General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Muswell Hill Pharmacy, 110 Fortis Green Road, Muswell Hill, LONDON, N10 3HN

Pharmacy reference: 1040398

Type of pharmacy: Community

Date of inspection: 18/02/2020

Pharmacy context

The pharmacy is located on a main road in a residential area. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs to some people who need help managing their medicines. The pharmacy also supplies medicines to people residing in two care homes. It also provides Medicines Use Reviews (MURs) and the New Medicine Service (NMS).

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 not all met	1.7	Standard not met	The pharmacy does not always dispose of people's personal information properly. This could result in this information being disclosed.
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 not all met**

Summary findings

The pharmacy doesn’t always dispose of people’s confidential information properly. And this could result in people’s personal information being disclosed. Otherwise however, the pharmacy generally identifies and manages the risks associated with providing its services. It largely records the records it needs to by law, to show it supplies its medicines safely and legally. Team members know how to protect vulnerable people. But the pharmacy doesn't consistently record near misses which may mean patterns are not identified and suitable remedial actions not put in place.

Inspector's evidence

Standard operating procedures (SOPs) were available and team members with the exception of the pre-registration trainee, who had started working at the pharmacy a few weeks prior to the inspection, had read and signed SOPs which were relevant to their roles. Core dispensing SOPs did not incorporate the Falsified Medicines Directive (FMD). Team roles were defined within the SOPs.

The responsible pharmacist (RP) said near misses were recorded on a near miss log, however there was no record sheet available for February 2020. The RP said that there had been some near misses since the start of February. Previous near miss records were said to be with the superintendent pharmacist (SI) who was completing the annual patient safety review. There were some near miss records and patient safety reviews seen from May 2019. As a result of past reviews, the dispensary layout had been changed and medicines were now arranged on the shelf from A-Z by the generic name. Once the review was completed the RP briefed the dispensary team. However, until recently other than the medicines counter assistant (MCA) there had not been any other regular staff.

Dispensing incidents were shared with the SI and reported on the National Reporting and Learning System (NRLS). The RP described an error that had occurred with where a person residing in a care home had been supplied with 50mg of a medicine instead of the prescribed 25mg. The person was usually given both strengths to take a daily dose of 75mg. The prescription had been self-checked by a locum pharmacist. The RP had liaised with the care home team who had spoken to the GP. The incorrect medication had been taken for two to three days. The locum pharmacist had been made aware of the incident and the team ensured that there was another team member present who could check prescriptions when the pharmacist was working.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaint procedure. The pharmacy also completed an annual patient satisfaction survey. People also left reviews on the internet. As a result of feedback on the waiting area the chairs had been moved.

Records for emergency supplies, unlicensed specials, controlled drug (CD) registers and RP records were well maintained. Private prescription records did not always have the date written on the prescription recorded. CD balance checks were frequently carried out. A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received.

Assembled prescriptions were stored in the dispensary out of the view of people. The RP had a

smartcard to access the NHS electronic systems. The RP had contacted the local NHS team as his access to Summary Care Records was still linked to the previous pharmacy that he worked at. Team members had completed training on data protection and information governance. Confidential waste with people's private information on it was found in the general waste bin. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. A shredder was available.

The RP and SI had completed the level 2 safeguarding training and the MCA had completed the level 1 course. The pre-registration trainee (pre-reg) had not completed any training and was due to complete the level 2 course. Details of local safeguarding contacts were not available. This could cause delay in concerns being escalated.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy provides its services using a team with a range of skills and experience. The pharmacy staff levels mean that on occasions the team struggles with the workload. But they are generally up-to-date with their dispensing. Staff are given some ongoing training. But this is not very structured, and they are not given time set aside for training. This could make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP, the pre-registration trainee (pre-reg) who had recently started, and a trained medicines counter assistant (MCA) who had worked at the pharmacy for a number of years. The team said that the day of the inspection was busier than most days. The RP said that the first three weeks each month were relatively steady and the final week was busier with both care homes due. The pharmacy was supported by a dispenser two or three times a week for half a day each week. With the additional support of the dispenser the team were better able to manage the workflow. Multi-compartment compliance packs and dispensing for the care home was done all prepared and checked by the RP. No second independent check was obtained as the pre-reg was usually busy dealing with other dispensing. To help manage the workflow and ensure that they were generally up-to-date with their dispensing, the RP was preparing multi-compartment compliance packs ahead of receiving prescriptions and as there was only one terminal a vast majority of these were not labelled.

