General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medicare Dispensing Chemist, 10 Handel Parade, Whitchurch Lane, EDGWARE, Middlesex, HA8 6LD

Pharmacy reference: 1034849

Type of pharmacy: Community

Date of inspection: 09/10/2024

Pharmacy context

This is a community pharmacy along a row of shops in Edgware, Middlesex. The pharmacy dispenses NHS and private prescriptions. It's team members sell over-the-counter medicines and provide advice. The pharmacy provides some people's medicines inside multi-compartment compliance packs. And the pharmacy offers seasonal flu vaccinations as well as a delivery service.

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	1.2	Standard not met	The safety and quality of the pharmacy's services are not regularly reviewed and monitored. The pharmacy is unable to fully demonstrate that it records all its mistakes, monitors and informs others or learns from them.
		1.3	Standard not met	New members of staff are carrying out tasks without understanding their own accountabilities and responsibilities, the pharmacy's internal processes or about data protection. They have not undergone a suitable induction process and they lack basic knowledge about what they can or cannot do in the absence of a pharmacist.
		1.6	Standard not met	The pharmacy has not routinely maintained and recorded details of the responsible pharmacist (RP). There are consistent gaps within the RP log where no details about the pharmacist have been recorded.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy premises are very cluttered and untidy in some places. The consultation room looks unprofessional as several unnecessary items (such as Jam and bread) have been stored here as well as in the dispensary.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy's services are not always managed or delivered safely and effectively. The pharmacy has been unable to show that it has appropriate audit trails in place to verify its local delivery service.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not effectively identify and manage all the risks associated with its services. The pharmacy is unable to demonstrate that its team members record all their mistakes or learn from them. And, it has not been able to show that it is maintaining all its records, in accordance with the law or best practice. But the pharmacy protects people's confidential information appropriately and it has the right insurance in place to help protect people if things go wrong.

Inspector's evidence

The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display. This provided details of the pharmacist in charge of the pharmacy's operational activities. The pharmacy had a range of current documented standard operating procedures (SOPs) in place. They provided guidance for the team to complete tasks appropriately. The responsible pharmacist (RP) had read and signed them, the trainee dispenser said that he had read the SOPs and whilst he understood his responsibilities, there was no evidence of this as at the point of inspection as only the pharmacist's signatures were present. Evidence to verify this was provided following the inspection. However, a new member of staff who was initially described as a volunteer, then said to be on work experience was said to have started work at the pharmacy on the day of the inspection. They had been put to work on dispensing people's prescriptions without reading SOPs. The RP had showed them where medicines were kept but they had no knowledge of the activities that could take place in the absence of the RP, nor did they know anything about data protection. This was unsafe and risked mistakes occurring.

The pharmacy was cluttered with unnecessary items in the dispensary and consultation room (see Principle 3). The dispensary was compact with little workspace and minimal areas for staff and the pharmacist to work in. The pharmacist said that she used the consultation room to accuracy check prescriptions from. Staff used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them, but the pharmacy's workspaces were not as clear of clutter as they could have been, some of this was observed to be work in progress. After dispensing labels had been generated, there was a facility on them which helped identify who had been involved in the dispensing process. However, aside from the RP, team members were routinely failing to use this as an audit trail. In addition, the trainee dispenser was observed using generated dispensing labels to select medicines against instead of prescriptions. This increased the likelihood of mistakes occurring.

Only a few near miss mistakes had been recorded, this was in accordance with the pharmacy's volume of workload but the necessary details to help identify and learn from mistakes were being infrequently recorded. There was nothing noted for September 2024, three entries in August 2024, and prior to this one entry in February 2024 and four entries in January 2024. Staff were unable to provide specific examples of any action taken in response, they cited look-alike and sound-alike medicines being selected incorrectly and there were no details recorded about any review of mistakes occurring collectively. The pharmacist's process to manage dispensing errors which reached people was adequate, but the RP was unsure about where to record the relevant details. The inspector was told that details would be recorded on individual people's medication records. This risked information not being directly accessible unless the name of the person involved was known which could make it harder to spot patterns and trends.

Team members used their own individual NHS smart cards to access electronic prescriptions and the pharmacy's computer systems were password protected. Confidential waste was shredded. The pharmacist was trained to level two to safeguard the welfare of vulnerable people. The new member of staff knew about this topic through school, but the trainee dispenser lacked knowledge in this area and had not received any formal training. They were also unaware of any local contact details for relevant agencies which could lead to delays in the event of a concern.

The pharmacy had appropriate indemnity insurance in place. Records of emergency supplies and a sample of registers seen for controlled drugs (CDs) were maintained in accordance with legal requirements. Records of CDs that had been returned by people and destroyed at the pharmacy were also complete. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. However, there were some issues with the pharmacy's other records. There were consistent missing entries in the RP log where no pharmacists had signed in or out, so it was unclear who the pharmacist responsible for the day's activities was. Incorrect prescriber details had been entered in the electronic private prescription register. In addition, staff could not locate any records to verify that supplies of unlicensed medicines had been made appropriately.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an adequate number of staff to manage its workload safely. The pharmacy provides services using a team with various levels of experience. But the pharmacy only has limited resources available to help improve and keep the team's skills and knowledge up to date. This could affect how well they carry out tasks and adapt to change with new situations.

