General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Murray's Chemist, 96-98 Murray Grove, LONDON, N1 7QP

Pharmacy reference: 1105743

Type of pharmacy: Community

Date of inspection: 16/09/2019

Pharmacy context

This pharmacy is co-located in a building with a Post Office in a parade of shops in a residential area. People who use the pharmacy are mainly from the local area. The pharmacy was taken over by new owners in August 2019. The pharmacy supplies medicines in multi-compartment compliance packs to people who need help managing their medicines. It provides Medicines Use Reviews and the New Medicine Service, emergency hormonal contraception and runs a travel clinic. One of the pharmacists is also an independent prescriber.

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

Overall, the pharmacy's working practices are safe and effective. The pharmacy asks its customers for their views. It largely keeps the records it needs to so that medicines are supplied safely and legally. Team members know how to safeguard vulnerable people. The pharmacy doesn't consistently record or review mistakes that happen during the dispensing process. And this may that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) available, these had been implemented by the previous owner and had not been reviewed since 2015. The responsible pharmacist (RP) who was also the superintendent pharmacist (SI) said that he was working on reviewing and organising the SOPs. The RP confirmed that team members had read and signed updated essential SOPs.

At the time of the inspection near misses were not being recorded. As the team was small near misses were discussed as they occurred; a discussion was also held to identify what the error was and how it had occurred. The RP said that most near misses were due to picking errors or team members picking the incorrect formulation. The RP was in the process of getting a software program to allow near misses to be recorded electronically.

There had been no reported dispensing incidents since the new owner had taken over. The RP described the steps that he would take in the event that an incident occurred which included making a record and following the NHS process.

The pharmacy had current professional indemnity insurance. The NHS complaints notice was displayed alongside the results from the latest patient satisfaction survey. The RP was planning to implement Numark's complaint policy. The RP said that since taking over he had not received any feedback or complaint which had resulted in changes needing to be made. Since taking over the team had made numerous changes.

Records for emergency supplies, unlicensed medicines and RP records were generally well maintained. Private prescription records did not always have the correct prescriber details recorded. And this may mean that this information is harder to find out if there was a query. Electronic CD registers were used and they were well maintained. A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in an electronic register as they were received.

The SI was working through the information governance toolkit and was reading through a PSNC workbook on the General Data Protection Regulation. Team members had been verbally briefed on confidentiality and data protection. Team members, with the exception of the pre-registration trainee, had individual smartcards to access NHS systems. Summary Care Records could be accessed by the SI and he was due to arrange for the independent prescriber to also be set up to use the system. Consent to access these was gained verbally from people.

Both pharmacists had completed the level two safeguarding training course and details for local safeguarding contacts were available. The RP was unsure of any training that team members had

completed and following the inspection team members were enrolled onto the Numark training portal which had a training module on safeguarding. The SI had also put into place a policy for safeguarding vulnerable adults and children.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for its services, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively. Team members are given ongoing training to keep their knowledge and skills up to date.

Inspector's evidence

At any given time, the pharmacy team comprised of four team members including the RP and on some days this went up to six team members. The team on the day of inspection comprised of a pharmacy student, a pre-registration trainee (pre-reg), a trained dispenser, a trained medicines counter assistant (MCA) and two pharmacists.

The SI felt that there was an adequate number of team members. Travel vaccinations were offered on a walk-in basis but in the event that the pharmacist was on his own people would be asked to call back when the second pharmacist would also be available.Since taking over the pharmacists had not had a chance set up formal appraisals. Both pharmacists worked closely with the team and provided team members with feedback as well as discussing with team members as to how the workflow could be streamlined. Where necessary team members were taken aside to discuss matters.

The MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She checked with the RP before selling certain medicines such as those containing pseudoephedrine or when someone wanted to purchase multiple items.

