General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Broadway Pharmacy, 185 Muswell Hill Broadway, LONDON, N10 3RS

Pharmacy reference: 1040401

Type of pharmacy: Community

Date of inspection: 14/02/2023

Pharmacy context

This is a family-run independent pharmacy situated on a main road. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs to some people who need help managing their medicines. The pharmacy also provides flu vaccinations, malaria prophylaxis and travel vaccinations including yellow fever. And it delivers medicines to some people in their own homes.

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's working practices are generally safe and effective. People who use the pharmacy can give feedback on its services. The pharmacy largely keeps the records it needs to by law so that medicines are supplied safely and legally. And the pharmacy team knows how to help protect the welfare of vulnerable people. Team members respond appropriately when mistakes happen during the dispensing process. But the pharmacy could do more to make sure that it keeps people's private information secure at all times.

Inspector's evidence

Standard operating procedures (SOPs) were available but there was no recorded date of review. The responsible pharmacist (RP) said the superintendent pharmacist (SI) had reviewed these last year and he would speak to him about updating the records. Team members had read SOPs relevant to their roles and signed them. Responsibilities were listed on individual SOPs and a completed roles and responsibilities matrix was displayed in the dispensary.

The pharmacy recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and where the medicine was handed to a person (dispensing errors). The RP described how the team had a no blame culture and used mistakes to share learning. Changes were made depending on the type of mistakes that were happening and in the past the team had completed a date check as a result of a mistake and some medicines were also moved on the shelves. A record was made of near misses, however, this was not available at the pharmacy as the SI had taken the folder home. A photograph was sent by the SI to show completed near miss entries during the inspection. Following the inspection, the SI informed the inspector that he had taken the folder home to complete the annual report but due to an emergency had not been able to return the folder. Red stickers were attached to the shelves were medicines which looked-alike or sounded-alike were kept. There had been no near misses since November 2022. The RP said there had not been any recent reported dispensing errors and he described the process that he would follow in the event that there was one. This included investigating how the error had occurred, rectifying the error and completing an incident report.

A correct responsible pharmacist (RP) notice was displayed. 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. Complaints related to the counter were dealt with by the pharmacy manager. The RP said the team tried to take a customer-centred approach and tried to see what could be done to help. People generally were said to leave happy with the way in which the matter was resolved. Complaints had mainly been about people buying the wrong product. Team members ensured people were given their receipt and understood that medicines were nonreturnable.

Records for private prescriptions, emergency supplies, unlicensed medicines dispensed, controlled drug (CD) registers and RP records were generally well maintained. However, there were some occasions where the RP was not signing out of the register, there was some overwriting in the CD register and some of the prescriber details were incorrect on private prescription records. CDs that people had returned were recorded in a register as they were received. A random check of a CD medicine quantity complied with the balance recorded in the register.

Assembled prescriptions were stored in the dispensary and behind the medicines counter and people's private information was not visible to others using the pharmacy. However, some prepared medicines were stored in the consultation room. People’s details were potentially visible to those accessing the room. The RP and later the SI provided an assurance to ensure this information was covered. An information governance policy was available and team members had been briefed at a staff meeting and read through SOPs. Confidential paperwork and dispensing labels were segregated and shredded. Pharmacists had smartcards. Summary Care Records (SCRs) could be accessed by two of the regular pharmacists, the RP was due to apply to be granted access. Consent was gained verbally from people and in some cases written confirmation was also gained.

All team members had either completed level one or two safeguarding training. Details for the local safeguarding contacts were available

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to dispense and supply its medicines safely. Team members are given some ongoing training to keep their knowledge and skills up to date. But the pharmacy could do more to ensure team members are enrolled on the right training courses in a timely manner.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP, who was a locum pharmacist but worked at the pharmacy four days a week regularly. Other team members included a trained dispenser and three trained medicines counter assistants (MCAs), one of who was the pharmacy manager. The RP felt there were enough staff. The SI and his wife, who was also a pharmacist worked at the pharmacy regularly. The travel vaccination service was provided by a locum pharmacist who worked on Saturdays. He was an independent prescriber and very rarely issued prescriptions from the pharmacy.

