General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Shore Pharmacy, 79 Russell Lane, Whetstone, LONDON, N20 0BA

Pharmacy reference: 1040508

Type of pharmacy: Community

Date of inspection: 24/04/2019

Pharmacy context

The pharmacy is situated in a residential area, in a small parade of shops. It provides NHS and private prescription dispensing mainly to local residents. It provides multi-compartment compliance packs for around 100 patients who collect their packs either from this pharmacy or another one close by, owned by the same company. There is a home delivery service. There is a Post Office in the pharmacy.

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	1.1	Standard not met	The pharmacy staff do not routinely assess risks to people's safety. They are aware that routine tasks are not being done as required, but they do nothing to remedy this.
		1.2	Standard not met	The pharmacy team does not routinely assess the quality and safety of the services it provides.
		1.3	Standard not met	The pharmacy did not display the Responsible Pharmacist notice.
		1.7	Standard not met	The pharmacy does not adequately protect people's confidential information.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.4	Standard not met	The premises are not protected against unauthorised access.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy cannot show that it has stored medicines requiring refrigerated storage appropriately.
		4.4	Standard not met	The pharmacy doesn't respond routinely to medicines alerts. So people may be put at risk.
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 identify and manage risks well. It has written procedures but staff do not always follow them. The regular pharmacist does not undertake tasks which she knows should be performed, and there is little oversight by management to ensure these are done. The pharmacy does not follow some legal formalities, such as display the Responsible Pharmacist notice. And some of its records are not completed fully. The pharmacist does not record near misses and this may mean the pharmacy is less able to identify risks in the dispensing process, establish any patterns or trends and coaching needs, and make changes to minimise risks. The pharmacy does not fully protect people's information.

Inspector's evidence

The pharmacy had written procedures to tell the team how they should undertake the work in the pharmacy. The management team reviewed the procedures regularly and these had been signed by the staff. The pharmacy team members did not make sure that procedures were followed and the procedures did not cover all the tasks required to be undertaken by them. For example, staff did not always sign 'dispensed by' and 'checked by' boxes on dispensing labels. So, it was not always possible to identify who had made a mistake, making it harder to learn from these events. There was a reference in the written procedures to a "delivery driver book" where signatures were to be collected. The pharmacist was unaware of any such book, but did use a copied sheet to list deliveries. There were no procedures about balance checks the dispensing of high-risk medicines, such as warfarin or sodium valproate.

The pharmacist and dispenser both knew that they should record mistakes when they happened in order to learn from them, but they did not do this. The pharmacist told the Inspector that the person making a mistake was told about the error. The team sometimes separated similar items.

The pharmacist reported that the superintendent pharmacist telephoned the pharmacist about every two weeks to check that everything was all right. The pharmacy did not have a responsible pharmacist notice on display. The pharmacist said it had not been displayed since she started work in the pharmacy on 4 March 2019. They filled in the legal record correctly and it was up to date. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice, when appropriate.

The pharmacy undertook a customer survey annually, and the results were generally positive. The pharmacist could not say if any changes to how the pharmacy operated had been made since the last survey as she had not been present during most of that period.

The pharmacy had professional services insurances in place. The pharmacy recorded private prescription records and emergency supplies on the computer, although the details of the prescriber and the date of the prescription were not always accurate. The reason for an emergency supply being made was recorded at the time of supply, but the pharmacist did not know how to retrieve that information for review. The controlled drugs registers were up to date and legally compliant. A spot check of one item showed that the balance recorded agreed with the stock level. The pharmacist said that she knew that she should record the maximum and minimum temperatures of the fridge, but did

not do so.

The pharmacy kept confidential material in the dispensary where it could not be accessed by the public, although it could be by the Post Office worker, who used the staff facilities off the dispensary. The pharmacy team segregated confidential waste and it was removed by the delivery driver and taken to the another pharmacy under the same ownership for disposal. The pharmacist was not sure if there were appropriate licences in place to do this. The pharmacist had had some training about data protection during her pre-registration year. She said that she had had some tests on the subject, but was not aware of any policy about data sharing. The rest of the staff knew that they should not “gossip” about information seen in the pharmacy with people who did not work there. They did not remember signing any confidentiality agreements, but said that they may have done so. Passwords and NHS smart card access was not well controlled.

The pharmacist had undertaken some formal training about safeguarding vulnerable children and adults, but did not know where she would refer people if needed. The inspector informed her of the NHS phone app which contained all relevant telephone contact numbers. The rest of the staff had not had any training about this. It was unknown what training the delivery driver had had.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe services. However, they are not provided with ongoing training and so staff may not be up to date with the changing knowledge required in pharmacy. The team members regularly see the management team and they feel able to make suggestions to improve the running of the pharmacy.

Inspector's evidence

The pharmacy was run with one pharmacist who worked a regular five-and-a-half-day week. There was a part-time dispenser, who worked until 3.30pm when a member of another branch's team helped out until closing time. There was a full-time medicines counter assistant.

