General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Reena Pharmacy, 222 Regents Park Road, Finchley, LONDON, N3 3HP

Pharmacy reference: 1040330

Type of pharmacy: Community

Date of inspection: 27/06/2019

Pharmacy context

This pharmacy is in a parade of shops in a residential area. The pharmacy dispenses NHS prescriptions and offers private services for erectile dysfunction, salbutamol and travel vaccinations. It also supplies medicines in multi-compartment compliance packs to a number of people to help them take their medicines safely.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	Not all team members have the appropriate qualifications for the tasks that they carry out.
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 has written instructions which tell the team how to complete tasks safely. The pharmacy asks its customers for their views. Team members protect people's private information. And they know how to safeguard vulnerable people. The pharmacy generally keeps the records it needs to by law. But not all of them are complete or accurate. This could make it harder for it to show what had happened if there was a query.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were up to date and had been read and signed by most team members. Team roles were defined within the SOPs.

Near misses were recorded on a near miss log. The responsible pharmacist (RP) said that when she had been working at the pharmacy she would have a conversation with the team member who had made the mistake and try to understand how the mistake had occurred and what could be done differently to avoid reoccurrence. She was unsure if the pharmacy carried out regular reviews of near misses. She said that in the past the pre-registration trainee (pre-reg) had told her of meetings held to discuss near misses and inform her of any changes that had been made. She said that the team had tried to separate drugs and obtain a second check where possible.

Dispensing incidents would be investigated and a note would be made on the electronic patient medication record. The RP said that she would report all dispensing incidents on the National Reporting and Learning System (NRLS) website. The RP would also notify the person's GP, the superintendent pharmacist (SI) and the owner.

An incorrect RP notice was initially displayed. The displayed notice was for the regular pharmacist who had not worked at the pharmacy since the previous week. This was changed during the course of the inspection. 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 and also completed an annual patient satisfaction survey. As the pharmacist was a locum she was not familiar with any changes made as a result of patient feedback.

Records for emergency supplies and unlicensed specials were well maintained. RP records were largely well maintained but some pharmacists were not signing out. Controlled drug (CD) registers had a number of missed headers. Private prescription records did not always have the correct prescriber details recorded.

The RP said that CD balance checks were carried out every few months, the CD liquid balance was done more frequently. A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received.

Assembled prescriptions were stored in the dispensary. The RP said that she thought there was an information governance policy in place, and colleagues had read and signed the confidentiality agreement. The RP did not have access to Summary Care Records.

The RP had completed the level 2 safeguarding training. An SOP was in place for safeguarding. The RP was not familiar with the details of the local safeguarding boards. This could cause delay in concerns being escalated.

Principle 2 - Staffing **Standards not all met**

Summary findings

The team members generally manage the pharmacy's workload well. But not all of them have the appropriate qualifications for the tasks they carry out. Staff are given some ongoing training. But this is not very structured, and they are not given time set aside for training. This could make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP and another team member who had been preparing compliance packs and was working as an assistant. This team member was a university student who had previously worked on Saturdays since April 2017 and had not completed any accredited pharmacy training. The assistant had prepared a number of compliance packs in the week that she had worked at the pharmacy. The RP said that the team member had been asked to help whilst the pre-reg was away. The regular pharmacist was off and the pre-reg had taken some time off to sit her exam. The company director, a pharmacist, who was semi-retired sometimes came in to help. The RP said that as there were also absences in other branches the company director was helping across all three. Where possible the regular pharmacist tried to get the pre-reg to prepare compliance packs before she went on leave. A trained medicines counter assistant worked from 9am to 2pm each day. The team members present appeared to be managing the workload well.

The pre-reg was due to leave at the end of July. The RP thought that a new pre-reg was due to start after this.

The counter assistant did not sell any P medicines or handout any prescriptions she was observed to refer to the RP during the course of the visit. She occasionally helped with date checking and record keeping.

The team member said that there was no formal procedure in place for ongoing training. She was sometimes briefed by representatives from manufacturer's when they visited.

The team member had not worked at the pharmacy regularly, she said previously when she had worked there more regularly the regular pharmacist would give her feedback verbally on how she could improve. The team member and RP said that they felt able to raise concerns or share feedback with the regular RP or company director.

The locum pharmacist was not set any numerical targets for the services offered.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services.

Inspector's evidence

The pharmacy was generally clean. The cellar area was used for the wholesale side of the business. There was enough space for the workload. Workbenches were clear of clutter. Medicines were arranged on shelves in a tidy and organised manner. A sink was available. Cleaning was done by the MCA.