In September 2019, a full-time dispenser had left along with a few other team members. Until the pre-reg had joined the RP usually worked on his own and had a dispenser occasionally working alongside him.

Staff performance was managed informally, and the RP provided team members with feedback. The MCA had worked at the pharmacy for a number of years and was familiar with the processes. The MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was aware of the maximum quantities of certain medicines which could be sold over the counter and would not recommend ibuprofen to be used for someone with chicken pox. She described the process that she would follow when handing out prescriptions.

To keep up-to-date team members read through material sent by Avicenna as well as leaflets from manufacturers. The RP passed on training pages to team members from pharmacy magazines. The RP also verbally went over different areas with team members depending on areas that they had asked questions on. The latest area which had been discussed was medicines for babies.

The pre-reg had moved to the pharmacy from a different pharmacy and was enrolled on the Propharmace course. He attended training session every two weeks. The RP was the pre-reg's tutor. The pre-reg would speak to the RP if he was unsure of anything. The RP communicated with the SI via email or over the telephone.

Team members had a group chat on a messaging application and used this to share information. The team also went through things as they came up. Team members felt able to give the SI feedback and share concerns with her. The RP had suggested launching the travel vaccination service when he had

first started the pharmacy. There were no numerical targets in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services. People can have a conversation with a team member in a private area. But the pharmacy could do more to ensure that it does not leave items in the consultation room unsecured.

Inspector's evidence

The dispensary was large with ample workspace which was allocated for certain tasks. The work benches used for dispensing and checking were largely clear and organised. Dispensary shelves were tidy and organised. A sink was available for the preparation of medication. A separate area was dedicated for the preparation of multi-compartment compliance packs for care homes. A separate workbench was also used for checking. Cleaning was done by the team.

A signposted consultation room was available which was easily accessible and unlocked when not in use. Access to the staff toilets was through the consultation room. There was no confidential information held within the room. However, prescription only medicines including a patient returned medicines were found in the room. These were removed by the RP during the inspection. The room was used to provide vaccinations and there was a glass window on the door. The inside of the room was clearly visible from the shop floor through the window. The RP described how he used posters to cover the window when he was administering and vaccinations and had discussed having a blind fitted with the owners.

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of healthcare.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. It obtains its medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services. But the pharmacy does not always give people the information leaflets that come with their medicines. So, patients and carers may not always have all the information they need to use their medicines safely. The pharmacy does not always refer to the prescription when it is assembling compliance packs. And this could increase the chance that a mistake is made.

Inspector's evidence

The range of services offered by the pharmacy was adequately promoted. Access into the premises was via a flat entrance from the street with electronic doors at the entrance. Aisles were also wide and clear with easy access to the counter. The local population predominantly were English speaking and the pharmacy had not had issues with languages in the past. The team used online translation applications when needed. Team members were aware that signposting may be necessary where people required an additional or alternative service. The pharmacist used the internet to find local services. The pharmacy had the ability to produce large print labels when needed.

The RP felt that the services which had the most impact changed depending on the seasons. The flu vaccinations and travel vaccination services were very popular particularly before school holidays. The pharmacy was situated in an affluent area and people were generally knowledgeable. The MCA had found that people came in already having found out a lot of information. People locally were also engaged with services such as sexual health services. The RP and another regular pharmacist were due to attend training for other sexual health services provided locally such as chlamydia testing. At the time of the inspection, the pharmacy was only supplying people with testing kits when they needed.

Prescriptions were received electronically, printed and labels were processed and placed in a basket. These were dispensed by the dispenser or pre-reg and left for the RP to check. The pharmacy sent surgeries request by email using the electric patient recording system. The pharmacy was ahead of preparing prescriptions which were due within the next few days. A second check obtained on most occasions when the pre-registration trainee was available. If it was really busy or when one member was on lunch the RP would self-check. Taking a mental break in between the dispensing and checking processes was discussed. Dispensed and checked-by boxes were available, the pre-reg was not routinely signing these. Baskets were used to separate prescriptions, preventing transfer of items between people.

