

Registered pharmacy inspection report

Pharmacy Name: Med-Chem UK Ltd, 73 Grand Parade, Green Lanes,
LONDON, N4 1DU

Pharmacy reference: 1092551

Type of pharmacy: Community

Date of inspection: 13/02/2023

Pharmacy context

The pharmacy is open extended hours and is located within a parade of shops on a busy main road. People who use the pharmacy are mainly from the local area. The pharmacy supplies medicines in multi-compartment compliance packs to people who need help managing their medicines. It provides the Community Pharmacist Consultation Service, the New Medicine Service and flu vaccinations.

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's working practices are largely safe and effective. The pharmacy generally keeps the records it needs to by law so that medicines are supplied safely and legally. The pharmacy asks its customers for their views. Team members use the procedures in place to protect vulnerable people. The pharmacy doesn't consistently record or review near misses which may mean that team members are missing out on opportunities to learn and make the pharmacy's 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. SOPs were obtained from a third-party provider and reviewed by the superintendent pharmacist (SI) and responsible pharmacist (RP). The RP explained that the pharmacy had SOPs to cover all services and tasks that were completed.

Dispensing mistakes which were identified before the medicine was handed out (near misses) were handed back to the team member who had dispensed the prescription and they were asked to identify and rectify their mistake. A book was available to record near misses but there had not been any recent entries made despite the pharmacist describing some picking errors that had occurred. The RP provided an assurance that she would ask all team members to start recording near misses. The pharmacy recorded instances where a dispensing mistake had happened, and the medicine had been handed to a person (dispensing errors). The pharmacy had not had any recent dispensing errors. The RP described the process which would be followed if an error was reported. This included rectifying the error, completing an investigation, informing the team and GP, and making a record of the error.

A correct responsible pharmacist (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. Complaints first came to the RP who would investigate and respond to the person. If the person was not satisfied with the outcome, they would be referred to the SI. Team members said there had not been any recent complaints.

Records for emergency supplies, RP records and controlled drug (CD) registers were well maintained. Private prescription records were generally in line with requirements, but the prescriber details were missing from some entries. CDs that people had returned were recorded on a form held with the CD registers. The pharmacy had not recently dispensed any unlicensed medicines, the RP was able to describe the records that they would keep in the event that they were.

The pharmacy had an information governance policy. Team members had completed training on confidentiality and data protection, which was also covered in the SOPs and team members were verbally briefed. Relevant team members who accessed NHS systems had smartcards; the pharmacy was in the process of ordering cards for the trainee pharmacists. The pharmacists had access to Summary Care Records (SCR); consent to access these was gained verbally. Confidential waste was shredded. Assembled prescriptions were stored in the dispensary and people's private information was not visible to others using the pharmacy.

All team members had completed level 2 safeguarding training. The RP was also due to complete the level 3 training. Details for local safeguarding contacts were available.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members for the services provided, and they do the right training for their roles. They work effectively together. The pharmacy supports its team members with ongoing training. This helps them keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the team comprised of the RP, a trainee pharmacist, a trainee pharmacist who had already completed their placement and was waiting to sit their exam, and a trained medicines counter assistant (MCA). Other team members who were not present included another trainee pharmacist, two trained MCAs who worked at the weekend and a trained dispenser. A trainee pharmacy technician also helped three times a week mainly on the pharmacy's busiest days. There were another two pharmacist and the SI who also worked at the pharmacy. The RP felt that there were enough staff given the extended hours the pharmacy was open. She said this was the only pharmacy in London which was open until midnight on a Sunday. At any given time, there were three team members working alongside the pharmacist including on Sundays.

Staff performance was managed by the RP and SI. Team members had appraisals and review meetings were held every two weeks. The RP felt that this way issues were identified and resolved quicker, and the meetings were fairly quick. The RP noted down points in between reviews and discussed this with individuals at the meetings. The owner gave team members feedback. Team members felt they were able to raise concerns or give feedback. The trainee pharmacist 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 some medicines that could be sold over the counter.

Training was completed in line with requirements and recommendations from NHS schemes and for some services provided. Team members were provided with set-aside time to complete these training modules. The trainee pharmacist was enrolled on a structured training programme with a third-party provider as part of which she attended face-to-face or virtual training days. Team members would speak to one of the pharmacists if they needed help with any parts of their training.

Team meetings were held on a monthly basis. These were used to discuss steps that could be taken to improve services and patient satisfaction. Team members were able to discuss and raise issues that they had and also provide pharmacists with feedback. Any urgent issues were discussed as they arose. Team members felt able to provide the SI and RP with feedback and suggestions. There were no formal targets set by the owners for services provided. However, the RP set herself targets, the targets set did not affect the RP's professional judgment. The RP described how she had increased staffing hours to get help with certain tasks to free up time for her to provide services.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises provide an appropriate environment to deliver its services from. And its premises are suitably clean and secure. People using the pharmacy can have conversations with team members in a private area.

Inspector's evidence

The pharmacy was bright and airy and had ample workbench space which was tidy and organised. This was roughly allocated for certain tasks. Cleaning was done by team members in accordance with a rota. A clean sink was available for the preparation of medication.

