the measures had a considerable amount of limescale. The team assured that this would be cleaned. A separate, clearly labelled, tablet counting triangle for cytotoxic drugs was available for use.

The blood pressure monitor used as part of the services offered was replaced annually. The blood glucose monitor was rarely used, the SI said that a new monitor would be used when needed.

A fridge of adequate size was also available.

Up to date reference sources were available including access to the internet.

Confidential waste was shredded. Computers were password protected and faced away from people who used the pharmacy.

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.