General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Muxton Pharmacy, 9C Fieldhouse Drive, Muxton, TELFORD, Shropshire, TF2 8JQ

Pharmacy reference: 1088121

Type of pharmacy: Community

Date of inspection: 20/08/2019

Pharmacy context

The pharmacy is located within a small parade of shops in a residential area of Telford. It dispenses NHS and private prescriptions and sells a small range of over-the counter medicines, as well as other health and beauty items. The pharmacy delivers medicines to people who are housebound, and it can provide multi-compartment compliance aid packs to help people manage their medicines more effectively. Several other NHS services are available including Medicines Use Reviews (MURs) and influenza vaccinations during the relevant vaccination season.

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 met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy cannot always demonstrate that it is storing and managing medicines appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy asks for feedback and uses this information to make improvements. It keeps people's private information safe and maintains the records it needs to by law. But records are sometimes inaccurate or incomplete, which might mean that the pharmacy cannot always explain what happened in the event of a query. The pharmacy team members understand their roles, but standard operating procedures are not always followed so they might not always work effectively. And they could do more to learn from their mistakes.

Inspector's evidence

A set of standard operating procedures (SOPs) covered operational tasks and activities. The procedures had been recently produced in July 2019 and defined staff responsibilities. But audit trails to confirm staff acknowledgement and understanding of the procedures were incomplete, and some team members confirmed that they had not read the procedures. So, the pharmacy may not always be able to demonstrate that team members are clear about their responsibilities. There were also several instances identified where procedures were not being followed, which may introduce some unnecessary risks and lead to tasks not being completed effectively. Discussions were held with some of the team members present, who demonstrated a general understanding of the limitations of their role. And a medicine counter assistant (MCA) was aware of the activities which were permissible in the absence of a responsible pharmacist (RP). Professional indemnity insurance covering pharmacy services was provided through the National Pharmacy Association (NPA).

The pharmacist reported that dispensing incidents would be recorded. He was initially unsure of how he would do this and explained that he was unaware of any recent incidents. After reviewing the procedures, the pharmacist confirmed that he would report incidents through the National Reporting and Learning System (NRLS). Team members did not always record their near misses. The inspector was provided with a near miss log which contained several entries from July 2019. Prior to this, the only other records available were from 2017. The pharmacist confirmed that no entries had been documented in the months in between and no reviews of near miss incidents had been conducted. So, underlying themes and issues may not be identified and opportunities for learning could be missed.

The pharmacy had a complaint procedure, but this was not clearly advertised so people may not always be aware of how they could formally raise a concern. The pharmacy had previously participated in a Community Pharmacy Patient Questionnaire (CPPQ) and a feedback poster appeared generally positive. But some more recent comments received through a suggestions box had provided some negative feedback mostly regarding the cleanliness and organisation of the premises. The comments were not dated but the pharmacist indicated that the suggestions box had been in place for a couple of months. The MCA explained that in light of these comments, she had made several changes to the organisation in the retail area and was cleaning each section as part of this process. She also disposed of several empty carboard boxes which were cluttering the dispensary, whilst the inspector was present.

The correct RP notice was displayed near to the medicine counter. The electronic RP log was generally

compliant, but one entry indicated that the pharmacist had been absent for a period of time exceeding 200 minutes. The pharmacist confirmed that this was an oversight and that he had forgotten to record his return to the premises in a timely manner. He was aware of the maximum permitted time an RP could be absent for in a 24-hour period and no other problems were identified. Private prescription and emergency supply records contained the information required by law, but three emergency supplies made on the weekend proceeding the inspection had not yet been recorded in the register, in line with requirements. The pharmacist had informal records of the supplies and said that he would formally document them as a matter of urgency. Specials procurement records provided an audit trail from source to supply. The pharmacy kept paper CD registers and maintained a running balance. A patient returns CD register was in use and previous destructions had been signed and witnessed.

The pharmacy team members had a general understanding of how they would protect people's privacy. They segregated confidential waste into a designated bin, which was removed for suitable disposal and appropriate use of NHS smartcards was seen on the day. The pharmacist reported that information governance procedures were in place, but these could not be located during the inspection. The pharmacy was registered with the Information Commissioner's Office and a privacy notice was displayed in the consultation room.

The pharmacist had completed some safeguarding training. He discussed some of the concerns that he might identify but he did not have up-to-date details available to support the escalation of concerns. He agreed to obtain and display the relevant information during the inspection.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy can manage the current dispensing workload. Its team members are able to provide feedback and make suggestions for improvements. And some of them have access to ongoing training. But this is not currently available to everyone, which may restrict the ability for some team members to stay up-to-date. And may mean that the pharmacy cannot always show that learning needs are fully identified and addressed.