The second pharmacist was the pre-reg tutor and when the pre-reg had first started their placement a meeting had been held to discuss the pharmacist’s expectations. The pre-reg had been enrolled on the Greenlight pharmacy pre-registration training course and attended training sessions once a month. The pre-reg tutor received feedback on what training had been covered during the session as well as the area that was due to be covered in the next session. The pharmacist described that the pre-reg was due to have a maths test in the next session and both the tutor and RP would help her prepare for this. The pre-reg did not get set-aside study time in store. Both pharmacists discussed different topics with her and tested her knowledge from time to time.

Pharmacists listened to conversations and counselling that team members were providing people with. And discussed any areas where they needed to work on. Team members picked up counselling advise from pharmacists. Following the inspection all team members were enrolled on the Numark training portal which had a large selection of training modules available for them to complete for their own development. Training modules available included the General Data Protection Regulation, Data Protection, Oral Health, OTC Conditions, Legal, OTC Product Training, Health Conditions and Safeguarding. Team members were asked to ensure they spoke to the pharmacists if they were unsure.

Team meetings were held as things came up and needed to be discussed. The pharmacist was the clinical pharmacy lead for the area, which included six other pharmacies. As part of this she had monthly meeting with GPs to discuss issues pharmacies are facing. There were no numerical targets set for the services offered.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe, secure and appropriately maintained. People can have a conversation with a team member in a private area.

Inspector's evidence

The dispensary was bright and spacious with plenty of work bench space. Workbench space was allocated for certain tasks. The RP said that since taking over the team had worked at cleaning and organising the entire pharmacy. Medicines were arranged in an organised manner on shelves in the dispensary. A sink was available for the preparation of medication. The premises were shared with a Post Office. Team members who worked in the post office were also employed by the pharmacy. One of the team members, an MCA worked both on the medicines counter and in the Post Office.

The consultation room was spacious and clean. A couch was being used by the pre-reg to prepare multi-compartment compliance packs. There was some confidential information held within the room, the RP said that most of this paperwork belonged to the previous owner and agreed to move it to an area that could not be accessed by the public. The room also held a fridge, which was used to store vaccinations. Following the inspection, the RP confirmed that he had located a key for the fridge and planned to keep it locked.

The premises were kept secure from unauthorised access; the opening hours for both the pharmacy and Post Office were the same. The room temperature and lighting were adequate for the provision of pharmacy services. Air conditioning was available to help regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely delivers its services in a safe and effective manner. 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. This means that people get medicines and devices that are safe to use.

Inspector's evidence

There was step-free access, automatic doors in to the pharmacy and space for the movement of a wheelchair. There was also easy access to the counter. Team members would help people if they required assistance. The pharmacist used online translation applications when needed and some people came into the pharmacy with carers who spoke English. Team members knew what services were available and described signposting people to other providers if a service was not offered at the pharmacy. The pharmacy was also able to produce large print labels when these were needed.

The RP felt that the essential services like providing people with medicines that they needed and safely disposing of medicines had a positive impact on people. He said that services such as minor ailments and the emergency hormonal contraception service also helped people who may not be able to purchase the medicines. And there was a high prevalence of unwanted pregnancies locally. Being able to access the services also saved GPs time.

The pharmacy offered travel vaccinations; both pharmacists were accredited to provide these. The SI mainly provided the services and the second pharmacist concentrated on dispensing and checking. The RP said that generally there were two pharmacists working so one could cover dispensing activities whilst the other provided services.

The pharmacy had an established workflow in place. Approximately 70%-80% prescriptions were received electronically and a number of there were repeat prescriptions. The dispensers processed prescriptions, ordered stock and dispensed them after which they were checked by the RP. The RP said that it was very rare that the pharmacists had to self-check. Colour coded baskets were used to separate prescriptions and to manage the workflow. Dispensed and checked by boxes were available on labels; these were routinely used by the team.

Both pharmacists were aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. The pharmacy did not have anyone who collected sodium valproate regularly who fell in the at-risk group. The RP was unsure if the pharmacy had any warning labels available, but after the inspection confirmed that more had been ordered from Sanofi. The pharmacy did not keep the 10mg strength of methotrexate in stock and would order them as needed. The RP said that lithium had not been dispensed since the pharmacy had been taken over and very few people were on warfarin. The pharmacist said that they looked at people's blood test records if they were collecting warfarin, but a record was not made of this in the pharmacy. The surgery did not issue prescriptions until they had checked the INR and the pharmacy had a good working relationship with the surgery.

