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: 21/01/2020

Pharmacy context

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

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

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 its records up to date.

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. The SOPs covered the services that were offered by the pharmacy. A sample of SOPs was chosen at random and had been reviewed within the last two years. They were signed by the pharmacy's team members to indicate they had been read.

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. This was to try to understand how the mistake had occurred and what could be done differently to avoid reoccurrence. She said that the pre-registration trainee (pre-reg) and she had meetings to discuss near misses and improve the way she dispensed. The team separated medicines and placed notices near medicines to highlight those with similar names or in similar packs and tried to 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. There had been no recent incidents recorded.

The pharmacy conspicuously displayed the responsible pharmacist (RP) notice. The RP record required by law was up to date and filled in correctly. 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 complaints procedure and also completed an annual patient satisfaction survey. The survey had not highlighted any significant learning except for the need to be more pro-active in health promotion. It was said that conversations about this were started with people wherever possible.

The pharmacy team recorded private prescriptions and emergency supplies in a book. The controlled drugs (CD) registers were up to date and legally compliant. The team did regular checks on the recorded balance and actual stock of CDs to ensure that there were no missing entries. Fridge temperatures were recorded daily and were within the recommended range. CDs that people had returned were recorded in a register as they were received.

There was an information governance policy in place, and colleagues had read and signed the confidentiality agreement. The RP had access to summary care records. Staff had NHS smartcards to access electronic prescriptions and were seen to remove them from computer terminals when not in use. A shredder was used to destroy confidential waste which was first separated from other waste

using separate baskets.

The RP had completed the level 2 safeguarding training. There was an SOP for safeguarding. The RP had access to the local safeguarding boards' contact details as she had the NHS app on her phone.

Principle 2 - Staffing ✔ Standards met

Summary findings

The team members generally manage the pharmacy's workload well. 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 mean that learning needs of staff members are not always identified and supported. There are currently enough staff to cope with the workload though the departure of one of the team later in the year may put some pressure on the rest of the team if there is no replacement for them.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the responsible pharmacist, a trained medicines counter assistant who worked from 9am to 2pm each day and the pre-registration pharmacy student. The team members present appeared to be managing the workload well. The pre-registration pharmacy student was due to leave at the end of July. There was also a Saturday assistant. Both counter assistants were on a on the counter assistant's training course. They were both also given manufacturer's training materials to improve their knowledge of the products available. But there was no formal training structure in place. The most recent information had been about cold and flu products. The counter assistant sold pharmacy (P) medicines but any prescriptions to be handed out were checked by the pharmacist or pre-registration pharmacy student first.

The pharmacist had opportunity to discuss matters with the superintendent pharmacist and owner of the business. She had informal meetings where they could discuss issues which had come up. The regular pharmacist was not set any numerical targets for the services offered. The responsible pharmacist was not the 'responsible person' for the wholesaling activities undertaken by the business, and she had no dealings with it.

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 pharmacy had a wholesale dealer and export licence in place with the Medicines and Healthcare products Regulatory Agency (MHRA). The cellar area was used for the wholesale side of the business. Upstairs was a store room, the toilet facilities, with wash-hand basin and a kitchen area and staff room. The areas used by the pharmacy were generally clean and tidy with adequate lighting

In the dispensary 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 staff. 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.

The consultation room was generally clean. The premises were kept secure from unauthorised access when the pharmacy was closed.

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. But the systems are not robust, so some people may not receive the best service, as others do.

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.

A 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. The team dispensed a large number of private prescriptions each month as well as their NHS work.

Most NHS 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-registration pharmacy student was available, she would assemble prescriptions and the RP checked the accuracy of the dispensing. Dispensed and checked by boxes were available on dispensing labels; these were initialled by team members to show who had carried out these tasks 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. She said that there were a few people who regularly collected sodium valproate . These patients were advised about pregnancy prevention if they were in the at-risk group and the inspector was told that warning stickers were put onto split boxes. The RP annotated prescriptions with 'warfarin' so that she could check the INR and current dose with the person. But this process was not robust; if she did not hand out the prescription the INR and other relevant information would not be checked.

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 their individual record was updated. Packs were usually prepared by the pre-registration pharmacy student. 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 their 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. A moderate number of people used this service.

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. The responsible pharmacist said that she would review the delivery service.

Patient group directions (PGDs) were present for those services offered by this route. They were in date and relevant staff had done the appropriate training for a safe service. The documents were kept on the computer, and if the PGD was no longer valid, or the pharmacist's training had expired they would not be accessible for use. It was reported that use of the travel clinic was quite good, whereas the flu vaccination service this year had been poor.

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. No date-expired medicines were found on the shelves checked. 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.

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

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.