General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dowsett Pharmacy, 70 Dowsett Road, LONDON, N17 9DD

Pharmacy reference: 1040468

Type of pharmacy: Community

Date of inspection: 13/05/2019

Pharmacy context

This is a busy pharmacy situated in a residential area. It dispenses NHS prescriptions and offers travel vaccinations. A chiropodist also provides services from the pharmacy one day each week.

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	3.3	Standard not met	The premises are not maintained to an appropriate level of hygiene for some of the services provided.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not always keep prescription only medication securely. And the temperature probe for the fridge is not working.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally keeps the records it needs to by law. But not all of them are complete or accurate. This could make it harder for it to show what had happened if there was a query. The staff are not all fully clear about what they are allowed to do and not do when the pharmacist is not there. This may make it harder for the pharmacy to show that tasks are being supervised properly. Team members protect people's private information. And they know how to safeguard vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). These had been read and signed by most team members with the exception of the part time dispenser. The responsible pharmacist (RP) said that the dispenser had read the SOPs but not signed them. A roles and responsibilities matrix was available and had been completed but the information in this had not been updated.

The RP said near misses were recorded on a log; there were no near misses recorded since January 2019. The RP said that there had not been any near misses in that period. Near misses were discussed with the owner and the team had been asked to be more vigilant when dispensing. The RP said that near misses and dispensing incidents were covered at the team meetings but there was no record of these in the notes made at the meetings.

In the event that a dispensing incident occurred the RP said that he would contact the person, rectify the error and make a record. Dispensing incident forms were available, but these did not include details of the prescriber or details of who had been involved. The RP said that incidents were discussed with the team including what could be done to avoid reoccurrence. Most common errors were due to the wrong strength being picked from the shelves. The team had been asked to be careful when picking and checking their own work.

The responsible pharmacist (RP) notice was clearly displayed. The RP record had been completed in advance including the time of absence. This did not correlate with the exact timings that the RP was away from the pharmacy. Team members were not fully clear of the activities that could and could not be carried out in the absence of the RP. The inspector reminded them of what they could and could not do.

The pharmacy had current professional indemnity insurance. Following the inspection, the RP confirmed that the pharmacist independent prescriber was covered for her prescribing activities through her personal cover.

The pharmacy had a complaints procedure. The pharmacy also completed annual patient satisfaction surveys. The RP said that previous feedback had been in relation to the appearance of the premises.

Records for private prescriptions, emergency supply, unlicensed specials and controlled drug (CD) registers were well maintained. CD balance checks were carried out on a monthly basis. The liquid CD balance was checked weekly. A random check of a CD medicine complied with the balance recorded in the register. A CD patient returns register was available, but returns were not recorded as they were received. This could make it harder for the pharmacy to identify any diversion or loss of medicines.

The RP and two dispensers had their individual Smartcards. The RP had access to summary care records and consent to access these was gained verbally from people. The confidentiality SOP had been read and signed by the team including the chiropodist. The information governance policy was reviewed annually. The RP said that the team had been briefed on taking care of people's private information.

The RP had completed the level 2 safeguarding training and there were SOPs for safeguarding children. The RP said he had verbally briefed the team. Contact details for the safeguarding boards were not available, the RP said that he would find these on the internet. This could result in there being a delay in concerns being escalated.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff and the team members are trained for the jobs they do. But once they complete their basic training, they do not do much ongoing training. This means their knowledge may not always be fully up to date.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the RP, who was also the superintendent pharmacist and a newly trained dispenser. The RP had initially not been present on the premises. A trainee dispenser started work towards the end of the inspection. Other team members included a trained dispenser and a part time team member who had started working at the pharmacy in March 2019. She was due to be enrolled on a course. There were two additional pharmacists who covered the RP's day off. The RP said that there were enough staff for the services provided.

Staff performance was managed informally by the RP. He said that if he felt that a team member had an area of weakness, he would first have a discussion with the owner and then with the team member.

The dispenser counselled patients on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was aware of the maximum quantities of some medicines that could be sold over the counter.

Team members who were undergoing formal training were given time to go through the workbook; team members said that they had completed most of their training at home. They were also able to approach the RP if they needed help. The dispenser said that she worked at one of the pharmacies other branches and had been supported with her training at both branches.

The RP passed information to the team as he received it. Magazines received in the post were also passed to the team. The team had last been briefed on electronic CD prescriptions and were asked to be more careful to ensure these were spotted. These prescriptions were highlighted with a sticker and a 'check date' annotation. The team then checked these with the RP before handing them out.

Issues and concerns were discussed with the owner. The owner came in every Tuesday to have a chat with the team. He was also available on the telephone. Team meetings were held on Tuesdays on an as needed basis. Most of the team worked on Tuesday morning. The RP would pass information on to the team members who were not present. Team members said that the last meeting had covered the change in schedule of gabapentin and pregabalin.

The owner set targets for the number of items to dispense, but there were no numerical targets set for the other services. Team members said that there was no pressure to meet the item targets.

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

Summary findings

Some areas of the pharmacy including the dispensary are untidy and require maintenance. The premises are kept secure.

Inspector's evidence

The pharmacy had not received a refit for some time. Many tiles on the shop floor were peeling in places. The dispensary had various different pieces of carpet stuck together which was dirty and a number of unidentified tablets and capsules were found on the floor. This detracted from the appearance of the premises. The ceiling in the dispensary and on the shop floor was stained and some of the ceiling tiles were missing. Workbenches were tidy and allocated depending on the workload. A sink was available in the dispensary. The pharmacy was cleaned by the team.

