General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Frost & Co, 9 High Street, Hornsey, LONDON, N8 7PS

Pharmacy reference: 1040374

Type of pharmacy: Community

Date of inspection: 01/11/2024

Pharmacy context

This community pharmacy is located on a busy high street in Hornsey, North London. It dispenses both NHS and private prescriptions and provides medicines in multi compartment compliance packs for people who have difficulty remembering to take their medicines. It also provides medicines to people in a care home.

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 met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	There are areas of the pharmacy that are very cluttered and untidy which are detrimental to the safe provision of services.
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's working practices are generally safe and effective. The pharmacy generally keeps the records it needs to by law and the pharmacy team knows how to help protect people's personal information. Team members respond appropriately when mistakes happen during the dispensing process. But they do not routinely make records of dispensing mistakes, which could make it harder for them to learn from these events.

Inspector's evidence

The correct responsible pharmacist (RP) notice was on display in the pharmacy. The RP was also the superintendent pharmacist (SI). The pharmacy had up to date standard operating procedures (SOPs) and most of them had been signed by the team to confirm they had been read and understood. The SI signed and dated the SOPs each time he reviewed them. But it was not clear that these signatures meant the SOPs had been reviewed so the SI said in future he would annotate these as review dates. The SOPs covered a range of pharmacy activities and team members were observed working in a safe and efficient manner during the inspection. When questioned, the dispenser was aware of what they could and couldn't do in the absence of the RP.

The pharmacy did not record dispensing mistakes which were spotted before a medicine was handed to a person (near misses). This meant the pharmacy may not always be able to identify emerging patterns or trends in the types of near misses being made. The SI said incidents were discussed as soon as any near misses occurred, and action was taken if necessary to avoid repetition. For example, when preparing multi-compartment compliance packs, the dispenser added a step of counting all the tablets in each compartment to ensure the correct number of tablets were inserted. Additionally, similar sounding and similar looking medicines were separated on the shelves to avoid picking errors. The SI explained that he normally personally put away stock orders, and was familiar with all the medicines and their packaging, which he believed reduced the risk of errors. The SI often self-checked medicines he had dispensed, but a third check was carried out by the team member handing out the medicine to reduce the risk of errors occurring. The SI said there had not been any dispensing mistakes where the medicine had been handed out to a person (dispensing errors), but he described what he would do if an error occurred. He would report the error online and complete a root cause analysis.

The pharmacy had a complaints procedure in place, but this had only been signed by the SI. He said that he was always overlooking the counter so he would know when a complaint was being made and could intervene. The SI confirmed that any complaints or feedback about the pharmacy could be given in person, by leaving reviews online or via a phone call, and they would always be dealt with by him. Some people who had used the pharmacy service had left thank you cards where they felt the pharmacy team had provided good care. The SI gave the examples of contacting the GP on behalf of a person to help resolve issues and arranging a taxi for a person who found it difficult to make their own way home. He explained that the pharmacy team focused on building a good rapport with people and the local community. The pharmacy also had a sign at the medicines counter explaining how to make a complaint.

The pharmacy had current professional indemnity insurance. Records of private prescriptions, controlled drug (CD) registers and RP records were generally well maintained. A random check of a CD

medicine quantity complied with the balance recorded in the register. A prescription for one of the entries in the private prescription register could not be found and there were a couple of errors on entering the date of prescription. However, the RP record was generally complete with most entries seen having a start and finish time. The SI stated that the pharmacy had not made any emergency supplies or dispensed any unlicensed specials for a long time, but was able to describe the records that would need to be kept.
Confidential material was shredded as soon as it was no longer needed. No confidential waste was found in the general waste bin. And no confidential information could be seen from outside the dispensary area. The pharmacy had a confidentiality SOP that the team members had signed.

The SI confirmed that he had completed level two safeguarding training. He stated that he would find contact details of local safeguarding leads online if needed, but he had not needed to deal with a safeguarding concern for some time. The dispenser had not completed safeguarding training, but she said she would refer any concerns or suspicions to the SI.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team but is able to manage its workload effectively. And the dispenser completes some ongoing training in the pharmacy to keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection, the pharmacy team consisted of the SI and his wife who worked as a dispenser and counter assistant. The SI confirmed that his wife had completed both dispenser and counter assistant training. The SI stated that he normally did the dispensing and self-checking of prescriptions in the pharmacy, while his wife worked on the counter and dispensed multi-compartment compliance packs for people. The SI felt the pharmacy had just enough team members to cope with the workload at present. Medicines were prepared when people came to collect them, and these were seen to be prepared efficiently with very little waiting time.

The SI stated that he provided teaching sessions to the dispenser when there were new services or pharmacy updates. The pharmacy also had access to pharmacy journals and magazines, which the SI and dispenser read when they had time, to keep up to date. The dispenser was also provided with opportunities to develop their skills, for example they had completed both the counter assistant course and dispensing course and was intending to enrol onto an accuracy checking course. The SI did not set any performance targets in the pharmacy. The SI and the dispenser were observed working very well together during the inspection, efficiently seeing to patients, and answering the phone. They were observed asking the appropriate questions when supplying Pharmacy-only (P) medicines and giving advice to people. The dispenser was aware of the maximum quantities of some medicines that could be sold over the counter. And the SI gave examples of where they had refused sales due to concerns of misuse of medicines and provided explanations to those customers, so they understood the reason behind the refusal.

