

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: 23/05/2024

Pharmacy context

The pharmacy is in a building shared with a Post Office, in a row of shops in a residential area in Hoxton, Greater London. The pharmacy provides both private and NHS services such as dispensing prescriptions, the New Medicine Service (NMS), Emergency Hormonal Contraception (EHC), COVID and flu vaccinations, the Pharmacy First service, and it runs a travel clinic. The pharmacy supplies medicines in multi-compartment compliance packs to people who need this support to manage their medicines at home, and it offers a limited delivery service.

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 uses written procedures to ensure that team members understand their responsibilities and how to carry out activities. People using the pharmacy's services can easily provide feedback. Team members protect people's information well and have the relevant training to safeguard the welfare of people using their services. The pharmacy mostly keeps the records it needs to by law. The pharmacy doesn't consistently record or review mistakes that happen during the dispensing process. And this may mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

Standard operating procedures (SOPs) were in place and each team member had signed the ones that were relevant to their role. The superintendent pharmacist (SI) said that they were in the process of updating the SOPs. Team members were clear about their roles and knew when to refer to the responsible pharmacist (RP). When asked, the medicines counter assistant (MCA) was unsure of what activities could and could not be done in the absence of a pharmacist, as this had never occurred. They were reminded of the requirements in practice. The SI said that risk assessments had been completed for the services provided, these were not seen during the inspection.

The pharmacy had logs available to record dispensing mistakes that were identified before reaching a person (near misses), however the last entries were from March 2023 and some near misses had occurred since then. The RP showed that a few medications that looked alike and sounded alike were highlighted on the shelf, which demonstrated some action taken to minimise mistakes. Assurances were provided that near misses would be recorded in the future, to further improve safety. There had been no reported dispensing mistakes which had reached people (dispensing errors). The RP described the steps they would take in the event that a dispensing error occurred, which included identifying the cause, speaking to the person who had received the error and following the SOP which involved reporting to the NHS 'learn from patient safety events' (LFPSE) service.

The correct RP notice was visible to the public at the time of inspection, but an additional notice for a different RP was also displayed. The additional notice was removed when highlighted. The RP record was held electronically, and it was completed correctly. Records for emergency supplies and unlicensed medicines were well maintained. Private prescription records did not always have the correct prescriber details recorded. And this may mean that this information would be harder to find out if there was a query. Some private controlled drug (CD) prescriptions had not been sent to the NHS Business Services Authority in reasonable time, the SI gave assurances they would send these off at the end of the month. The CD register was held electronically and a random physical check of two CD medicines matched the balance recorded in the register. The SI was an independent prescriber, but rarely prescribed, he said he had completed training and felt competent in the areas which he had prescribed for in the past. Only one prescription written by the SI in the last year was found, and the SI explained that he had prescribed the medicine in the context of an emergency. The record did not have associated consultation notes. The SI was reminded of the need for comprehensive consultation documentation and agreed that these would be made if any prescribing was done in the future.

The pharmacy had current professional indemnity insurance. Feedback or complaints from people using

the pharmacy's services could be received verbally in person, by telephone or through an online form on the pharmacy's website. If a complaint was received, team members had an SOP to refer to and they could escalate issues to the SI.

Computers were password protected meaning that confidential electronic information was stored securely. Confidential paper waste was separated and destroyed appropriately using an external contractor. And patient-returned medicines that were to be sent for destruction had patient details removed. Completed prescriptions that were awaiting collection were stored appropriately to ensure that people's information was not visible from the retail area. The SI said that all team members had completed General Data Protection Regulation (GDPR) and information governance training prior to providing the NHS COVID vaccination service.

The pharmacy team members understood safeguarding requirements and were able to describe some of the signs to look for and the actions they would take to safeguard a vulnerable person. The SI had completed level 3 safeguarding training, the RP had completed level 2 and other members of the team had completed level 1. The training had been done through the Centre for Pharmacy Postgraduate Education (CPPE).