A consultation room was available which was accessible from the shop floor and behind the medicines counter. The consultation room was used on Monday by a chiropodist and had an examination couch. This limited the space within the room making it inaccessible to people with mobility aids. Conversations held in the consultation room could be heard on the shop floor. The RP said he had not been aware of this and would discuss it with the owner. The RP said that on days when the chiropodist was working in the room he would either ask people to come back later or take them to a quiet area in the shop. The chiropodist had access to all areas of the pharmacy including the dispensary during opening hours.

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of healthcare. Air conditioning was available to help regulate the temperature.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always keep its medicines securely. This increases the risk of these medicines being removed from the pharmacy without it knowing. The pharmacy does not always provide people with detailed descriptions of their medicines when they pack these in multi-compartment compliance aids. So, patients and carers may not always be able to identify which medicines are which. It does not use some of the safety materials (such as warning stickers) for the supply of valproate. This means that people may not always have the information they need to take their medicines safely. It obtains medicines from reputable sources. But the temperature probe for the fridge is not working. This makes it harder for the pharmacy to show that the medicines in the fridge are still safe to use. But people with a range of needs can access the pharmacy's services. The pharmacy generally provides the services safely.

Inspector's evidence

The range of services offered by the pharmacy was adequately promoted. The pharmacy was easily accessible from the street with a ramp at the front. Team members were aware that signposting may be necessary where people required an additional or alternative service and used the internet to find details of nearby services.
The local area had mixed demographics. The team were multilingual and mostly met the language needs of the local area. The dispenser was observed communicating with people in Turkish.

Travel vaccinations were offered by the pharmacist who worked on Friday. These were offered on an appointment basis. There were plans for the RP to also be trained to provide the service so that it was available more frequently.

The majority of prescriptions were received electronically and were mainly repeat prescriptions. Walk-in prescriptions were taken in at the counter and left for the pharmacist, who then dispensed and checked the prescription. The dispenser was not always used to dispense prescriptions.

Dispensed and checked by boxes were available on the labels but these were not always used by all the pharmacists. This would make it harder to find out who was involved if there is a mistake or query. The pharmacy team used baskets for prescriptions to ensure that people's prescriptions were separated and to reduce the risk of errors.

The RP had some awareness of the change in guidance for dispensing sodium valproate. He said that there was one person who fell in the at-risk group and when he had spoken to her she had been aware of the guidance. The RP was unaware of the need to use the warning stickers when sodium valproate was not dispensed in its original pack and said that there was one person who was supplied sodium valproate in a compliance aid. The 'Prevent' pack was found on a shelf in the dispensary.

People who had their medicines in multi-compartment compliance aids had individually labelled boxes which contained stock as well as individual records. Prescriptions were ordered by the pharmacy. On receipt of the prescription the RP would check for changes. If there were any changes the RP would check with the person if they were aware of it and would also cross check against repeat slips and on the person's SCR. Confirmation of changes were not recorded anywhere. Compliance aids were prepared by the dispensers and checked by the RP. In the event that someone was admitted into

hospital, the hospital called to inform the pharmacy and a note was placed in the box to make the team aware. The hospital sent a fax or email with discharge information after which new compliance aids were prepared.

Assembled compliance aids observed were labelled with mandatory warnings. Patient information leaflets (PILs) were handed out monthly. Product descriptions were not always included and there was an incomplete audit trail to show who had dispensed and checked the compliance aids.

Deliveries were carried out by a designated driver every two weeks. The pharmacy mainly delivered multi-compartment compliance aids. Signatures were not obtained for medicines delivered, including CDs. This could make it harder for the pharmacy to show that people had received the medicines safely. The driver marked off when medicines were delivered. In the event that a patient was not available a note was left and medicines were returned to the pharmacy.

One of the pharmacists who worked at the pharmacy was an independent prescriber. The RP said that they would see the person and issue a prescription which was then left for the RP to dispense. Prescriptions issued in the past had been for malaria prophylaxis, eye drops and medicines for erectile dysfunction.

The RP did not offer any services under a patient group direction. Services were offered by other pharmacists and the RP was unsure as to where the documentation was kept.

Medicines were obtained from licensed wholesalers. The RP said that fridge temperatures were monitored daily. However, there were some gaps in recordings over the past few months including on the day of the inspection. The probe to measure the temperature was also not working on the day of the inspection. The RP said that this had been working previously and had broken that morning. Recorded temperatures were within the required range for the storage of medicines. Other medicines were not always stored securely.

The pharmacy was considering options available for the Falsified Medicines Directive (FMD) and looking at pricing. The RP said that there were plans to have the system in place as soon as possible following a chat with the owner.

Date checking was done approximately every three months by the dispenser and another member of staff who started working at the pharmacy a few months ago. A date checking matrix was used. There were no date expired medicines found on the shelves sampled. Short-dated stock was marked.

Out of date and other waste medicines were segregated and then collected by licensed waste collectors. Drug recalls were received via email. Relevant alerts were printed and filed. The last actioned recall was for prednisolone tablets.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services.

Inspector's evidence

The pharmacy had glass, calibrated measures, and tablet counting equipment. The electronic tablet counter was checked by the RP from time to time using a known quantity of tablets. Separate labelled measures were available for CDs to avoid contamination. Cytotoxic medicines were counted in the hand using gloves.

Up-to-date reference sources were available including access to the internet. The pharmacy had a domestic fridge of adequate size. Confidentiality was maintained through the appropriate use of equipment and facilities. The computer in the dispensary was password protected and out of view of people using the pharmacy. Confidential waste was shredded.

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.