The consultation room was generally clean. There was a large bag in the room which had a Nigerian address. The RP said that it was to be exported and she was unsure of what was in it. She said that it had been left there by the company director and another man who dealt with the exports. This was moved during the course of the inspection. The pharmacy had a wholesale dealer and export licence in place with The Medicines and Healthcare products Regulatory Agency (MHRA). The premises were kept secure from unauthorised access when the pharmacy was closed.

The room temperature was appropriate for the for the provision of pharmacy services. And lighting was good throughout the pharmacy. Air conditioning was available to help regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are largely delivered in a safe and effective manner. The pharmacy obtains its medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use.

Inspector's evidence

The pharmacy was accessed via a small step. There was a glass door at the entrance and the team would help people who required assistance. The RP said that some medicines boxes had braille and the pharmacy had the ability to produce large print labels. A list of the services provided by the pharmacy was displayed in the window of the pharmacy. Team members were aware of the need to signpost people to other providers. Team members used the internet to find other services if they were not familiar with the details. The team were multilingual.

The RP did not provide all the services offered, but she felt that the Medicines Use Reviews had an impact to people as there was a larger proportion of older people who were sometimes confused about their medicines. The travel clinic was offered by the regular pharmacist and the RP said that it was popular as it was hard to get appointments at the local surgery.

Most prescriptions were received electronically by the pharmacy. The RP said that the beginning of the week was usually busier compared to the end of the week. The RP said that she had not felt that she could not cope or felt stressed. The RP processed prescriptions, ordered stock and when the pre-reg was available she would assemble and the RP double checked. As the RP was working on her own she asked the MCA to double check her work. The RP also took a mental break between dispensing and checking.

Dispensed and checked by boxes were available on labels; these were initialled by team members when they were dispensing or checking. The pharmacy team used baskets to ensure that people's prescriptions were separated, to reduce the risk of errors.

The RP was aware of the change in guidance for dispensing sodium valproate and the Pregnancy Prevention Programme. However, she was not aware of the need to use the warning stickers. The inspector reminded her of the requirements. She said that there were a few people who regularly collected sodium valproate from the pharmacy but she was unsure if they fell in the at-risk group

The RP annotated prescriptions with 'warfarin' so that she could check the INR with the person. Emergency supplies for warfarin were not really given unless there was a real urgency. The RP said that the pharmacy did not routinely record the INR.

Prescriptions for people who were supplied their medicines in compliance packs were ordered by the pharmacy. Individual records were in place for each person which were used to compare against the prescription. Any changes were queried with the surgery and the individual record was updated. Packs were usually prepared by the pre-reg. In the event that someone was admitted into hospital, the pharmacy usually received a call from the hospital and received a discharge summary. This was cross-checked against the patient medication record and the record sheet was annotated.

Assembled packs observed were labelled with mandatory warnings and product descriptions. There was an audit trail to show who had prepared and checked the packs. Patient information leaflets were supplied on a monthly basis.

Deliveries were carried out by a designated driver who obtained signatures when medicines were delivered. Other people's private information was visible to people signing for their delivery. The driver said in some instances medicines were posted through the letter box. The delivery driver said that he was aware of some people's circumstances and only put medicines if there was a cubby hole and the medicines did not fall onto the floor. Some people were called before the driver attempted delivery.

PGDs and other services provided by the regular pharmacist who was not present at the time of the inspection.

The pharmacy was reusing methadone bottles for people who administered their medicines in the pharmacy. This increases the risk of contamination and is unhygienic. The inspector discussed this with the RP who said that she would use a fresh bottle for each dispensing.

Medicines were obtained from licensed wholesalers and stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of medicines. CDs were kept securely.

Short-dated stock was observed to be marked. The RP thought that there was a regular procedure in place for date checking. And that this was usually done on a Friday or Saturday. No date-expired medicines were observed on the shelves checked. The RP and assistant were unsure if there was a date checking matrix in place.

The pharmacy was not compliant with the Falsified Medicines Directive (FMD). The RP was unsure of what the plans were.

Out-of-date and other waste medicines were segregated at the back of the pharmacy away from stock and then collected by licensed waste collectors.

Drug recalls were received from the suppliers or via email to the pharmacy's email address which the RP could access. These were printed and filed in the dispensary.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services.

Inspector's evidence

Glass calibrated measures were available. Tablet triangles were available. A separate counter for use with cytotoxic medicines was available to avoid cross-contamination. A fridge of adequate size was available. Up-to-date reference sources were available including access to the internet.

Calibration of equipment was not recorded, but the pharmacist was aware of the need to have this done regularly.

The computers were password protected and the RP had an individual smartcard to access the PMR system. 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.