The RP was aware of the change in guidance for dispensing sodium valproate. Warning cards were given to people when they were supplied with sodium valproate. The RP would check what conversation people in the at-risk group had with their prescriber. Two people had been identified as falling in the at-risk group when the pharmacy had completed the audit. They had been referred to their GP. The RP was not aware of the need to use the warning stickers if valproate was not dispensed in its original pack. The inspector reminded him of the requirements.

For prescriptions for warfarin, the RP asked when the person last their INR had checked. He was unsure

if the pre-reg or dispenser were checking this when they were handing out the prescription. The RP tried to make a record on the electronic recording system of the INR when the person had their yellow book. Regular people were asked to bring in their yellow book. A lot of people had their medicines delivered but their INR was only checked on some occasions. This could make it harder for the pharmacy to confirm that people were receiving the necessary checks for their medicines.

The pharmacy supplied medicines in multi-compartment compliance packs to a number of people including some people staying in a care home. Prescription forms were not always printed for packs prepared, although the SOP required stock selection, preparation and checking to be carried out using the prescription forms. Some packs were also prepared and sealed several days in advance of prescription forms being received by the pharmacy. The RP said that this was done to manage the workflow and he prepared and checked the packs on his own. This was discussed with the RP during the inspection, and the RP said that he would talk about this with the SI. A number of prepared packs seen during the inspection had also not been labelled, but the packs were stored in individual baskets to help avoid them becoming mixed up. Individual record cards were in place for each person. The pharmacist used the electronic records to check for any changes to medication histories. However, communication was not always recorded. Packs were generally prepared by the RP or the SI and both checked their own work. The pharmacy used a tracker to order prescriptions and this was done two to three days in advance. Prescriptions for the care homes were ordered by them but for some people these were also ordered by the RP. The RP described how due to issues with the quantities being prescribed the pharmacy was having to dispense more interim prescriptions. When prescriptions were received the RP confirmed these against the repeat slips supplied by the care home and submitted a missing item report back to the home. Some people were supplied their medications covertly and the care home would bring in the form, the RP provided advise on the best way to administer specific medicines. The RP visited the care home every six months to carry out a review. Medication administration charts were provided to one of the homes. The other care home (60 people) was supplied medicines in original packs. A special barcoding system was used to label these medicines and the medication packs were scanned by the care home each time the medication was administered. The RP said that at the point of dispensing the system highlighted if an incorrect item had been scanned.

Assembled packs observed were labelled with mandatory warnings, but product descriptions were not included. This could mean that people may not be able to identify the medication within the packs. Patient information leaflets were not routinely supplied and there was no audit trail in place to show who had prepared and checked the packs.

Deliveries were carried out by team members for a few local housebound people. In the event that a person was not available medication was returned to the pharmacy.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of medicines. CDs were kept securely. Mixed brands of medication were observed to be stored in the same packaging with different expiry dates observed on the blisters. Medicines were also found to be stored in brown bottles with no expiry date or batch numbers recorded.

Date checking was completed every four to six weeks, short-dated stock was marked with stickers. There was no date-expired medicine found on the shelves checked. A date-checking matrix was not available as the RP said that this was in the folder which was with the SI. Out-of-date and other waste medicines were disposed of in the appropriate containers which were segregated and collected by a licensed waste carrier. The pharmacy had some chemicals including potentially hazardous ones at the back in the stockroom which had been inherited from the previous owners. At the previous inspection the SI had been recommended to contact the local council and arrange for disposal. No action had been

taken. The RP gave an assurance that he would raise this with the SI. Fridge temperatures were recorded and within range.

The pharmacy had the scanners in place for the Falsified Medicines Directive. The RP was unsure if the software was available and gave assurances that he would confirm with the SI.

Drug recalls were received via email, these could be accessed by all team members. The last alert which the pharmacy had actioned had been for ranitidine. Alerts were usually printed and filed but the RP had not done this in the last month although he had actioned the alerts.

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 a range of clean glass calibrated measures available. Tablet counting trays were available. Separate measures were marked for methadone use only and a separate counter was used for cytotoxic medication to avoid contamination. One of the measures had a fair amount of limescale build up and another measure had a residue of a liquid CD. The RP gave assurances that these would be cleaned. Up-to-date reference sources were available including access to the internet. The pharmacy had a fridge of adequate size. A blood pressure monitor was available which was approximately one year old.

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.