General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Arkle Pharmacy, 39 Junction Road, LONDON, N19 5QU

Pharmacy reference: 1040500

Type of pharmacy: Community

Date of inspection: 23/07/2024

Pharmacy context

The pharmacy is in a row of shops, located near Archway underground station. The pharmacy provides both private and NHS services such as dispensing prescriptions, the New Medicine Service (NMS), Emergency Hormonal Contraception (EHC), COVID and flu vaccinations, the Pharmacy First service under patient group directions (PGDs), and it runs a travel clinic. The pharmacy supplies medicines in multi-compartment compliance packs to people who need this support to manage their medicines at home, and it offers a delivery service.

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 not all met	1.6	Standard not met	The pharmacy does not always keep its records accurate and up to date, particularly its records about controlled drugs and vaccinations.
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 not all met**

Summary findings

The pharmacy does not keep all the records it needs to, particularly in relation to its controlled drugs and its vaccination service. However, people using the pharmacy's services can easily provide feedback. Team members protect people's information well and have the relevant training to safeguard the welfare of people using their services. When a dispensing mistake happens, team members generally respond well. But they do not always record any mistakes, which could make it harder to review them and identify any patterns or trends.

Inspector's evidence

Standard operating procedures (SOPs) were in place and each team member had signed the ones relevant to their role. The SOPs had last been reviewed in 2022 and were due for a review. Team members were clear about their roles and knew when to refer to the responsible pharmacist (RP). When asked, the medicines counter assistant (MCA) and dispenser knew what activities could and could not be done in the absence of a pharmacist.

The superintendent pharmacist (SI) said that logs were available to record dispensing mistakes that were identified before reaching a person (near misses), however these were not seen during the inspection. The pharmacist said that near misses were usually recorded by the pharmacists when checking prescriptions. And the SI explained that mistakes were discussed with the team member who dispensed the medication at the time the mistake occurred, to ensure learning and to take preventative action for reoccurrences were possible. The SI showed that a few medications that looked alike or sounded alike, had been separated on the shelf, demonstrating some action taken to minimise mistakes. There had been no reported dispensing mistakes which had reached the person (dispensing errors). The SI described the steps that they would take in the event that a dispensing error occurred, which included identifying the cause, speaking to the person who had received the error and following the SOP. This included completing an incident form and reporting to the NHS 'learn from patient safety events' (LFPSE) service.

The incorrect RP notice was visible to the public at the time of inspection, but this was rectified when highlighted with the SI. The RP record was held electronically, and it was mostly completed correctly but finish times were not always recorded. Private prescription records were well kept and records for emergency supplies were generally well maintained. The SI explained that the pharmacy rarely provided emergency supplies, due to the NHS 111 Emergency Prescriptions service. Records about unlicenced medicine supplies did not always have the appropriate details recorded. And this may mean that this information is harder to find out if there was a query.

The pharmacist explained the counselling points they went through with people receiving vaccinations. But some of the records about the vaccinations were incomplete, as there was not always a record that all the relevant points had been discussed. And there was not always a record made about people's relevant medical history.

Entries in the controlled drug (CD) registers were not always made within the required timeframe. Several registers were found where entries had not been made for several months, and there was evidence that the relevant CDs had been obtained or supplied in that time. The SI was aware of the

need to obtain authorisation from the controlled drugs liaison officer (CDAO) to destroy expired medications. And these medications were separated in the CD cupboard. The SI explained that the pharmacists were responsible for handing out controlled drugs and completing the relevant checks. The process they followed included counting the medicines in front of the recipient to ensure that there were no discrepancies with quantity.

The pharmacy had current indemnity insurance. Feedback or complaints from people using the pharmacy's services could be received verbally in person or by telephone. If a complaint was received, team members had an SOP to refer to and they could escalate issues to the SI. Annual customer surveys were collected through a third-party company and collated to provide the pharmacy with data for improving services.

