

Registered pharmacy inspection report

Pharmacy Name: Mayors Pharmacy, 67 Bow Road, London, E3 2AD

Pharmacy reference: 9011723

Type of pharmacy: Community

Date of inspection: 04/03/2022

Pharmacy context

This pharmacy is located within a parade of shops on a busy main road. The pharmacy dispenses medication against prescriptions and provides the flu vaccination service. It also provides medication in multi-compartment compliance packs to people who live in their own homes and need help managing their medicines. The inspection took place during the Covid-19 pandemic.

Overall inspection outcome

✓ **Standards met**

Required Action: None

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 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 appropriately identifies and manages the risks associated with providing its services. It generally keeps the records it needs to by law, to show that medicines are supplied safely and legally. People who use the pharmacy can provide feedback and raise concerns and the pharmacy team have some basic understanding on protecting the welfare of vulnerable people.

Inspector's evidence

The pharmacy had made a number of changes as a result of the Covid-19 pandemic. A staff risk assessment had been completed early in the pandemic. Signage was displayed to help remind people of the restrictions and a plastic screen had been fitted at the front counter. Personal protective equipment (PPE) and hand sanitisers were available for the team and members of the public.

Standard operating procedures (SOPs) were available at the pharmacy. All current members of the team had signed the relevant procedures to confirm that they had read and understood them. The SOPs had been updated in 2021. Responsibilities of team members were listed on individual SOPs.

Dispensing mistakes which were identified before the medicine was handed to a person (near misses) were seen to be routinely documented. Members of the team said that the pharmacists discussed near misses with them and described some changes which had been made to minimise the reoccurrence of these mistakes. For example, sertraline and sildenafil tablets had been separated on the shelves as they sounded similar.

Dispensing mistakes which reached people (dispensing errors) were referred to the pharmacist, investigated and documented. They were also reported on the National Reporting and Learning System. Members of the team described a dispensing mistake where the wrong medicine was handed out because an incorrect name label had been attached to the bag. They said that they now always double checked the person's details, particularly people with similar sounding names. The pharmacy manager, who was also a dispenser, said that the team regularly discussed different scenarios, for example, how they could reduce the likelihood of mishearing people wearing face masks. They said they now asked people to write their details, including their date of birth, on a piece of paper. They also asked people to repeat any advice provided to ensure that they had understood it.

The pharmacy had current indemnity insurance cover. A regular locum pharmacist arrived after opening time as the regular pharmacist had to leave. The correct responsible pharmacist (RP) notice was displayed. Samples of the RP record were seen to be well maintained. Other records required for the safe provision of pharmacy services were generally completed in line with legal requirements, including those for private prescriptions and unlicensed medicines. Emergency supply records did not always include the nature of the emergency. This may make it harder to show why the pharmacy had made a supply of a medicine in an emergency. A sample of controlled drug (CD) registers was inspected, and these were filled in correctly. The physical stock of a CD was checked and matched the recorded balance.

People were able to give feedback or raise concerns online or verbally. The pharmacy had a complaints procedure. Team members said that they regularly received thank you cards and gifts from people, and

some of these were seen to be displayed in the dispensary.

Members of the team had completed a training module and assessment on the General Data Protection Regulation. Confidential waste was shredded at the pharmacy, computers were password protected and smartcards were used to access the pharmacy's electronic records. Cordless telephones were available so that members of team could have private conversations away from people. Not all confidential material was stored as securely as it could have been, and team members said this would be addressed.

Some members of the team could not remember if they had completed training on Safeguarding children and vulnerable adults, but they were able to describe some signs of abuse and neglect. They said they would complete refresher training. The regular locum pharmacist had completed the Centre for Pharmacy Postgraduate Education module on the subject.

Principle 2 - Staffing ✓ Standards met

Summary findings

Team members work well together, and they manage the pharmacy's workload well. They feel comfortable about raising concerns and have opportunities to discuss ideas to help them to improve pharmacy services. They complete ongoing training in their own time as they do not always have time to do this during their working hours. This may make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

There was a qualified dispenser and a trainee dispenser present at the start of the inspection. The regular pharmacist, who was also the superintendent pharmacist, was not present during the inspection, and another regular pharmacist had been contacted to cover the shift. The locum pharmacist and pharmacy manager (who was also a dispenser) arrived sometime after the inspection had started. The dispensers could not find the pharmacy's business continuity plan but said they had access to the contact details of regular locum pharmacists who they could contact in an emergency.

Initially the dispenser said that she would hand out dispensed medicines if they had been checked by a pharmacist, if the RP was not present. Upon further questioning, both dispensers said that they would not hand out dispensed medicines or sell Pharmacy-only medicines in the absence of the RP. They were advised to read the relevant SOP to refresh their knowledge and understanding of the RP guidance. They were observed sorting the delivery and selling general retail products whilst a pharmacist was not present.

