General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Redwood Pharmacy, 116 Alexandra Park Road, Muswell Hill, LONDON, N10 2AH

Pharmacy reference: 1040395

Type of pharmacy: Community

Date of inspection: 13/09/2022

Pharmacy context

This pharmacy is in a parade of shops on a main road. As well as dispensing NHS prescriptions the pharmacy provides flu vaccinations and supplies medicines in multi-compartment compliance packs. The pharmacy also provides private services via CityDoc which included travel vaccinations and a phlebotomy service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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's working practices are largely safe and effective. The pharmacy generally keeps the records it needs to by law so that medicines are supplied safely and legally. People who use the pharmacy can provide feedback. Team members understand their role in protecting vulnerable people. Team members generally respond appropriately when mistakes happen during the dispensing process. But the way the pharmacy records its dispensing mistakes could make it harder for it to identify any patterns or trends. And this may mean that team members are missing out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

Standard operating procedures (SOPs) were available and had recently been reviewed. Most team members had read and signed SOPs relevant to their roles, one of the team members was in the process of reading and signing them at the time of the inspection. The team had been routinely ensuring infection control measures were in place

Dispensing mistakes which were identified before the medicine was handed out (near misses) were said to be recorded on individual's electronic record. The responsible pharmacist (RP) explained that near-misses occurred very rarely but agreed that recording near misses in this way made it difficult to analyse them to spot any trends or patterns. The RP planned to look into recording near misses on a log sheet. Team members said there had not been any reported dispensing errors (where a mistake happened and the medicine was handed to a person) as all items were checked thoroughly before being handed out. There was a process in place to investigate any dispensing errors in the event that one occurred.

There were three RP notices displayed initially, the RP removed two of these and displayed the correct notice. Not all team members were aware of the activities that could not be carried out in the absence of the RP. The inspector discussed this with them and the RP provided an assurance that she would ask team members to re-read the relevant SOP and check their understanding. The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure in place with a notice displayed, this explained to people how they could make a complaint.

Private prescription records were well maintained. Some emergency supply records seen did not have a reason for the supply recorded. Some pharmacists were not always signing out of the RP record. CD registers were generally kept in line with legal requirements but a number of headers were incomplete in registers seen. Most records seen for unlicensed medicines dispensed were incomplete, the RP provided an assurance that she would speak to the team. The pharmacy had not received any returned CDs from people and the RP was unsure of where these would be recorded. She agreed to review how any returned CDs would be recorded. A random check of a CD medicine quantity complied with the balance recorded in the register.

The pharmacy had SOPs for data protection and confidentiality which team members had read. Pharmacists had smartcards but the team were observed to be using the superintendent pharmacist's (SI) card despite him leaving at the start of the inspection. The RP provided an assurance that she would

look into obtaining cards for team members who needed to access NHS systems. Only the SI had access to Summary Care Records (SCR) and consent to access these was gained verbally. The RP's account settings on her smartcard had not been updated, so she was unable to access SCR and she had spoken to someone about this.

Pharmacists had recently completed the level 2 safeguarding training course for the flu vaccination service and the RP had verbally briefed team members. The trainee pharmacy technician had started the training course. The RP was aware of where to find details for the local safeguarding board and planned to print these out.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They have completed or are doing the required accredited training for their roles. They do ongoing training to help keep their knowledge and skills up to date. And they feel comfortable about raising any concerns.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP and a trained dispenser who was completing the pharmacy technician training and a trained medicines counter assistant (MCA). There were an additional two pharmacists including the SI who also worked at the pharmacy. The RP felt that there were an adequate number of staff for the services provided

Individual performance and development was managed informally, pharmacists provided team members with on-the- spot feedback as well as recognising things team members had done well. The RP also listened to team members consulting people and provided them with feedback on how they could improve. The team members felt able to provide the SI with suggestions and feedback.

The MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was aware of the maximum quantities of certain medicines which could be sold over the counter. She would refer to the RP before selling some medicines.

To keep the team's knowledge up to date, team members were all enrolled with a training provider and completed training modules on different conditions. On completing the training module, the team member was asked to brief the rest of the team on what they had learnt. The MCA had recently completed training modules on dermatitis and head lice. The dispenser had recently started the technician training course and preferred to complete her training at home. She had finished the dispenser training course the previous year. As the team was small and worked closely together, things were discussed as they arose. There were no numerical targets set for pharmacists.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are clean and tidy and well maintained. Space is effectively managed to improve the workflow. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean, tidy, and organised. There was ample workbench space available in the dispensary which was allocated for certain tasks. Stock held on shelves was tidy and organised. A clean sink was available for the preparation of medicines. Cleaning was carried out by the team at the end of each day and after all deliveries were put away all work surfaces were disinfected

A consultation room was available. The room allowed a conversation at a normal level of volume to take place inside without being overheard. The room was accessed from behind the medicines counter walking past the dispensary and assembled prescriptions. And people's private information was visible to people walking past. Following the inspection, the RP confirmed that the prescription bags had been placed in boxes and other bags had been placed in a way to ensure people's information was not visible. The RP also provided an assurance that she would speak to the SI to see if a covering or cupboard could be built.