Confidential paper waste was shredded on-site, and patient-returned medicines that were to be sent for destruction had patient details removed. Checked medications that were awaiting collection were stored appropriately to ensure that people's information was not visible from the counter. The SI said that the pharmacists completed General Data Protection Regulation (GDPR) and information governance training and renewed this annually. All other team members had received this training through their accredited courses for their roles. Any updates in this training were communicated to the team by the pharmacists.

The pharmacy team members understood safeguarding requirements and were able to describe some of the signs to look for and the actions they would take to safeguard a vulnerable person. The SI and regular pharmacist had completed level 2 safeguarding training, and other members of the team had completed level 1. The training had been done through the Centre for Pharmacy Postgraduate Education (CPPE).

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff for the services it provides and manages its workload safely. The team has the appropriate skill mix to ensure safe practice, and team members can raise concerns if needed, in an open environment. Some learning resources are available to the team for ongoing training, and team members can access these during work hours.

Inspector's evidence

The team present during the inspection consisted of the SI and a regular pharmacist, a trained dispenser, and an MCA. These team members were qualified through accredited courses. The SI said that there were also two pharmacy apprentices who worked in the pharmacy, that were not present on the day of inspection. The SI explained that locum staff were employed for business continuity when required to cover any pharmacist absences.

There were no numerical targets set for the services offered and the team was up to date with dispensing prescriptions with no backlog of workload. The dispenser and MCA were able to demonstrate an awareness of medicines with the potential for misuse and could identify people making repeat purchases. They knew questions to ask when selling medicines or providing advice and knew when to refer to the pharmacist. There was no formal structured process for ongoing development of the team. The dispenser said that they usually kept up to date with new information by reading material received through the wholesalers, such as magazines and leaflets. And if a new product was received, they would have an informal team discussion and look through the packaging information or leaflet. They were also able to attend product training offered by external representatives. The SI and pharmacist felt comfortable in using their professional judgement when decision making. The pharmacist explained that they often asked people to come back or book a specific appointment time for services, to ensure that they could allocate uninterrupted time to provide these safely.

Team members did not have a formal appraisal, but the SI said an informal discussion was held annually with individuals to discuss any feedback and what they did well. Team members felt able to raise concerns with the SI and RP. The team described working openly and had informal discussions regularly around concerns and feedback. The SI had a monthly briefing with the regular pharmacist where the efficiency and general running of the pharmacy was discussed, and there were opportunities to raise concerns or ideas to improve services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a safe environment for people to receive its services and they are mostly kept clean and tidy. They are secure from unauthorised access when closed. The premises help team members protect people’s personal information and there is a private room available. But the room is accessed via a few steps and so may not be accessible to all people.

Inspector's evidence

The dispensary was located at the rear of the premises, which allowed team members to see people entering the pharmacy and protected confidentiality. It had limited storage space and was slightly cluttered. There was a small consultation room for the provision of services, which was accessible from behind the medicines counter with a few narrow steps leading down into it. For people who were unable to climb down the steps the pharmacist used a quiet corner in the shop for sensitive and confidential conversations, or they were able to refer people to nearby pharmacies. The premises were kept secure from unauthorised access when closed.

The premises were well-lit, and there was air conditioning available to maintain a suitable temperature for the storage of medicines. Handwashing facilities were available in the dispensary, and a staff toilet with separate handwashing facilities was available. The pharmacy’s website was easy to navigate, with information on the services provided and health advice available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely delivers its services in a safe and effective manner, to a range of people with varying needs. It obtains its medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use.

Inspector's evidence

The pharmacy had step-free access which made it accessible to a wide range of people. All team members were multi-lingual and large-print labels were available on request.

Medicines were sourced from licensed suppliers. The SI said that checks for short-dated medications were completed every two months, and this was recorded. A current matrix for recording checks was not seen during the inspection. A random spot check of stock revealed no expired medicines and elastic bands were used to highlight short-dated items on the shelves. Dates of opening for liquid medicines were not written on the bottles to help staff know if they were still suitable to use. Assurances were provided that this would be completed going forward. Some bottles of medicines were found on the shelf which were not stored in their original container or labelled with an expiry date and batch number. The SI explained that these were from mistakes made with compliance pack dispensing and gave assurances that they would not do this in the future. These medicines were removed from dispensing stock for disposal. Medicinal waste bins were available and were collected periodically by a waste contractor. CDs were stored securely with expired and returned CD medicines separated while awaiting destruction. Records for the pharmaceutical fridges were completed daily and showed no deviations in temperature outside of the required range of between 2 and 8 degrees Celsius.