The two team members who worked at the pharmacy on Saturdays had worked at the pharmacy for a few months. They had not been enrolled on any formal accredited training courses at the time of the inspection. Following the inspection, the SI explained that in the past they had an issue with retaining staff and some had left after being enrolled on the course. The SI forwarded confirmation that both team members had subsequently been enrolled on the MCA course.

Individual performance and development were managed informally by the owners. Team members were provided with feedback. The RP also provided team members with feedback. Team meetings were held every two months, discussions from meetings were passed on to team members who were not present. Pharmacists had a record book with a task list of all the activities that needed to be completed on a daily basis. There was space in this to record any notes which needed to be passed on to the pharmacist working the following day. The SI was also contactable by telephone. Team members described that the owners were open to feedback.

The MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. He was aware of the maximum quantities of certain medicines which could be sold over the counter.

To keep up to date representatives from various companies provided team members with refresher training and often left training material and information for them. Team members also had access to online training modules provided by a third party. Training for NHS initiatives was completed at home. Team members completing formal training were well supported by their colleagues and completed any training at home.

Targets were set for the services provided such as flu vaccinations and hypertension service. The targets did not affect the RP’s professional judgment.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable to provide healthcare services from. The pharmacy is presented well and kept appropriately clean as well as tidy. The pharmacy has plenty of space to provide its services. And has separate spaces where confidential conversations and services can take place easily.

Inspector's evidence

The pharmacy was bright, clean, and organised. The shop floor and medicines counter were visible from the dispensary. Workbenches were allocated certain tasks. Medicines were held on shelves in a tidy and organised manner. A clean sink was available for the preparation of medicines. Cleaning was carried out by team members at regular intervals in accordance with a rota.

The pharmacy had a consultation room which was easily accessible and clean. It was next to the dispensary and the entrance was visible from there. The room allowed a conversation at a normal level of volume to take place inside and not be overheard. The room temperature and lighting were adequate for the provision of pharmacy services and the safe storage of medicines.

The pharmacy had two additional rooms which were accessed from the back garden. The back garden was also used to access the top floors of the premises which contained apartments. The two rooms on the ground floor were used by a chiropodist and osteopath. Access to these rooms were via a locked door. There were two additional doors and a metal shutter leading into the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy largely provides its services safely. It obtains its medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services. But the pharmacy does not always give people the information leaflets that come with their medicines. So, patients and carers may not always have all the information they need to use their medicines safely.

Inspector's evidence

The pharmacy was accessible, there was a small step at the entrance from the street and team members helped people who needed assistance. The RP explained that as far as he was aware there had been no issues with people being able to access the pharmacy. The medicines counter was easily accessed. Services were appropriately advertised to patients and team members knew of other services which were available locally and described signposting people to these where needed. The RP also used the NHS service finder when needed. A delivery service was offered to those people who were unable to access the pharmacy. And large-print labels could be produced if needed. Some of the team members were multilingual. Team members described how they were able to find ways to communicate with people if there was a language barrier wither by using translations applications or speaking to a friend or family members of the person over the phone.

The RP described that in the last few years the flu vaccination service had a huge impact on the local community. The number of people who had come in for vaccinations had increased since the pandemic. The pharmacy was trying to do more of the hypertension case finding consultations to help identify people with undiagnosed hypertension.

One of the locum pharmacists who worked on Saturdays and provided the travel vaccination service was an independent prescriber (PIP). The RP and SI said he very rarely prescribed from the pharmacy. And generally, on the rare occasions that he did he would issue a prescription for antibiotics or antihistamines if needed. During the inspection only one prescription was seen that had been issued by him for sildenafil. This had not been entered on to the computer system correctly and the private prescription record held the incorrect prescribers' details Consultation notes associated with the prescription were not seen during the inspection. During and after the inspection the SI confirmed that the prescribing was covered both by the pharmacy's and the PIP's individual indemnity insurance. The SI confirmed that the PIP very rarely prescribed and had probably done so only a few times in the last year. He confirmed that the PIP had an assessment form which people were required to complete, and the PIP used these to record any notes. This form was not seen during the inspection The SI confirmed that he would suspend any prescribing activities carried out from the pharmacy.