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff for the services it provides and manages its workload safely. The team has the appropriate skill mix to ensure safe practice, and team members can raise concerns if needed, in an open and honest environment.

Inspector's evidence

The team comprised of the SI and RP, two foundation year trainee pharmacists, two trainee pharmacy technicians, a trained dispenser, the pharmacy manager, and an MCA. The pharmacy manager was a trained dispenser but did not regularly participate in dispensing. All team members were qualified through accredited courses.

There were no numerical targets set for the services offered and the team was up to date with dispensing prescriptions with no backlog of workload. Team members that were questioned were able to demonstrate an awareness of medicines with the potential for abuse and could identify people making repeat purchases. They knew the correct lines of questioning when selling medicines or providing advice and knew when to refer to the pharmacist. The RP felt comfortable in using their professional judgement when decision making.

The SI said that the team had access to a few online training platforms. And although there was no designated training time for this, when mandatory training was due all staff were asked to complete it on the same day within work hours. Team members did not have a formal appraisal but said they felt able to raise concerns with the SI and RP. The team described working openly and honestly and had informal discussions around concerns and feedback. The pharmacy manager reported that when he had issues sourcing medications, he was able to ask for help from the SI and felt comfortable in doing so. The RP said that the team had a weekly staff meeting where the efficiency and general running of the pharmacy was discussed, and there were opportunities to raise concerns or ideas.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and generally tidy, with adequate space for providing its services safely. It keeps its premises safe and appropriately maintained. And people visiting the pharmacy can have a conversation with a team member in private. The premises are secure from unauthorised access when closed.

Inspector's evidence

The pharmacy had double door access large enough for wheelchair users, with a retail area and some seating for people awaiting service. It had limited storage space but this was generally used well. Pharmacy-only medicines were kept behind the counter. And medications awaiting collection were kept at the entrance of the dispensary to ensure that patient identifiable information could not be seen by people in the retail area. There was a suitably-sized consultation room for the provision of services, which was accessible from the shop floor. And a small office to the left of the medicines counter which was sometimes used to prepare compliance packs to keep distractions to a minimum. The premises were kept secure from unauthorised access when closed.

The premises was clean and generally tidy, with good ventilation and it was well-lit. There was air conditioning available to maintain a suitable temperature for the storage of medicines. Handwashing facilities were available in the dispensary, and a staff toilet with separate handwashing facilities was available. The pharmacy's website was easy to navigate, with information on the services provided and health advice available. Contact information and details of the SI were clearly displayed.

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. Its team members identify people taking high-risk medicines and provides them with appropriate advice. This helps make sure that they are taken safely.

Inspector's evidence

The pharmacy had signs in the window to tell people when it was open and what services it provided. Step-free access made it accessible to a wide range of people. A hearing loop and large-print labels were available to people on request.

Medicines were sourced from licensed suppliers. A random spot check of stock revealed no expired medicines and stickers were used to highlight items on the shelves with short expiry dates. Some bottles of medicines were found on the shelf which were not stored in their original container or labelled with an expiry date and batch number. The batch numbers and expiry dates were put on to most of the bottles when it was highlighted with the team. The SI and RP explained that these were from mistakes made with compliance pack dispensing and gave assurances that they would not do this in the future. And these would be removed from dispensing stock and placed with the pharmaceutical waste. Medicinal waste bins were available and were collected by an approved waste contractor. Dates of opening for liquid medicines were generally written on the bottles to help staff know if they were still suitable to use. CDs were generally stored securely. Expired and returned CD medicines were segregated in clearly marked bags while awaiting destruction. Records for the pharmaceutical fridges were completed daily and showed no deviations in temperature outside of the required range of between 2 and 8 degrees Celsius.

The pharmacy received safety alerts and drug recalls, or information about other problems with medicines or medical devices, through the pharmacy's email and pharmacy computer system. The SI and pharmacy manager were responsible for monitoring these alerts and could explain what action was taken in response, however there was no audit trail of the action taken. This may make it harder for the pharmacy to show what it has done in response, and the SI gave assurances that he would find a way to highlight alerts which had been actioned.