The staff reported that once they had completed their formal training, and passed the assessments, they had not been provided with any more training material. The counter assistant was observed to ask appropriate questions of a customer before selling medicines to them, and was also seen to ask the pharmacist for advice when needed.

The staff said that they did not have formal annual appraisals but the management team came regularly and that they were able to discuss issues with them. There were no targets set by the owner for the pharmacist.

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

Summary findings

The consultation room does not present a professional image to the public. Security of the premises and key control is not robust. The premises are generally clean and provide a safe and professional environment for patients to receive healthcare.

Inspector's evidence

The shop area was clean and tidy. Some lights were flickering over some of the shelving units. To the rear was a store room which was fairly tidy.

The dispensary was quite cluttered in places. There was some clear bench, where multi-compartment compliance packs were being prepared, but there was clutter around the computer. The dispensary sink was covered in lime-scale and the draining board was also cluttered. The toilet area was dirty and needed cleaning.

The pharmacy had a consultation room, which the public could access through a door to the right of the Post Office unit. There was also a door to the dispensary. Both of these were kept locked and the room could only be accessed if the Post Office worker unlocked the doors. The door to the shop was kept locked whilst the room was in use. The room was grubby, the desk area being covered with coffee rings. There was a storage area for post office rubbish, which was visible to people using the room, and did not present a professional image. One of the chairs in the room had badly damaged vinyl covering.

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

Summary findings

The pharmacy cannot show that it always stores its medicines correctly. The pharmacy does not always perform appropriate check when supplying higher-risk medicines so some people may not receive appropriate advice about the medicines they receive. The pharmacy team members do not flag prescriptions for schedule 4 controlled drugs so there is some risk these could be supplied to patients after the expiry date of the prescription. As the pharmacy does not act on MHRA drug alerts this could increase the chance that medicines are not removed from the supply chain when necessary. The pharmacy's working practices are generally safe and effective and it gets its medicines from reputable sources.

Inspector's evidence

The pharmacy was accessed up a step from the pavement. There was a heavy door. Staff said that they opened the door for people if they needed help. This was observed. Services were advertised in the window.

The pharmacy sometimes used a dispensing audit trail to identify who had dispensed and checked each item. It was not consistently used and many items were seen with no indication as to who had dispensed the item. The team members usually marked who had checked the medicines. The pharmacy did not always use baskets intended to ensure that prescription items were kept together and were easy to move from one area of the dispensary to another. When dispensing multiple packs, boxes of medicines were sometimes stuck together with one label rather than applying individual labels to each box. This could mean that people lose important information about their medicines if the boxes are separated later.

There were prescriptions awaiting dispensing from 11 April 2019, about two weeks before the inspection. This led to an increased time looking for prescriptions when people came in to collect them, and an increased time to wait if they were not yet dispensed.

Some people were supplied with medicines in multi-compartment compliance packs. These were labelled with the information the person needed to take their medicines in the correct way. They also had tablet descriptions to identify the individual medicines. Each person had a summary sheet which recorded their current medication and changes made to it. There were some spelling mistakes on these forms which could cause confusion. There was a list of which packs were due to be dispensed each week and a record of them having been dispensed. The packs were sealed after checking by the pharmacist. Packs for two people would be dispensed and then checked before any more packs were dispensed. People receiving packs who were also on higher-risk medicines were not asked for monitoring information.

Schedule 4 controlled drug prescriptions were not highlighted to staff who were to hand them out so there was a risk these could be given out more than 28 days after the date on the prescription.

People taking warfarin, lithium or methotrexate, who brought their own prescriptions into the pharmacy or had prescription on repeat, were not always asked about any recent blood tests or their

current dose.

Women and children who were receiving prescriptions for valproate were not routinely counselled regarding pregnancy prevention. There were no warning cards or stickers available for use.

The pharmacy got its medicines from licensed wholesalers and stored them in a generally tidy way. There were some medicines where the outer box had been discarded and the loose foil was put onto the shelf. This could increase the risk of picking errors. The team did regular date checking. The fridge thermometer was reading a maximum temperature of 16 degrees Celsius which was well above the required temperature of 8 degrees Celsius. The pharmacist had not read the thermometer since she started in post. The current temperature was 4.3 degrees Celsius, within the required range, and this was what the pharmacist said she looked at. There was milk and other food stored in the fridge with the medicines. The pharmacy had paid for the software to comply with the requirements of the Falsified Medicines Directive, but was not able to use it at the moment due to technical issues.

Drug alerts were not received or actioned regularly, limiting the ability of the pharmacy to ensure that recalled medicines did not find their way to the public. The last one the pharmacist remembered was in December 2018.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The equipment that the pharmacy uses is mostly fit for purpose. Providing blood pressure readings for people with machines of unknown accuracy may give false readings.

Inspector's evidence

There were various sizes of glass, stamped measures. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets. The pharmacy had access to up-to-date reference sources, meaning that the information provided to patients from these was current.

The blood pressure machine could not be shown to be within the period guaranteed for accuracy. It appeared to have been manufactured in 2014. One in a box, manufactured in 2007 had had a three year guarantee period. The pharmacist said that the machine usually agreed with those at the home of people who had them.

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.