Inspector's evidence

The pharmacy team on the day of the inspection consisted of a locum RP, a trainee dispensing assistant who stated that he was on an accredited training course and the new member of staff described under Principle 1. The pharmacy had an adequate number of staff to support the workload and the team was up to date with this. Members of the pharmacy team asked relevant questions before selling medicines. They were aware of medicines which could be abused or had legal restrictions and sales of these medicines were monitored. Except for the newest member of staff, other team members knew when to refer to the pharmacist appropriately. They were a small team, so communicated verbally. The inspector was told that the trainee dispenser was provided with little protected time at the pharmacy to complete his course. Performance reviews were said to be an informal process and aside from course material, staff were not provided with many resources to help develop their skills and knowledge.

Principle 3 - Premises **Standards not all met**

Summary findings

Parts of the pharmacy's premises are currently unsuitable for the safe delivery of healthcare services. The pharmacy does not do enough to keep its premises free from clutter. And the consultation room does not present a professional image. But the pharmacy is secure.

Inspector's evidence

The pharmacy was based on the ground floor of the building and included a small retail area with a medicines counter, a consultation room, and a very compact dispensary to one side. The pharmacy was generally clean. The ambient temperature and lighting were suitable for storing medicines and safe working. The dispensary was appropriately screened to assist with privacy, but it had limited workspace. The premises were secure from unauthorised access. However, the dispensary and consultation room were very cluttered with excess stock and paperwork. The stock was said to have been for the owner’s other pharmacy and included loaves of low carbohydrate bread, nuts, jam, and other consumables. This rendered these areas unprofessional in their appearance and took up necessary space. The consultation room was of an adequate size for its intended purpose.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy cannot always show that all its services are provided safely. It does not adequately maintain its records or make them available for inspection. The pharmacy cannot show that it safely delivers medicines to people. But the pharmacy has some checks in place to ensure that medicines are not supplied beyond their expiry date. And the pharmacy obtains its medicines from reputable sources.

Inspector's evidence

The pharmacy's opening times were clearly advertised, and the pharmacy had a few posters on display about services offered. There were two seats available for people who wanted to wait for their prescriptions. People could enter the pharmacy from a wide front door which had sloped access outside. The retail area consisted of some clear, open space and wide enough aisles for people with wheelchairs or restricted mobility to easily access the pharmacy's services. Staff provided people with different needs written details, they communicated verbally to people who were visually impaired, spoke slowly and could speak some different languages if English was not the first language.

The pharmacy provided medicines inside multi-compartment compliance packs to some people who lived in their own homes and for a few people in residential care homes. The team ordered prescriptions on behalf of people. They identified any changes that may have been made, maintained records on people's medication records to reflect this and queried details if required. All the medicines were de-blistered into the compliance packs with none supplied within their outer packaging. Compliance packs were not left unsealed overnight. However, descriptions of the medicines inside the compliance packs were inaccurate and patient information leaflets (PILs) were not routinely supplied. This is a legal requirement and risked people not having up to date information about their medicines. In addition, there were some potential concerns noted with the pharmacy's practice of placing sodium valproate inside compliance packs due to issues with its stability. The team had not discussed this practice with the person's GP nor documented any relevant details to justify this situation.

The pharmacy also offered a local delivery service. Failed deliveries were brought back to the pharmacy, notes were left to inform people about this, and subsequent attempts were made to redeliver. Medicines were not left unattended. However, there were no records retained at the pharmacy or available for inspection about this service.

People could order Pharmacy (P) medicines from the owner's other company website (**https://britishchemist.co.uk/**). No prescription-only medicines (POMs) were advertised or available through here. The process involved people completing questions relating to them or the product before being assessed by the pharmacist. There was no risk assessment about the potential issues when people ordered medicines online as well as the measures that the pharmacy had in place to minimise them. However, the team could demonstrate making relevant checks before medicines were supplied and refusals took place particularly if repeat requests occurred. Medicines sold through this website were delivered through Royal Mail which could be tracked.

Staff were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). They ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them. They had also

previously identified people in the at-risk group who had been supplied this medicine. However, the team did not routinely identify people with other higher-risk medicines, unless they were newly prescribed. This meant that they did not routinely ask relevant questions about blood test results, nor did they record any information about this.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Medicines were stored in a relatively organised way. CDs were stored securely whilst the RP was present. The team said that medicines were date-checked for expiry regularly and short-dated medicines were routinely kept. However, there were no records available to help verify that this was routinely taking place. Staff said that this was given to the pharmacy's manager who predominantly worked elsewhere. Medicines which were returned to the pharmacy by people for disposal, were accepted by staff, and stored within designated containers. The pharmacy used a data logger to help verify that temperature sensitive medicines had been stored appropriately, the appropriate records were supplied following the inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the appropriate equipment and the facilities it needs to provide its services safely. But the pharmacy is using conical measures that have not been approved to the required standards. This means that it may not always be accurately measuring its liquid medicines.

Inspector's evidence

The pharmacy mostly had access to the necessary equipment and resources in line with its activity. This included internet access, tablet counting triangles and capsule counters, a dispensary sink, which could have been cleaner and a legally compliant CD cabinet. Computer terminals were password protected and their screens faced away from people using the pharmacy. Portable telephones helped conversations to take place in private if required. However, plastic conical measures were present and were being used to reconstitute medicines. They had not been manufactured to specific standardised requirements which meant that they may not give accurate measurements. This risked people receiving inaccurate doses.

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.