Team members were aware of the risks involved when supplying valproate products to people who could become pregnant. The team members explained that they would check whether people were on a Pregnancy Prevention Programme (PPP) where necessary and record interventions on the patient medication record (PMR) system. They also knew about the guidance to supply these products in complete original manufacturer's packs, and to ensure they didn't cover any of the warnings with dispensing labels. The pharmacy did have some people who had valproate supplied in compliance packs. The RP said that the risks versus benefits to these people had been discussed, however no documented risk assessment had been completed. The SI gave assurances that individual risk assessments would be completed for these people. Prescriptions for other high-risk medicines were highlighted on the PMR, this prompted the pharmacist to provide appropriate advice and counselling to these people. Prescriptions for CDs were not routinely highlighted, which may make it harder for the team member handing them out to know if the prescription was still valid. Several dispensed

prescriptions for Schedule 3 CDs were found which were no longer valid. Although the dispensed medicines had been removed from the 'awaiting collection' shelf and returned back to stock. Team members said that people were contacted if they had not collected their medications, and the prescriptions were returned to the prescriber. However, this had not been done for the prescriptions found during the inspection. This could mean that the prescriber is unaware that people had not received their medications.

Team members were observed following the SOP for dispensing prescriptions and baskets were used to separate people's prescriptions. Dispensing labels included 'dispensed by' and 'checked by' boxes to indicate who had carried out those tasks. And if medicines were dispensed in white cartons the batch number and expiry date were written on the box. The pharmacy dispensed some medicines in multi-compartment compliance packs for people who needed help to manage their medicines. The pharmacy held information sheets for each person requiring a compliance pack which helped them to order prescriptions on people's behalf on a four-week cycle. Team members checked prescriptions against the PMR and any discrepancies were followed up with the GP practice. A brief description of each tablet or capsule was written inside the compliance pack, alongside any medicine warnings. Patient information leaflets (PILs) were not routinely provided, the RP said that most people did not want these, but they had not documented these conversations. Not routinely supplying the PILs could make it harder for people to have up-to-date information about how to take their medicines safely. Assurances were given that PILs would be put with the dispensed packs and taken back by the pharmacy if the patient refused them at handout. The SI said that the pharmacy had access to NHS care records and the East London Patient Record (eLPR). These allowed the pharmacy to see further details relating to people's medications, and enabled the pharmacy to see blood results. The SI explained that this helped with continuing the supply of medicines following hospital discharge, and made the transition from hospital to community pharmacy smoother.

The pharmacy delivered some medicines to a few people who lived close by. There was not a designated delivery driver and team members delivered these within the pharmacy opening hours. They did not request a signature for receipt of items and medicines were returned to the pharmacy if a person was not home. The pharmacy had a sheet available that listed medications to be delivered, however there was not an audit trail about deliveries made, which may make it harder for it to deal with queries relating to delivery. The SI said they would create an audit trail for this in the future.

The pharmacy offered a number of private and NHS services and there were valid patient group directions (PGDs) for providing these. The SI said that the PGDs had been signed and dated by the pharmacists providing the services, however only electronic versions were seen during the inspection and not signed copies. NHS Pharmacy First clinical pathways were printed for reference.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use and uses it to help protect people's personal information.

Inspector's evidence

The pharmacy used suitable standardised conical measures for measuring liquids and had separate ones for certain substances that were marked to avoid contamination. Clean tablet counters were available for dispensing loose medication, and a new digital otoscope was available for providing the Pharmacy First services. There was a blood pressure monitor in the consultation room, the SI said that this was replaced annually, along with the 24-hour ambulatory blood pressure monitors. Sharps bins were available in the consultation room for safe disposal of vaccinations. The pharmacy had three pharmaceutical fridges which were in range at the time of inspection.

Team members had their own NHS smartcards, this enabled individuals to access electronic prescriptions. All computers were password protected to safeguard information, and a portable telephone enabled the team to ensure conversations were kept private where necessary.

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.