General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 417 Hertford Road, ENFIELD, Middlesex, EN3 5PT

Pharmacy reference: 1034873

Type of pharmacy: Community

Date of inspection: 16/08/2021

Pharmacy context

The pharmacy is in a main road setting, in a parade of local shops close to a surgery and provides services to the local population. The pharmacy provides general dispensing services as well as supplying medicines in multi-compartment compliance packs to some people. The team also deliver medicines to some people. A flu vaccination service is available seasonally.

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

Members of the pharmacy team usually work to professional standards and identify and manage risks effectively. They record or discuss mistakes they make during the dispensing process with the regular pharmacist. And they try to learn from these to avoid problems being repeated. The pharmacy generally keeps its records up to date and these show that it is providing safe services. Its team members understand how they can help to protect the welfare of vulnerable people. And the pharmacy team members keep people's private information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were issued by the company. The SOPs covered the services that the pharmacy offered. A sample of SOPs was chosen at random and these had been reviewed within the last two years. The written procedures said the team members should log any mistakes they made which were corrected during the dispensing process in order to learn from them. They regularly logged any issues and discussed trends and learning from these events.

The pharmacy displayed the responsible pharmacist notice where it could be seen easily. The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice when they were unsure of the information to give to people.

The pharmacy had professional indemnity and public liability insurances in place. The pharmacy team recorded private prescriptions and emergency supplies in a book. The controlled drugs registers were up to date and legally compliant. The pharmacist checked them every week to ensure that there were no missing entries, there was legal compliance and that the stock levels were as expected. This had not been done for two weeks as the regular pharmacist had been on holiday.

The pharmacy team members had undertaken information governance training and assessments and they had a contingency plan in case of unforeseen events. Computers and labelling printers were used in the pharmacy. Information produced by this equipment was not visible to people in the retail area. Computers were password protected to prevent unauthorised access to confidential information. Other patient-identifiable information was kept securely away from the public view. Confidential waste was separated from general waste and disposed of securely by a licensed waste contractor.

The team members had done some training about safeguarding and were regularly updated about it. There were local contact details available for the staff to use if they needed to report any safeguarding concerns. The staff were not sure if the delivery driver had had any training about safeguarding, as he worked across several branches.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services, and they work effectively together. They generally have the appropriate qualifications and training to deliver services safely. The team members' skills are being reviewed to ensure they are working to current standards and they are given some ongoing training.

Inspector's evidence

There was a pharmacist and two part-time pharmacy technicians present during the inspection. There were also two dispensers and a delivery driver in the team, who were not present during the inspection. The pharmacist had been in post since December 2020 to improve the running of the pharmacy. He said that he was making progress, but it was slower than he would have liked.

Some of the staff occasionally tried to help but in a way that made the dispensing process less safe. For example, they used to keep dispensing prescriptions even though the number to be checked was too great and piling up on the work benches. The pharmacist had changed the process so that there was now a limit to the number of prescriptions dispensed until he had had time to check them. This reduced the clutter on the bench at any time and the risk of baskets overflowing with medicines getting mixed up. Only one person's multi-compartment compliance packs could be dispensed at a time, following a mix-up with bag labels. It was noted that some staff were dispensing from the labels rather than the prescription, which increased the risks of picking errors. The risks this posed were discussed with the pharmacist and the individual concerned.

Staff training was provided by the company but staff were not given allocated training time. However, they still managed to complete the training provided. They were currently being encouraged to review the SOPs, consider how their practice differed from the SOPs and make changes accordingly. The staff said that they were able to discuss matters with the pharmacist. The company did not set any targets for staff which might interfere with their ability to act in a professional way.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are small but are generally clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area. The pharmacy could do more to reduce clutter and keep dispensing areas as clear as possible.

Inspector's evidence

The shop area was tidy but was very small with very limited space. This meant that the pharmacy was limiting people to two in the shop at any one time. There was a queue outside before and during much of the inspection. There were markings on the shop floor to indicate where people were to stand to maintain social distancing and there was a plastic screen in front of the till to protect the public and the staff. There were also signs on the doors to remind people to wear face masks.

The dispensary was also quite small and many of the work surfaces had clutter at the back of them, allowing dispensing to occur on the front half only. This was discussed with the pharmacy team. There was not enough space for storing prescriptions awaiting collection on the designated shelves so some had to be stored in tote boxes on the floor. However, there were separate benches for labelling, dispensing and checking, as well as an area to the rear which was used to dispense multi-compartment compliance packs. This meant that these tasks could be separated and undertaken more safely.

The consultation room was of adequate size and was suitable for vaccinations. There was a separate small staff area and toilet facilities. There was a dispensary sink which was clean and the area around it was tidy.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy delivers its services in a safe and effective manner and it gets its medicines from reputable sources. Pharmacy team members are helpful and give advice to people about where they can get other support. They try to make sure that people have the information they need so that they can use their medicines safely although this does not happen consistently, especially for higher-risk medicines. So some people may not receive appropriate advice about the medicines they receive. However, the improvements already identified by the pharmacy will help to address this.

Inspector's evidence

Access to the pharmacy was via a step with an automatic door. Services were advertised in the window and people were being offered the opportunity to sign up for a flu vaccination. There were notices on the door and inside the shop, and staff asked customers if they would like an appointment for a flu vaccination.

Computer-generated labels for dispensed medicines included relevant warnings and were initialled by the dispenser and checker which allowed an audit trail to be produced. The pharmacy used baskets during the dispensing process to help ensure that prescription items were kept together and were easy to move from one area of the dispensary to another. There was a computerised retrieval system in place for finding prescriptions which had already been dispensed and which were waiting to be collected by people.

Some people were being supplied their medicines in multi-compartment compliance packs. These packs were labelled with the information the person needed to take their medicines in the correct way. The packs also had tablet descriptions to identify the individual medicines contained in the packs, but these were not always accurate. The team members present said that they would ensure these were checked as part of the dispensing and checking processes. Patient information leaflets (PILs) were supplied, meaning that people could easily access the information provided by the manufacturer about their medicines. There was a summary sheet in the pharmacy for each person receiving these packs showing any changes to their medicines and where the medicines were to be placed in the packs.

Prescriptions for warfarin, lithium or methotrexate were not marked in any way so staff did not know to ask about any recent blood tests or the person's current dose. So, there was some risk that the pharmacy wasn't always able to monitor the patients in accordance with good practice. There were "Therapy Check" stickers available to the team, but the team did not use them. When asked the technicians knew what they should ask but said that they did not do so all the time and they did not think that the dispensers would know what to do. People in the at-risk group who were receiving prescriptions for valproate were not routinely counselled about pregnancy prevention. Appropriate warnings stickers were available for use if the manufacturer's packaging could not be used, but the technicians did not do so. The pharmacist said that all these high-risk medicines were an area where he was aware that further training and reinforcement was needed, and it was high on his priority list. He would take immediate action to ensure that everyone in the at-risk group taking valproate was asked about the pregnancy prevention programme (PPP) on each occasion they had their prescription

dispensed. And he would make sure that the patient medication record system was updated to help with this.

The pharmacy got its medicines from licensed wholesalers and stored them on shelves in a tidy way. There were coloured dots on the shelves and boxes to indicate items which were short dated. Regular date checking was done, and no out-of-date medicines were found on the shelves. The fridge temperatures recorded showed that the medicines in the fridge had been consistently stored within the recommended range. Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. Electrical equipment was regularly tested. Stickers were affixed to various electronic equipment and displayed the next date of testing.

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.