The list of people who had their medicines supplied in multi-compartment compliance packs was divided into four separate weeks to help manage the workflow. Individual record sheets were in place

for each person and any communication was recorded. Prescriptions were usually ordered two weeks in advance. When prescriptions where labelled, the system identified any new medicines or identified any missing items. Dispensers then checked this against the individual record. The surgery also called the pharmacy team and informed them of any changes. All records were made on the person's record. Packs were only prepared once the prescription was received. Packs were prepared by the pre-reg or dispenser and checked by the RP. Ongoing assessments for the suitability of people being supplied their medicines in multi-compartment compliance packs were not done. The RP said that most people had been supplied their medicines in this way for a while and would not be happy to change. He gave an example of a person who had been supplied their medicines in original packs after a consultation with the GP, but after this the person had asked for their medicines to be supplied in compliance packs again.

Assembled multi-compartment compliance packs seen were labelled with mandatory warnings and product details, although these did not contain all the required information and were ambiguous particularly where there was more than one type of similar medicine. There was an audit trail in place to show who had dispensed and checked the packs. Information leaflets were supplied monthly. Deliveries of medicines to people's home were rare, and they were done by the dispenser. The pharmacy were in the process of setting up audits and records for the delivery service.

The pharmacists had completed training on the Sonar online portal to gain accreditation to provide services. Signed and in date patient group directives were in place for the services offered. The RP had completed the NaTHNaC training for yellow fever accreditation but had not started providing this service at the time of the inspection.

One of the pharmacists was an independent prescriber, she prescribed medicines for conditions in therapeutic areas that she felt confident in. She had specialised in asthma and previously ran a clinic at the local surgery. Antibiotics were prescribed for conditions such as urinary tract infections and the pharmacist said that she followed the Sonar guidance. The pharmacist said that she checked allergies, any other medicines the person was taking, did a blood pressure check and either made a record on the electronic patient medication record or on a piece of paper. However, this was not seen for all the prescriptions issued. At the time of the inspection there had been no records kept of the consultations carried out or for the reason to supply. Following the inspection, a new consultation form was introduced. Prescriptions were usually checked by the second pharmacist. However, on some occasions the independent prescriber also checked the dispensed medicines. The inspector reminded the pharmacist of the RPS prescribing guidance. People's regular GPs were not informed of any medication issued. And this could make it harder for the person's GP to monitor the person's medical condition.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and recorded; these were observed to be within the required range for the storage of medicines. CDs were held securely.

Expiry date checks had been carried out by stock-takers on the day the pharmacy had been taken over. Team members checked dates as part of the dispensing process and the team members who covered the medicines counter had been asked to double-check stock before it was sold. There were no date-expired medicines found on the shelves checked. The RP was in the process of formulating an SOP for the date checking process. The pharmacy team agreed to carry out a date-check on all stock following the inspection.

The pharmacy had the equipment that it needed to comply with the Falsified Medicines Directive (FMD). The RP said it was not consistently used. The pharmacy team received information of drug recalls on an electronic portal 'PharmaData.' Email alerts were received on the pharmacy's NHS email.

The team had received the more recent recall for Aripiprazole which they did not have in stock. Team members stamped the recall notice once it had been read and checked.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment which included an electronic tablet counting device. One of the measures had limescale around the rim and the electronic tablet counter was dirty. The RP explained that the counter had been inherited from the previous owner and had not been used. In the event that the team decided to start using it they would clean it thoroughly and the RP would find out about calibration requirements. Tablet counting triangles were also available. Following the inspection, the RP confirmed that the measure had been descaled. Two medical fridges of adequate size were also available.

The previous owners had also left blood pressure monitors, however, as the RP was not sure of when they had first been used he planned to replace them before using them for any of the services provided.

Up-to-date reference sources were available including access to the internet. The computer in the dispensary was password protected and out of view of 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.