The pharmacy had recently employed another person to help cover the medicines counter. The pharmacy manager said that they would be enrolled onto the relevant course. A staff handbook was in place and covered absence reporting, accidents, confidentiality, and whistleblowing.

Members of the team understood their role and responsibilities. They completed some ongoing training, for example, on antimicrobial stewardship, Covid-19, obesity, chlamydia and infection control. But they mainly completed these at home as they did not have time during working hours. The pharmacists also observed team members whilst they were selling or handing out medicines and gave them feedback when necessary. The regular locum pharmacist had provided team members with details of websites which provided useful information on minor ailments.

Team members reported that the SI and regular pharmacists were open to feedback and they felt comfortable to approach them with any issues regarding service provision. Team members said that they were always working on improving services, for example, they tried to make the delivery service accessible to as many people as possible. They also tried to cater for people's needs and described researching about any new products which people had queried about and tried to keep them in stock. Performance was discussed informally. Targets were not set for team members.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are suitable for the services offered and they are kept secure. There is a room where people can have private conversations with a team member.

Inspector's evidence

The pharmacy had moved into the current premises several months ago. Fittings were new and maintained to a level of hygiene appropriate for the provision of healthcare. There was ample work and storage space, and workbenches were kept clean and tidy. Members of the team shared housekeeping tasks and said that they disinfected surfaces throughout the day. A cleaning rota was in place and was updated once a task was completed.

There were two spacious consultation rooms available for private conversations and services. One was currently being used by the pharmacists as an office. Both rooms were fitted with a lock but were kept unlocked. Members of the team said they would keep the rooms locked when the not in use. A screen was fitted at the medicines counter and chairs were wipeable.

There was a toilet, a small kitchenette, and lockers for members of staff. The room temperature and lighting were adequate for the provision of pharmacy services. The premises were secure from unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

People can access the pharmacy's services. The pharmacy has some systems in place for making sure that its services are organised. It orders its medicines from reputable sources and largely manages them properly. But it does not always keep records of fridge temperatures. This may make it difficult for the pharmacy to show that medicines requiring cold storage are stored appropriately.

Inspector's evidence

Access into the pharmacy was step-free and via an automatic door. There was sufficient space in the retail area, and this assisted people with restricted mobility or using wheelchairs. The pharmacy had a small seating area for people to use when they wanted to wait. Some members of the team were multilingual. Services were listed on the window and in the waiting area. There was sufficient workspace and baskets were used to separate prescriptions and prevent transfer between people. Dispensing audit trails to identify who dispensed and checked medicines were not always completed. This may make it difficult to identify who was involved in these processes, for example, if a dispensing mistake occurred.

Prescriptions were not always retained with dispensed medicines. This meant that team members relied solely on bag labels when handing out medicines, which may increase the likelihood of hand-out errors. It may also mean that staff were not able to identify if a Schedule 3 or 4 CD was inside the bag, which may increase the risk of supplying these medicines past the valid date on the prescription.

An amber medicine bottle was seen to be reused for a person receiving substance misuse treatment as it had several labels attached to it. The pharmacy team were advised against reusing bottles for hygiene purposes. They said that this practice would stop, and a new bottle would be used for each instalment.

Team members were aware of the checks and labelling requirements of dispensing sodium valproate to people in the at-risk group and said they would provide them with an information card. One dispenser could not correctly describe the 'at-risk' group. She was advised to reread the guidance. Team members checked the person's understanding on how to take their medicines and highlighted dose instructions, particularly when the medicine was newly prescribed. The pharmacy did not always check if people taking higher-risk medicines such as methotrexate and lithium, were being routinely monitored. They provided examples of advice given to people on lithium, such as the importance of maintaining salt and hydration levels.

Multi-compartment compliance packs were assembled in the dispensary, on a designated work bench. Prepared packs observed were labelled with product descriptions though these were not always updated. Patient information leaflets were routinely supplied. The pharmacy had clear audit trails for the service to help keep track of when people were due their packs and when their packs were ready. Original packs were retained with the assembled trays for the pharmacist to check.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices tidily on the shelves within their original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines at regular intervals and kept clear records of this. No expired medicines were found on the shelves in a random check in the dispensary. Fridge temperatures were

not recorded consistently, for example, only five readings had been recorded in February 2022. The fridge temperature fell within the recommended range during the inspection. The pharmacy manager said that the temperatures were checked daily and that they would be documented in the future. Drug alerts and recalls were received electronically and filed for reference. A log was completed to keep track of action taken in response to the alerts. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had several glass measures and tablet counting triangles, including a separate triangle for cytotoxic medicines. This helped avoid cross-contamination. There were two fridges, one was in the dispensary and was used to store dispensary stock, and another was in the consultation room and was used to store flu vaccines. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Members of the team had access to the internet and several up-to-date reference sources.

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.