General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Murray Miller Pharmacy, 526 Sutton Road, SOUTHEND-ON-SEA, Essex, SS2 5PW

Pharmacy reference: 1031425

Type of pharmacy: Community

Date of inspection: 18/07/2019

Pharmacy context

The pharmacy is located on a main street near to Southend-on-Sea. It is surrounded by residential premises. The people who use the pharmacy are mainly older people. It receives around 90% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service, a stop smoking service and seasonal influenza vaccines. The pharmacy provides multi-compartment compliance packs to around 60 people who live in their own homes to help them take their medicines safely. And it provides substance misuse medications to two people.

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 largely identifies and manages the risks associated with its services to help provide them safely. It generally protects people's personal information well. And it regularly seeks feedback from people who use the pharmacy. It mostly keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible, sometimes using card dividers. 'Check strength' stickers were placed on shelves to alert team members.

Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that he was not aware of any recent incidents. All near misses and incidents were reported to the National Pharmacy Association so that learnings could be shared with different organisations. The pharmacist produced an incident summary report every three months and shared the findings with the team.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The dispenser was clear on which tasks could and should not be carried out before the pharmacist had turned up. The medicines counter assistant (MCA) knew that she should not sell pharmacy only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed special was made. The private prescription record and emergency supply record were completed correctly.

Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked weekly. Liquid CD balances were checked monthly, and overage was recorded in the register. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The responsible pharmacist (RP) log was largely completed correctly. There was one occasion in December 2018 where the log had not been completed on a day when the pharmacy was open. The pharmacist said that a locum pharmacist had been working that day. He said that he would contact him and complete the log with an explanation. The correct RP notice was clearly displayed.

Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected. Smartcards used to access the NHS spine were stored securely and team members used their own Smartcards during the inspection. The pharmacy team members had completed General Data Protection Regulation training. The pharmacy obtained people's signatures for deliveries where possible; these were not recorded in a way so that another person's information was protected. The pharmacist said that he would revise the signature sheet to ensure that people's information was not visible to others.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were displayed in the shop window. Results showed that 100% of respondents were satisfied with the pharmacy overall. The pharmacist said that he was not aware of any recent complaints. Results from previous surveys were available on the NHS website. But results from the most recent survey were not yet available on there. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had received some safeguarding training provided by the pharmacy. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. Team members discuss any concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

There was one pharmacist, one dispenser (level 3 student), one pre-registration trainee, one fourth year pharmacy student and one MCA working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And said that she would refer to the pharmacist if someone asked to buy two boxes of any medicine. She confirmed that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

Team members had completed accredited pharmacy courses or were enrolled on one. The MCA said that she completed regular training modules on the pharmacy's hand-held electronic media device. And she could access training modules at home and the pharmacist monitored training. She had completed recent training on children's oral health and head lice products. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members had yearly appraisals and performance reviews. The pharmacist said that he had an informal review with the superintendent pharmacist, but this was not documented. He said that information was passed on to team members informally. And there were no formal meetings. He said that issues were discussed during the day and processes changed if needed to make the pharmacy safer. Targets were not set for staff. The pharmacist said that he provided the services for the benefit of the people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was secured from unauthorised access. An alarm sounded when the main door was opened, which let team members know that there was a person in the shop area. The pharmacy was bright, clean and tidy throughout; this presented a professional image. Pharmacy only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. Air-conditioning was available and the room temperature was suitable for storing medicines.

There was one chair in the shop area for people to use. This was directly in front of the medicines counter which meant that conversations at the counter may possibly be overheard. The pharmacy's consultation room was located at the back of the dispensary. There was a step up to the room from the dispensary and it was not easily accessible to wheelchair users. The pharmacist said that people were escorted through the dispensary. There were bags of dispensed medicines kept on shelves on the way to the consultation room. And some people’s personal details were potentially visible on them. The pharmacist said that he would store these in a way which protected people’s information. The consultation room was suitably equipped and well-screened. Low level conversations in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy generally manages its services well and provides them safely. It gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises if needed. Services and opening times were clearly advertised. And a variety of health information leaflets were available. Two of the regular pharmacists provided the stop smoking service.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for schedule 2 and 3 CDs were dispensed when the person collected them. And prescriptions for schedule 4 (part 1) CDs were annotated with the date that the items were not to be handed out after. The pharmacist said that he checked CDs with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy did not have the up-to-date patient information leaflets or warning cards available. The pharmacist said that he would order these from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next three months was generally marked. There were several date-expired items found in with dispensing stock. These had been written on a short-dated stock list but had not been removed promptly. The pharmacist said that he would ensure that items were removed before they had gone past their 'use-by' date in future.

The pharmacist said that part-dispensed prescriptions were checked daily. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacist said that uncollected prescriptions were checked regularly and people were sent a text message reminder if they had not collected their items after two months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that the pharmacy contacted people to ask if they needed them. The pharmacy kept a record for each person

which included any changes to their medication. They also kept hospital discharge letters for future reference. Compliance packs were suitably labelled and there was an audit trail to show who had dispensed and checked each compliance pack. Medication descriptions were put on the compliance packs and patient information leaflets (PILs) were routinely supplied. The pharmacy did not order prescriptions on behalf of the care home. The dispenser said that the care home team ordered these from the surgeries. The pharmacy supplied administration charts to help the care home give the medicines safely.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. If the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The pharmacy had the equipment for the EU Falsified Medicines Directive and this was in use when possible. The pharmacy was scanning items when they were dispensed which produced a 2D barcode. And this was attached to the bag if the person was collecting their medicines later. Items were decommissioned from the system at the point of supply. Team members had received training and there was an SOP for the process.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Suitable equipment for measuring medicines was available. Separate liquid measures were marked for CD use only. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor had possibly been in use for over three years. He said that he would replace this and keep a record of when it was first used. The carbon monoxide testing machine was calibrated by an outside agency. The shredder was in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

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.