Inspector's evidence

On the day of the inspection the regular pharmacist, who was also the superintendent pharmacist, was working alongside a dispenser and an MCA. This was one team member below the usual staffing level, as another regular dispenser was on planned leave. The pharmacy also employed an additional part-time MCA and delivery driver who were present for short periods of time. Leave within the pharmacy was restricted to help maintain sufficient staffing levels. The pharmacist said that the workload was usually still manageable with one person off, but he had access to a locum agency if cover was required. The team were generally up-to-date with dispensing activities, deliveries and compliance aid packs were being supplied on time. There were several prescriptions which were awaiting a final accuracy check, some of which had been received and dispensed at the end of the previous week. Most were dated from the day before the inspection.

The dispenser had completed an MCA qualification. A certificate was seen to demonstrate this, and the pharmacist confirmed the enrolment of both regular dispensers on an appropriate training programme provided by Scientia Skills on the day. The MCA was untrained, and she independently confirmed that she had been in post for approximately four-weeks. The pharmacist said that he intended to enrol the MCA on an appropriate training programme. The GPhC education and training requirements were discussed and reinforced, to ensure the pharmacist was aware that enrolment should take place within three-months of employment. There was limited ongoing training provided. The pharmacy had access to an e-Learning platform but only two members of staff had password accounts to access to the site. The pharmacist reported that he would arrange for the other team members to have access to the system. During the inspection, he obtained a report of modules which had been completed. This demonstrated that the system was not always being used regularly and no protected training time was currently available to support staff in completing modules. The pharmacy did not have a formal system to provide feedback to team members. The pharmacist explained that he would identify any learning points through general observation, and where he identified a problem he would intervene and then discuss this with the team member. No records of this were maintained.

The MCA discussed the sale of medicines within the pharmacy and explained how she would manage frequent requests for medicines. Appropriate questions were asked to help confirm that sales were safe and appropriate, and concerns were referred to the pharmacist.

The team were happy to discuss things amongst one another. The MCA said that the pharmacist had been receptive to feedback and changes that she had suggested to improve the organisation and

cleanliness of the environment and was supportive of other ideas such as improvements in displays. A notice was placed in the dispensary which informed the team of some organisations which they could contact to enable an anonymous concern to be raised. There were some targets in place for professional services and the pharmacist explained how the patient medication record (PMR) system was used to help ensure services were carried out only where appropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is suitably maintained for the provision of healthcare services. It has a consultation room to enable it to provide members of the public with access to a private area for discussions. But the dispensary is compact and this impacts on general organisation which may detract from the overall professional appearance.

Inspector's evidence

The pharmacy, including the external facia was in an appropriate state of repair. The pharmacist was responsible for arranging any necessary maintenance repairs and daily cleaning duties were completed by the pharmacy team. The ambient temperature on the day was appropriate for the storage of medicines and there was adequate lighting throughout.

The retail area appeared generally tidy on the day. The floor space was free from obstructions and chairs were available for use. The pharmacy sold an appropriate range of goods and pharmacy medicines were behind the medicine counter or behind a screen which advised people to ask for assistance. An enclosed consultation room was available off the retail area. The room was appropriately maintained and had a desk and seating to facilitate private and confidential discussions. The computer terminal was occasionally used as a second labelling station if the workload got busy, but no confidential information was visible on the day.

The dispensary was compact. There was a computer terminal which was used for labelling and prescription assembly then took place on a separate small bench, with a third area reserved for checking. There were some baskets stored on the work benches which limited the space available for dispensing. To increase storage space the pharmacy had two metal trolley’s which were being used to store prescriptions which needed to be checked. These may create a trip hazard for staff. Several empty cardboard boxes were removed during the inspection to create more space. The dispensary had a sink for the preparation of medicines which was equipped with appropriate hand sanitiser. And other staff facilities were reasonably well maintained.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy manages its services adequately and they are generally accessible to members of the public. However, it does not routinely identify people on high-risk medicines, so people may not always receive all the information they need to take their medicines properly. The pharmacy sources its medicines suitably but it cannot demonstrate that it carries out appropriate checks to show that it stores them appropriately and they are fit for supply.

Inspector's evidence

The pharmacy was accessible from the street via a single step. No ramp facility was available, but an MCA said that she would assist anyone who needed help with access and she provided an example of how she had done this the day before the inspection. There was limited advertisement of the pharmacy' services, which included a flyer promoting the collection and delivery service and a window display. No practice leaflet was available. The pharmacy had a stand near to the main entrance with some health promotion literature and leaflets advertising local services such as Shropdoc. The MCA said that she had knowledge of the local area to be able to direct anybody that needed another service and internet access was also available to support this.