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

Summary findings

The pharmacy is generally untidy and large parts of the dispensary are very cluttered. This makes it harder for the team to work effectively and presents some health and safety risks. However, the retail area is clean and clear of obstructions. The pharmacy is kept secure from unauthorised access. But the lack of a consultation room means private conversations may sometimes be difficult.

Inspector's evidence

The SI stated the pharmacy had been undergoing a renovation recently, but this had stopped due to issues with the builders. As a result, the floor of the pharmacy was concrete, and no floor covering had been laid yet. Display stands had been moved from the shop floor and gathered near the medicines counter. This blocked public access to some of the products. The shop floor area of the pharmacy had delivery totes and boxes against the walls under the display shelves, which affected the overall look of the shop. However, it had a chair for people who wished to wait for their prescription. And the front of the pharmacy shop was in a moderate state of repair. The pharmacy was cleaned once a week.

Boxes of extra stock were stored above the display shelves on the shop floor. This included some P medicines. Although a person of average height would not be able to reach the boxes, the SI accepted that some people may be able to reach and agreed to move the P medicines to storage areas behind the counter.

The dispensary area was very cluttered. There were large piles of boxes near the counter which looked unprofessional and were a tripping hazard. Much of the desktop space in the dispensary was covered in papers and boxes which could increase the chances of items being lost or misplaced. But the pharmacy had a clean sink for preparing liquid medicines. The temperature and lighting of the pharmacy were adequate.

The pharmacy did not currently have a consultation room. The SI sated that he spoke to people in the shop floor area of the pharmacy, but said he only discussed confidential matters when no one else was in the pharmacy and if someone else came in during the consultation, they would be asked to wait at the front of the store until the consultation was complete. The pharmacy was kept secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. It orders its medicines from reputable sources and manages them properly. And it ensures that people who get their medicines in multi-compartment compliance packs receive all the information they need to take their medicines safely.

Inspector's evidence

The pharmacy had a step up to the main entrance which had a manual door. If someone could not enter the pharmacy, the pharmacy team would speak to them outside. The SI and dispenser were observed signposting people to another pharmacy for items they did not have in stock. The dispensary did not have a separate area for dispensing and checking medicines, so there could be an increased chance of medicines getting mixed up. However, the SI explained that they mainly dispensed items when a person came into the pharmacy to collect their item rather than preparing in advance. This meant there were fewer dispensed items waiting to be collected.

Multi-compartment compliance packs were prepared by the dispenser and checked by the SI. Packs seen included all the required dosage and safety information. They also had descriptions of the medicines contained in the packs, including the shape, colour and any marking on the medicines to help people identify them. The SI confirmed that patient information leaflets (PILs) were always sent to people each month with their packs. The SI also said that he always contacted the surgery if there were any queries with prescriptions, such as unexpected changes to people's treatment. Changes were logged and attached to the persons file, and the medicine chart was amended to reflect the changes.

The pharmacy provided a delivery service for people in a care home. The deliveries were made by the SI. Two records of the deliveries were made with one copy given to the care home and one kept by the pharmacy for archiving. When a delivery was made, the care home staff would check against the sheet provided to confirm that all medicines had been received.

The pharmacy obtained its medicines from licensed wholesalers. CDs requiring safe custody were stored securely. The pharmacy had a fridge for storing medicines, fridge temperatures were recorded daily. Records showed that the temperatures had been within the required range for storing temperature-sensitive medicines. The current temperature of the fridge was also within the required range. The SI had a robust system in place to check expiry dates of stock medicines every four weeks and this was recorded on a date checking matrix. Medicines with short expiry dates were logged so the SI could keep an eye on them. A random sample of stock was checked, and no out-of-date medicines were found.
Safety alerts and recalls were received electronically by email. The SI said these alerts would be actioned when received, but no documentation of the action taken was recorded, and alerts were not archived after actioning. So, the pharmacy could not demonstrate what action had been taken for previous alerts. The SI was aware of the risks associated with sodium valproate, and he knew what to do if a person in the at-risk category presented at the pharmacy. And he was aware of the recent guidance changes regarding supply of sodium valproate. The pharmacy did not currently have any patients on valproate who were in the at-risk group. The SI confirmed he provided additional checks for people receiving higher-risk medicines, such as asking about routine blood monitoring for people taking methotrexate and checking the yellow book for people taking warfarin. The SI clinically screened

prescriptions and contacted the person's GP if there were any concerns. For example, he had received a prescription for Laxido prescribed to a child, which was changed to a more appropriate treatment after he spoke to the GP. The SI was observed counselling a person on how to take an antifungal medicine and described what medicines should be avoided.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment to provide its services safely. And it protects people's privacy when using this equipment.

Inspector's evidence

The pharmacy had internet access allowing team members to make use of any online resources they needed. Computers were password protected and faced away from public view to protect people's privacy. Team members were observed using their own NHS smartcards. The SI had access to summary care records and obtained consent from people when he accessed them. The pharmacy had cordless phones so conversations could be held out of earshot of the public. There was an appropriately calibrated glass measure for measuring liquid medicines, and this was clean. The pharmacy did not have a separate measure for CDs as it had recently broken, but the SI explained that he cleaned the measure thoroughly between liquids to avoid cross contamination, and said he was in the process of obtaining a second one. There were tablet triangles for counting tablets. They were not labelled for cytotoxic medicines, but the SI said all the cytotoxic medicines came in blisters.

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.