General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Woodhouse Pharmacy, 209 Woodhouse Road, Friern Barnet, London, N12 9AY

Pharmacy reference: 1040415

Type of pharmacy: Community

Date of inspection: 03/10/2024

Pharmacy context

The pharmacy is located in a parade of shops in Friern Barnet, London. It sells medicines over the counter and dispenses NHS and private prescriptions. The pharmacy supplies medicines in multi-compartment compliance packs to some people and it offers a prescription delivery service. The pharmacy offers some NHS services such as Pharmacy First and private services such as a travel vaccination 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

Overall, the pharmacy manages its risks well. It has written procedures for team members to follow to help them work safely. Team members record their mistakes and take action to prevent similar mistakes happening again. And they keep people's confidential information safe. The pharmacy largely keeps the records it needs to by law. And team members understand their role in safeguarding vulnerable people.

Inspector's evidence

The pharmacy had an electronic set of standard operating procedures which had been reviewed in March 2024 by the superintendent pharmacist (SI). There were signature sheets attached to each SOP showing which pharmacy team members had read them. Team members understood what activities they could and could not do in the absence of the responsible pharmacist (RP). And they explained that they would signpost people to nearby services if needed.

The pharmacy recorded near misses (mistakes that were identified and corrected during the dispensing process) onto an electronic system called Pharmsmart. Team members would record their own mistakes and discuss these with the RP. The team had identified a trend of near misses occurring between tramadol capsules and tramadol modified-release capsules. And so, these were separated on the shelf. This helped prevent any further mistakes with these medicines. The pharmacy had not had any recent dispensing errors (mistakes that were handed out). But the RP explained how these would be managed appropriately.

At the start of the inspection, the incorrect RP notice was on display. This was promptly changed when the RP was made aware. The RP record was kept electronically. It was generally completed as required but some entries were missing. The SI said he would ensure a complete record of who the RP had been on each day was made going forward. Private prescription records were also kept electronically. The prescriber details in the records did not always match those on the prescriptions. The SI explained there had been an issue with completing prescriber details which had previously caused a default prescriber to be set. He said he would contact the pharmacy software provider to get this issue resolved. And would ensure the details recorded going forward were correct. The electronic controlled drugs (CD) register was completed in line with legal requirements. And CD balance checks were completed regularly. The physical quantity of two randomly selected CDs matched the balance recorded in the register. The pharmacy kept the required records of supplies of unlicensed medicines.

The pharmacy had appropriate indemnity insurance in place. And the pharmacy had a complaints procedure. People could provide feedback about the pharmacy via a QR code which was displayed on the pharmacy counter. And people could also give feedback in person or over the phone. Complaints were managed by the SI if the team was unable to resolve them. Team members understood how to protect people's personal information. And they had signed the pharmacy's confidentiality agreement. Confidential waste was kept separate in the dispensary and then transferred to bags supplied by a third-party contractor who collected the waste for safe disposal. Assembled prescriptions were stored in the dispensary and were not visible to people using the pharmacy.

Team members explained how they might identify a vulnerable person requiring support. And they

would generally refer any concerns to the pharmacist. The RP had completed level 2 safeguarding training and could explain how he would manage a safeguarding concern. The pharmacy had a chaperone policy on display.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough, suitably trained staff to provide its services safely. And team members work well together to manage the pharmacy's workload. Team members feel comfortable about giving feedback to improve the pharmacy or raise concerns if they need to.

Inspector's evidence

During the inspection, there was the RP, a dispensing assistant, a trainee dispensing assistant and a medicines counter assistant (MCA) present. The SI was also present and was administering flu vaccinations. The pharmacy team had completed accredited training relevant to their roles. And they were observed working well together. The pharmacy was up to date with dispensing. And people visiting the pharmacy were served promptly. The RP said he felt the staffing was sufficient to manage the workload effectively. When asked, the MCA could describe how she appropriately managed sales of pharmacy medicines. She was aware of medicines which were liable to misuse. And she explained she would refer repeat requests for these medicines to the pharmacist.

Team members were not generally provided with formal training time. But they explained they kept their knowledge up to date through online learning modules or pharmacy magazines. For example, the dispensing assistant had recently completed a training module about hay fever. The trainee dispensing assistant also said she felt supported by the SI while completing her accredited training. Team members had appraisals every six months where they discussed their performance. But they were not set targets. The team felt comfortable providing feedback or raising any concerns to the SI.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and well maintained. And they provide a professional environment to provide healthcare services. The pharmacy is kept secure from unauthorised access. And it has a suitable consultation room so people can have a conversation in private if needed.