The pharmacy received safety alerts and drug recalls, or information about other problems with medicines or medical devices, through the pharmacy's general email. The SI and regular pharmacist were responsible for monitoring these alerts and could explain what action was taken in response, however there was no audit trail of the action taken. This may make it harder for the pharmacy to show what it has done in response, and the SI gave assurances that they would find a way to highlight alerts which had been actioned.

There were controls in place to help minimise errors, such as using baskets for each prescription so that their contents were kept separate from other prescriptions. The SI explained that many of the prescriptions dispensed were processed when people telephoned prior to collection or upon arrival at the pharmacy due to storage space. Only some were dispensed in advance at the request of people using the pharmacy's services.

The pharmacy dispensed some medicines in multi-compartment compliance packs for people who were referred by the GP as needing help to manage their medicines. The pharmacy held information sheets for each person requiring a compliance pack which helped them to order prescriptions on people's behalf on a four-week cycle. Upon receipt, the pharmacist clinically checked prescriptions and any discrepancies were followed up with the GP practice, with documentation made accordingly. Medicines warnings were printed on the dispensing labels inside the compliance packs and a brief description of each tablet or capsule was written inside one of the packs. This could make it harder for people to identify the medications inside of the other packs. Patient information leaflets (PILs) were not routinely

provided, which could make it harder for people to have up-to-date information about how to take their medicines safely.

The pharmacy used an external company to make deliveries. Team members logged deliveries on an online system and a trained and designated delivery driver would come to collect these. Signatures were obtained for receipt of items and medicines were returned to the pharmacy if a person was not home. If the item being delivered was a CD the drivers would also take a picture upon delivery to confirm receipt. The pharmacy had contact numbers for people receiving deliveries and would to reschedule where necessary.

The pharmacists were aware of the risks involved when supplying valproate products to people who could become pregnant. They also knew about the guidance to supply these products in complete original manufacturer's packs, and to ensure they didn't cover any of the warnings with dispensing labels. The pharmacy had some people with valproate medications in compliance packs. Individual risk assessments had not been undertaken for these people, but none of them fell within the at-risk group. The SI explained that prescriptions for other high-risk medicines were highlighted on the patient's medication record (PMR), and relevant blood results were recorded where available. For uncollected medications, people were contacted, and the prescriptions were returned to the prescriber and stock returned to the shelf where appropriate, the SI said this process was completed approximately every three months by the dispenser.

In-date PGDs were seen for the vaccination services. And the regular pharmacist was able to demonstrate that they had undergone the appropriate training to provide vaccinations and travel clinic treatments. The SI said that the PGDs for the Pharmacy First service had been signed and dated by the pharmacists providing the services, and the PGDs were available electronically. The SI explained that people requiring the Pharmacy First service were usually self-referred or signposted by the reception team from local surgeries. The pharmacy emailed the GP if a person fell outside of the criteria and provided details of the actions they had taken, to aid the surgery in triaging the person. Both pharmacists had completed face-to-face training with CPPE to provide the service and had communicated key points to the rest of the team to ensure they understood when to refer to the pharmacist.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use and uses it to help protect people's personal information.

Inspector's evidence

The pharmacy used suitable standardised conical measures for measuring liquids and clean triangle tablet counters were available for dispensing loose medication. Separate conical measures and triangle counters were available for certain substances that were marked to avoid contamination. A new otoscope with disposable specula covers was available for providing the Pharmacy First services. And there was a blood pressure monitor in the consultation room, the SI said that this was replaced annually. An in-date adrenaline auto-injector (AAI) was available in the consultation room for when vaccinations were administered. All computers were password protected to safeguard information, and a portable telephone enabled the team to ensure conversations were kept private were necessary.

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.