Prescriptions were dispensed using baskets to keep them separate and reduce the risk of medicines being mixed up. Team members signed 'dispensed' and 'checked' boxes as an audit trail to help identify those involved. Once complete, prescriptions were filed in a retrieval system. There were three photocopied prescriptions identified, two which were dated April and June 2019 were bagged and awaiting collection and a third dated from April 2019 was in a dispensing basket with a label. The pharmacist said that in this instance it was an owing item from the original prescription, but he could not account for the original prescription forms. Failing to retain original prescription forms until the point of supply may increase the risk that the team do not have access to important information and that prescriptions could be mistakenly claimed for prior to supply.

The supply of valproate-based medicines was discussed, although the pharmacist was aware of some of the risks of valproate-based medicines in people in the at risk group, he was not familiar with recent guidance from the Medicines and Healthcare products Regulatory Agency (MHRA) and did not have access to the necessary safety literature. This was reinforced on the day and the inspector advised on how the materials could be obtained. The pharmacy did not routinely highlight any other prescriptions for high-risk medicines, so people may not always get the additional counselling and monitoring that they need.

The pharmacy was able to order repeat prescriptions for patients of one local surgery. The remaining surgeries had moved to a local Patient Ordering Direct (POD) system, meaning patients ordered their medicines directly. Where the pharmacy ordered medicines, the repeat requests were sent to the surgery via fax, but no cover sheet was used so the transmission may not be in keeping with safe haven data transfer guidance. The pharmacy kept a basic audit trail to help identify unreturned prescriptions, but this was not always complete. One request made the week prior to the inspection was showing as being unreturned. The pharmacist said that this was not the case, and confirmed that the prescription

had been dispensed, but the record sheet had not been updated to reflect this. For people using multi-compartment compliance aid packs, the pharmacy used a diary to organise when packs were due. They ordered medications which went into compliance packs, but additional 'when required' items were only ordered upon patient request, to help prevent over ordering. Completed packs had patient identifying details to the front, descriptions were present to enable medicines to be identified and patient leaflets were supplied. The pharmacy had one patient who received Epilim in a compliance aid. The pharmacist stated that the tray was assembled weekly to help manage stability issues.

The delivery driver obtained signatures for the delivery of CDs using dispensing labels, which were placed into a designated book. Signatures were not routinely obtained for all other deliveries, unless the patient had an exemption which needed to be completed on the reverse of the prescription form. In these instances, the driver took the medication and the prescription form to the patient for them to complete and then returned the signed prescription to the pharmacy. He then kept a log using dispensing labels of successful deliveries that had been made on the day. Failed deliveries were returned to the pharmacy. This procedure was not in keeping with the delivery SOP and could increase the risk of prescription forms being lost.

The pharmacy sourced medicines from reputable suppliers and specials from a licensed manufacturer. Stock medicines were stored in their original packaging, but some areas were unorganised which may increase the risk of a picking error. The date checking systems were discussed but records were not available to confirm when checks had last taken place. The pharmacy had some records identifying some short-dated medicines, which had been highlighted on the shelves and no expired medicines were identified from random checks. Out-of-date and returned medicines were placed in pharmaceutical waste bins. Several blisters of tramadol and pregabalin were identified in a standard bin. These were removed and given to the pharmacist for denaturing prior to disposal. The pharmacist agreed to review schedule 3 and 4 CD denaturing requirements with members of the pharmacy team. A cytotoxic waste bin for the disposal of hazardous medicines could not be located. The pharmacy was not yet compliant with requirements as part of the European Falsified Medicines Directive (FMD). A scanner had been received and the pharmacist agreed to follow-up on the other aspects of implementation. The pharmacy received drug alerts through an email system. An audit trail was not kept showing the action taken in response to alerts, which may mean that the pharmacy cannot always demonstrate alerts are appropriately managed.

CDs were stored appropriately, but stock organisation was lacking, and some returned and expired CDs were found amongst stock. Random balance checks were found to be correct and CD denaturing kits were available. The pharmacy fridge did not have a maximum and minimum thermometer, when asked the pharmacist advised that this had broken 'sometime' ago. It was unclear as to how long the fridge had not been monitored for as temperature records were fictitious. The pharmacist informed the inspector that a temperature had to be entered as part of the system start up. Due to the lack of thermometer it was not possible to check whether the fridge was within the recommended temperature range.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services safely. But the location of the telephone may increase the risk that private conversations could be overheard.

Inspector's evidence

The pharmacy had several glass crown-stamped conical measures which were appropriately maintained and marked to indicate their use with different liquids. Counting triangles were clean and a separate triangle was marked for use with cytotoxic medicines. Access was available to paper pharmaceutical reference texts and internet access supported additional research.

Electrical equipment appeared to be in working order but had not been recently PAT tested. The computer and printer systems were contracted from the PMR provider who helped resolve any issues. Other problems were managed by the pharmacist. Systems were password protected and screens were located out of public view. But the phone was corded and located near to the medicine counter, which may increase the risk that conversations could be overheard.

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.