Inspector's evidence

The pharmacy's front fascia was in a good state of repair, and it projected a professional image. And the pharmacy premises were clean and well maintained. They consisted of a retail space, the dispensary and a consultation room. There was a small stockroom to the rear of the dispensary. A secure shed at the back of the premises was used to store pharmacy consumables. The pharmacy was kept well-lit and at an adequate temperature for storing medicines and working. And there was a sink in the dispensary with hot and cold running water. Pharmacy medicines were stored in Perspex cabinets to the side of the pharmacy counter.

The consultation room was located to the side of the pharmacy counter. It was clean and an appropriate size to provide healthcare services. There was no confidential information visible in the room. And it was suitably private so conversations could not be heard from outside the room.

Staff facilities included a small kitchen area and a WC. And team members kept the pharmacy clean. The pharmacy was secured from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people with different needs. And it provides its services safely. It obtains medicines from reputable suppliers and stores them appropriately. Team members highlight prescriptions for some higher-risk medicines so that people can receive additional safety information about their medicine. But this is not done consistently so the pharmacy may miss opportunities to speak to some people receiving these medicines. The pharmacy receives drug alerts and recalls but could do more to show what action has been taken in response to these.

Inspector's evidence

Access to the pharmacy was via a small step from the pavement. Team members explained they had a portable ramp which they could use to help those with mobility issues enter the pharmacy. The pharmacy services were listed in the front window. And there was a visual display unit which advertised these services. The team explained it could print labels in larger fonts for people with visual impairment if needed. And seating was available for people who wanted to wait. The pharmacy provided a prescription delivery service once a week on a Saturday. A delivery log was used to keep a record of deliveries. Any failed deliveries were brought back to the pharmacy and team members would contact people to organise another delivery or collection.

The pharmacy provided the NHS Pharmacy First service and flu vaccination service. The RP and SI had completed the necessary training and signed patient group directions (PGDs) were available for these services. The pharmacy also provided some other private services under PGDs such as weight loss and a travel vaccination service. The relevant signed PGDs were not available during the inspection but were sent to the inspector following the inspection. Consultation records for all services were kept appropriately.

Team members used baskets to separate prescriptions while dispensing. This helped reduce the chance different people’s medicines would get mixed up. And separate areas of the workbench were used for dispensing and checking medicines. Labels on assembled medicines contained the initials of the dispenser and checker to help maintain an audit trail. The pharmacy supplied medicines in multi-compartment compliance packs to some people. The SI was generally responsible for ordering and managing the prescriptions for these. But the dispensing assistant was also able to manage these if needed. Any changes to people’s medicines were recorded on the patient record. And the pharmacy would contact the GP if there were any queries. Sealed packs seen contained the correct labelling information. And drug descriptions were included to help people identify their medicine. Patient information leaflets were supplied with packs monthly.

The pharmacy obtained its medicines from licensed wholesalers and stored them appropriately. CDs were kept securely. Fridges used for storing medicines were clean. And fridge temperatures were recorded daily and were seen to be in range. A matrix was used to record date-checking activity. This was completed every three months and included both pharmacy medicines and dispensary stock. And short dated stock was highlighted. Waste medicines were stored appropriately in designated bins in the stockroom pending collection for safe disposal.

Team members highlighted some prescriptions for higher-risk medicines such as warfarin and lithium so

advice could be provided to people when these medicines were collected. But this was not always done consistently. This meant there was a chance people may not receive additional information about these medicines. The RP said he would review this going forward. Similarly, some prescriptions for CDs were not always flagged which could increase the chance of supplying these medicines when the prescription was no longer valid. The RP said although these were always double checked before being handed out, he would ensure these were highlighted going forward. Team members were aware of the guidance about supplying medicines containing valproate. They dispensed these medicines in their original packaging and provided people with additional safety leaflets. The pharmacy received drug alerts and recalls via NHS mail and the Pharmsmart platform. The SI explained they were actioned but could not provide any documented evidence of this. He said he would mark the alerts as actioned on the system going forward to provide a better audit trail.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely and it maintains its equipment so it is safe to use. The pharmacy uses its equipment in ways which protect people's private information.

Inspector's evidence

Pharmacy team members could access any resources they needed online. There were two computers in the dispensary and one in the consultation room which were password protected to prevent unauthorised access. And the screens were positioned so that information on them was not visible to people using the pharmacy. There was a cordless phone so phone calls could be taken in private if needed. All electrical equipment appeared to be in working order. The pharmacy had three fridges which had enough storage space for temperature-sensitive medicines. And the CD cupboard was secured.

The pharmacy had a number of tablet counting triangles available. And there was a range of calibrated, glass measures for measuring liquid medicines. The pharmacy had appropriate equipment, such as an otoscope for providing the NHS Pharmacy First service. And there was a new blood pressure monitor available in the consultation room. All equipment was kept clean.

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.