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: 13/10/2020

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). The inspection was undertaken during the Covid-19 pandemic.

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 adequately manages the risks associated with its services. People who use the pharmacy can provide feedback and raise concerns. And the pharmacy team knows how to help protect the welfare of vulnerable people. Team members generally respond appropriately when mistakes happen during the dispensing process. This provides them with opportunities to learn and make the services safer.

Inspector's evidence

Standard operating procedures (SOPs) were available and team members had read and signed SOPs which were relevant to their roles. Team roles were defined within the SOPs. New SOPs for the flu vaccination service had been added and the guidelines for team members about working during the Covid-19 pandemic had also been added. The team had been routinely ensuring infection control measures were in place and cleaned the pharmacy regularly through the day. Team members had been provided with personal protective equipment (PPE). The responsible pharmacist (RP) explained that the necessary risk assessments to help manage Covid-19 had been completed and this included occupational ones for the staff. However, a risk assessment had not yet been completed for the pre-registration trainee, and the RP said that he was due to complete an assessment.

The pharmacy recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). The RP said that there had been no near misses in October and hence there were no records available. However, there had been approximately eight to ten near misses in September which had been recorded on a near miss log. The superintendent pharmacist (SI) had taken all the logs from September and before away from the pharmacy to review and so these were not available to inspect. The SI had also taken the near miss logs away for review at the last inspection. As a result of past reviews, some medicines had been moved and the pharmacy were completing a date check more regularly. Dispensing errors were shared with the SI and reported on the National Reporting and Learning System (NRLS). There had been no recent reported dispensing errors.

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. And it completed an annual patient satisfaction survey. People also left reviews on the internet. Feedback received during the Covid-19 pandemic had been positive.

Records for private prescription, emergency supplies, unlicensed specials, controlled drug (CD) registers and RP records were well maintained. 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. Team members had completed training on data protection and information governance. This had been renewed recently. Confidential waste with people's private information on was segregated in a separate bin, and this was usually shredded at the weekend. The shredder at the pharmacy had recently broken and the SI said that this was due to be

replaced. The pharmacy's computers were password protected and screens faced away from people using the pharmacy.

The RP, trained medicines counter assistant (MCA) and SI had completed the level 2 safeguarding training 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 available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy provides its services using a team with a range of skills and experience. Team members work effectively together and are supportive of one another. Team members are given some ongoing training to keep their knowledge and skills up to date. The pharmacy staffing levels mean that on occasions the team members struggle with the workload. But they are generally up to date with their dispensing.

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, a trained MCA who had worked at the pharmacy for a number of years and another trainee MCA. The RP said that there had been an eight-week period where the previous and current pre-reg trainees had worked together. In the event that cover was needed a dispenser was available. Prior to the pandemic the plan had been for the SI to work alongside the RP. The RP and pre-reg explained that the pharmacy was up to date with the daily dispensing but staff did not have time to do other things such as organising the dispensary. A team member had left since the last inspection and the RP said that the pharmacy was currently recruiting a dispenser. Multi-compartment compliance packs and dispensing for the care home was 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. The previous pre-reg was potentially due to return to work at the pharmacy as a provisionally registered pharmacist.

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.

To keep up-to-date team members read through material sent by Avicenna and Numark 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 which areas that they had asked questions on. Team members had recently completed training for the latest Pharmacy Quality Scheme (PQS). The RP said following this team members also completed independent learning on the Centre for Pharmacy Postgraduate Education website.

The pre-reg had started at the pharmacy in August. He had not been enrolled on a training course but was doing independent learning. 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. The pre-reg was given set-aside study time.

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 secure and are suitable for the pharmacy's services. People can have a conversation with a team member in a private area.

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 and a separate workbench was also used for checking. Cleaning was done by the team daily and team members were able to maintain distance from each other. Team members were observed to use face shields and only two people were being allowed into the pharmacy at any given time. The retail area of the pharmacy was large and people waiting were able to maintain distance from other people. Hand sanitiser was also available for team members and people to use.

A signposted consultation room was available which was easily accessible and unlocked when not in use. The room allowed low-level conversations to take place inside which could not be overheard. Access to the staff toilets was through the consultation room. There was no confidential information held within the room. 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. Due to the Covid-19 pandemic the pharmacy had stopped providing face-to-face services between April and July. However, these had resumed and the pharmacy was also providing flu vaccinations when stock was available.

At the start of the pandemic the RP had worked with local leaders to set up a hub of almost 200 volunteers from the local area who were available to help cover the needs of the vulnerable people in the area. The person requiring help would dial a number and be put through to an automated system which would then notify available volunteers of the help required. The pharmacy had also increased the number of deliveries they carried out and delivered medicines to anyone who required it. The RP said people had provided positive feedback about the service.

Prescriptions were received electronically, then printed out 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 requests by email using the electronic patient recording system. The pharmacy was ahead of preparing prescriptions which were due within the next few days. Since the last inspection the RP had stopped self-checking most prescriptions with the exception of the multi-compartment compliance packs. Dispensed and checked-by boxes were available and were being used by most team members. Baskets were used to separate prescriptions, preventing transfer of items between people.

The RP was aware of the change in guidance around pregnancy prevention 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 had with their prescriber. The RP was aware of the need to use the warning stickers if valproate was not dispensed in its original pack.

For prescriptions for warfarin, the RP asked when the person last their INR had checked. The RP tried to make a record of the person's INR on the electronic recording system when the person had their yellow book. People who collected warfarin regularly 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 RP had noticed that some people were having INR checks less frequently during the pandemic. And counselled people on signs to look out for that would indicate that their warfarin blood levels were outside of the desired range.

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, any communication the pharmacy had had was not always recorded. Packs were generally prepared by the RP who checked his 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 instead 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 relevant 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 (40 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. Following the last inspection, the RP had discussed reviewing the service to avoid pre-packing the compliance packs in advance of receiving the prescription. The pharmacy was actively looking to employ another member of staff to help manage the workload. Packs were prepared on Saturday when it was quieter and if a change had been made when the prescription was received the whole pack was prepared again. The pharmacy had also started supplying packs on a monthly basis. Packs were double checked by a colleague as they were prepared and the RP said that he had started recording product descriptions which had helped him to identify medicines.

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. There was an audit trail in place to show who had prepared and checked the packs. But patient information leaflets were not routinely supplied, which could mean that people or their carers did not have all the information they needed to use the medicines safely.

Deliveries were carried out by team members for a few local housebound people and the pharmacy had also employed a driver. In the event that a person was not available medication was returned to the pharmacy. Signatures were not obtained from recipients to help with infection control. The RP had briefed the driver on the precautions that needed to be taken when delivering to someone who was Covid positive.

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.

Date checking was completed every four weeks, and short-dated stock was marked with stickers. There were no date-expired medicines found on the shelves checked. A date-checking matrix was available. Out-of-date and other waste medicines were disposed of in the appropriate containers which were kept separate from stock 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. The RP said that both he and the SI had called a number of places but had not been successful in finding someone who could safely dispose of these but would keep trying to find a company.

The pharmacy had the scanners in place for the Falsified Medicines Directive. However, these were not being used at the time of the inspection.

Drug recalls were received via email and these could be accessed by all team members. Alerts were usually printed and filed.

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 liquid CD use and a separate counter was used for cytotoxic medication to avoid contamination. 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 had been replaced following the previous visit.

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.