The pharmacy had a large consultation room which was easily accessible from behind the medicines counter. The room held some stock which had been received in deliveries earlier. The RP provided an assurance that this was due to be removed and showed a photograph of what the room usually looked like. The room allowed a conversation at a normal level of volume to take place inside and not be overheard. The room temperature was adequate for the provision of pharmacy services and the safe storage of medicines. Air conditioning was available to help regulate the temperature. The premises were secure from unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides its services safely and makes its services accessible for people. It gets its medicines and medical devices from appropriate sources and generally stores them properly. Team members make the necessary checks to ensure that the pharmacy's medicines and medical devices are safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacy was easily accessible with an internal ramp. Aisles were clear with easy access to the medicines counter. Services were appropriately advertised to patients. Team members spoke a range of languages including Turkish which was most spoken locally. Team members knew what services were available and described signposting people to other providers where needed. A list of services provided locally was used or team members used the internet. The RP had a list of nearby sexual health clinics and their opening times.

Both the RP and SI were independent prescribers, but the RP said neither did any prescribing at the pharmacy. The RP felt that the Community Pharmacist Consultation Service (CPCS) had the most impact on the local population, particularly due to the pharmacy's extended opening hours. The RP explained she felt the asthma service was particularly useful. For Schedule 4 or 5 CDs the pharmacy did not provide these as part of the self-referral service but asked for a prescription to be sent to the pharmacy which could be dispensed. The RP's prescribing area of expertise included urinary tract infections. If people presented with symptoms and had used medication in the past they were asked to purchase and use a sample test kit, based on the results the person was supplied with medication as part of the CPCS referral.

Prescriptions were received electronically, then printed out and labels were processed. These were then dispensed by the trainee pharmacists. Once dispensed, another trainee pharmacist checked the dispensed medicines and then left these aside for the RP to check. Before handing medicines to the RP for a final check at least a minimum of two other people needed to have checked the medicines. The RP said this had greatly reduced the number of dispensing mistakes. The RP refused to check any medicines which had not been initialled as dispensed. The RP did not self-check prescriptions due to reading about errors that had occurred in other pharmacies. An additional check was also carried out by the person who bagged the medicines. Dispensed and checked-by boxes were available on labels, and these were routinely used. Baskets were used to separate prescriptions, preventing transfer of items between people. Baskets were also colour-coded and different coloured baskets were used for prescriptions that were waiting, those that were fully dispensed and those that had missing items.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). The RP handed out most of the prescriptions and so was able to counsel people. Booklets and warning labels were available which were used. In the event that someone was not part of the PPP they were referred back to their GP. Additional checks were carried out when people collected medicines which required ongoing monitoring. The RP usually made a note of the INR on people's electronic record.

Some people's medicines were supplied in multi-compartment compliance packs, which were prepared at quieter times and weekends. The pharmacy had four separate folders for each week and people were divided into one of four weeks depending on when they were due their medicines. Each individual had a master sheet which had a record of all their medicines. Prescriptions were ordered by the pharmacist and were checked against the master sheet when they were received. Team members were required to check against the master sheet before assembled packs were handed out and to make sure the medicines contained within the pack matched the label. Pharmacists checked the medicines before the packs were prepared, checked the assembled pack once they were prepared and then checked once before handing out. Discharge information was sent on PharmaOutcomes, notes were added on to the persons electronic record and an email was sent to the surgery to request a new prescription. Nothing was handed out until a new prescription was received. The pharmacy recorded when packs were handed out as well as the number of packs handed out. Most assembled multi-compartment compliance packs seen were labelled with product details. Mandatory warnings were included on all. Information leaflets were supplied monthly, but some people requested to not have the leaflets, however, the RP provided an assurance that leaflets would be provided to everyone. There was an incomplete audit trail to show who had prepared and checked the pack. This could make it difficult to investigate who was involved in the event that there was an error.

Deliveries were carried out by a designated driver. People were called before delivery was attempted. If someone was not available when the medicines were delivered, the medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers. Medicines were organised on shelves in a tidy manner. There were several loose blisters seen on the shelves. The RP said the trainee pharmacist was going through the shelves and removing these. Fridge temperatures were monitored daily, and records were made for the fridge in the dispensary. There were no records available for the fridge in the consultation room. The RP provided an assurance that this was checked each day and was within the required range for the storage of medicines. The RP assured that she would start recording these temperatures as well. The fridge temperatures for this fridge were within the required range at the time of the inspection. CDs were held securely.

Expiry date checks were carried out every two weeks by team members. Short-dated stock was highlighted, and a record was made of when they were due to expire so that they could be removed from the shelves. No date-expired medicines were found on the shelves checked. Out-of-date and other waste medicines were kept separate from stock and were stored securely and then collected by licensed waste collectors. Drug recalls were received via email. These were printed and read by the RP who briefed the team and actioned the alert and filed the notice.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had calibrated glass measures for liquid CDs, however other measures were plastic. The RP explained that the glass measure had recently broken, and following the inspection, she confirmed that the new measure had been received. Tablet counting equipment was available. Equipment was clean and ready for use. Separate measures were used for liquid CDs and separate tablet counting triangles were used for cytotoxic medicines to avoid contamination. Two medical fridges were available. A blood pressure monitor was used for services provided and it was fairly new, monitors were replaced on a regular basis. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. Confidential waste was shredded.

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.