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services. The lighting had recently been changed to brighten up the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and effectively. It gets its stock from reputable sources and mostly stores it properly. It takes the right action in response to safety alerts to make sure that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access into the pharmacy and automatic doors with a slight indoor ramp. Services offered by the pharmacy were advertised on window and the team were aware of the need to signpost people to other providers if a service was not available at the pharmacy. The pharmacy had developed a website which people could use to see all the services provided and book appointments. There was also a poster displayed in the dispensary with details for useful contacts which included other services. The pharmacy team was able to produce large print labels. Some team members were multilingual and the surgery across the road from the pharmacy had a number of Turkish speaking staff who helped with translating.

The RP felt that the emergency hormonal contraception (EHC) service had a great impact on the local population. However, due to the pandemic the pharmacy had missed the cut-off date for renewing the service. During the peak of the pandemic the pharmacy had been the only place locally where people were able to come in to have their blood pressure checked. A number of local surgeries had stopped providing travel vaccination services and the pharmacist felt that the provision of this service also helped.

More than 80% of the pharmacy's prescriptions were received electronically. The pharmacy kept a record of all repeat prescriptions that were due to help ensure these were ordered and processed in time. Once prescriptions were received, they were marked off, the prescriptions were printed and dispensed. Team members chased up any prescriptions that were not received. Prescriptions were dispensed by the dispenser and checked by the RP. Dispensed and checked-by boxes were available on labels and these were routinely used. Baskets were used to separate prescriptions, preventing transfer of items between people.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). People who were not part of the PPP were referred back to their GP. The team was aware of the need to use warning labels when sodium valproate was not dispensed in its original pack. Placement of the label on the box was discussed with the team. Additional checks were carried out when people collected medicines which required ongoing monitoring. An alert stamp was used on the prescriptions where checks were required and people were counselled when they came to collect. Where information on test results was provided the RP made a record on the person's electronic notes. Some higher-risk medicines such as lithium and methotrexate were separated on shelves.

Some people's medicines were supplied in multi-compartment compliance packs. The pharmacy ordered prescriptions on behalf of people for this service. Any changes or missing items were queried with the surgery, the person's electronic record was updated with any information of changes or

stopped items. Discharge letters were received from the hospital, a copy of these was kept by the pharmacy. The dispenser prepared packs and left these for the RP to check. Assembled packs seen were labelled with mandatory warnings. Product descriptions were not included on the packs and this could make it difficult for people to identify the medication. The backing sheet was not securely affixed to the tray. Patient information leaflets (PILs) were not routinely supplied. The RP provided an assurance that she would ensure product descriptions were included and that backing sheets were stuck to the trays. She also agreed to ensure PILS were handed out monthly.

The phlebotomy service was provided via CityDoc. Both the RP and MCA had completed training at the London Medical Clinic. Once the blood had been taken and paperwork completed, the pharmacy called the courier to send the samples to the lab. The courier usually collected samples within an hour of being called, samples were stored in the fridge during this period. Results were sent to people via email by the pharmacy.

The travel vaccination service was also provided via CityDoc. People booked their appointments directly via CityDoc. The pharmacy checked bookings each morning and called people to confirm their appointment and check which vaccinations they were due to have so that stock could be ordered. The pharmacy could provide a maximum of four vaccinations per appointment. The pharmacy also provided yellow fever vaccinations and were registered with NaTHNac. CityDoc ensured training and audits were up to date. Previously the pharmacy had also provided chickenpox vaccinations for children but due to stock shortages these were not being provided.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and recorded, and the records were observed to be within the required range for the storage of medicines. CDs were held securely. The team used a task management diary which had a log of all the tasks that needed to be completed each morning, during the day and at the end of the day.

Expiry-date checks were carried out by team members on a monthly basis. Short-dated stock was separated from the main shelves. There were no date-expired medicines found on the shelves checked. Out-of-date and other waste medicines were segregated from stock and then collected by licensed waste collectors. Drug recalls were received via email. These were printed, checked, and processed by the team and signed once actioned and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps its equipment clean.

Inspector's evidence

Glass measuring cylinders and tablet and capsule counting equipment were clean and ready for use. A separate tray was available and used for cytotoxic medication and separate measures were used for liquid CDs to avoid cross contamination. A blood pressure monitor was available which was used as part of the services provided. This was fairly new and would be replaced in the future. Two fridges of adequate size were available. Up-to-date reference sources were available including access to the internet. The computer in the dispensary was password protected and out of view of patients and the public. A shredder was available and used to destroy confidential waste.

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.