The pharmacy received a combination of electronic prescriptions and paper prescriptions from local dental practices. Prescriptions were taken in at the counter and placed in a red basket if the person was waiting. Similarly for electronic prescriptions the person was requested to write their name on a piece of paper which was then placed in a basket. There was an allocated workbench space for dispensing and prescriptions were either dispensed by the RP or dispenser. The RP checked prescriptions dispensed by the dispenser and he handed these out so that people could be counselled. The RP also

self-checked. When self- checking the RP tried to take a mental break between dispensing and checking when there were multiple prescriptions. If there was just one prescription, he took his time and avoided distractions. Dispensed and checked-by boxes were available on labels, the RP signed the labels when he checked but was unsure if other pharmacists did. This could make it difficult to identify who was involved in dispensing and checking a medication in the event that something went wrong. Colour-coded baskets were used to separate prescriptions, preventing transfer of items between people and to manage the workflow.

The RP was aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). He described how he would check if the person was under the supervision of a specialist, if they had their reviews, if they were aware of how to take the medication and implications on what could happen. He was also aware of the need to use the warning labels and alert cards. The pharmacy did not have anyone who fell in the at-risk group at the time of the inspection.

Additional checks were carried out when people collected medicines which required ongoing monitoring and people were counselled on side-effects and over-the-counter medicines they should avoid. When supplying warfarin, the RP checked the INR was within range and the dates of the checks. If it was a new medicine the person would be offered to take part in the New Medicine Service.

Some people's medicines were supplied in multi-compartment compliance packs. Prescriptions were requested by the pharmacy. Backing sheets were prepared by the pharmacist and handed to the dispenser. Medicines were checked by the pharmacist before the packs were prepared. A record was made on cards with the date on which the packs were delivered, who collected them and how many packs were supplied. If notification was received that someone was in hospital, all deliveries were stopped until discharge information was received, and changes were made to packs. The pharmacy had a list of everyone on the service and when their packs were prepared. Assembled multi-compartment compliance packs seen were labelled with mandatory warnings. However, there were no product descriptions and information leaflets were not routinely supplied. There was an incomplete audit trail to show who had prepared and checked the pack. This could make it difficult to investigate who was involved if there was an error. Both the RP and SI provided assurances that they would review the service and ensure product descriptions were recorded as well as ensuring people were supplied with leaflets monthly.

The pharmacy provided a delivery service. Signatures were obtained when CDs were delivered. If someone was not available medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers. Medicines were organised on shelves in a tidy manner. Fridge temperatures were monitored daily and recorded. Records seen showed that the temperatures were within the required range for the storage of medicines. CDs were held securely. A few brown bottles were seen on the shelves. These contained medicines which had been removed from their blisters. There was no expiry-date or batch number recorded on these. This could make it difficult to identify stock if there was a product recall. The RP provided an assurance that these would not be used. Expiry-date checks were carried out regularly, the dispenser was in the process of completing a date check at the time of the inspection. Short-dated medicines were said to be highlighted but this was not seen. One date-expired medicine was found on the shelves checked. The dispenser explained that she had not checked that section at the time of the inspection and the RP provided an assurance that expiry dates were checked as part of the dispensing and checking processes. Out-of-date and other waste medicines were kept separate from stock and generally stored securely until collected by licensed waste collectors. Drug recalls were received via email, on the wholesalers' websites and on

invoices, once received the pharmacist checked for stock and actioned the alert.

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 them clean.

Inspector's evidence

The pharmacy had a range of clean glass calibrated measures available. Tablet counting trays were available. Equipment was clean and in good order. Separate measures were available for liquid CD preparations to avoid cross contamination. Up-to-date reference sources were available including access to the internet. The pharmacy had a fridge of adequate size. The pharmacy's computers were password protected and screens faced away from people using the pharmacy.

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.