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: 06/11/2019

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 a large number of people who collect their packs either from this pharmacy or another one close by, owned by the same company. The pharmacy has a home delivery service. And there is a post office in the pharmacy.

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

Members of the pharmacy team work to professional standards and now identify and generally manage risks effectively. They are clear about their roles and responsibilities. They log some of the mistakes they make during the pharmacy processes. They learn from these to avoid problems being repeated. The pharmacy keeps its records up to date and these show that it is providing safe services. It manages and protects private information. The team members also understand how they can help to protect the welfare of vulnerable people.

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. Both the older versions and the current procedures were available for staff to see. This made it harder for staff to know which version of the procedures they should be following.

The pharmacist and dispenser sometimes recorded dispensing mistakes they made when they happened in order to learn from them. These were reviewed every few months. The pharmacist said that the person making a mistake was told about the error. Following previous near misses, the team had separated similar items such as Tegretol and Tegretol MR to prevent picking errors. There were notices about 'look-alike, sound-alike' medicines where they could be seen by the staff. The pharmacist reported that the superintendent pharmacist telephoned the pharmacist about every two weeks to discuss the running of the pharmacy.

The pharmacy conspicuously displayed the responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly. 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 in a book as the computer records were not always accurate. The reason for an emergency supply being made was recorded at the time of supply. The controlled drugs registers were up to date and legally compliant. Fridge maximum and minimum temperatures were recorded on a daily basis and were within the specified range.

The pharmacy kept confidential material in the dispensary where it could not be accessed by the public. The post office worker could no longer access this material. The pharmacy team segregated confidential waste and it was removed by the delivery driver and taken to another pharmacy under the same ownership for disposal. The staff had all done data protection training and the telephone used was cordless, so that calls could be taken in the rear room, if necessary. NHS smart cards were protected by PIN numbers and were not shared amongst the staff.

The pharmacist had undertaken some formal training about safeguarding vulnerable children and adults and had access to the local telephone contacts for the safeguarding team. The rest of the team

was aware that they should tell the pharmacist about any concerns they had.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe services. The team members regularly see the management team and they feel able to make suggestions to improve the running of the pharmacy. However, they are not provided with formal on-going training. And they do not have performance reviews so gaps in their knowledge or skills may not always be identified and supported.

Inspector's evidence

The pharmacy was run with one pharmacist who worked a regular five-and-a-half-day week. There was a dispenser and a full-time medicines counter assistant. There was also a post office worker, who had no role in the pharmacy business.

The pharmacist reported that once the staff had completed their formal training, and passed the assessments, they had not been provided with any more formal training material. But all the pharmacy staff had access to pharmacy magazines. 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 dispenser who was present during the inspection was hoping to complete her dispenser’s training and then go on to train to be a registered pharmacy technician.

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

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The shop area was clean and tidy. The dispensary was also clean and generally tidy. There was a separate bench where multi-compartment compliance packs were being prepared, but there was a bit of clutter around the computer. The dispensary sink was clean, but the draining board was cluttered.

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 from the consultation room to the dispensary. Both of these were kept locked. The door from the consultation room to the shop was kept locked whilst the room was in use. The room was clean and the Post Office material kept in the room was behind closed doors, and so did not affect the professional image of the room. The desk had been painted to improve its look. The chairs were suitable for their job. To the rear was a store room which was fairly tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective and it gets its medicines from reputable sources. The pharmacy's team members are helpful and give advice to people about where they can get other support. They try to make sure that people have all the information they need so that they can use their medicines safely although there were times when this did not happen consistently. The pharmacy doesn't always implement improvements intended to prevent mistakes.

Inspector's evidence

There was a step up into the pharmacy from the pavement. And there was a heavy front door. Staff said that they opened the door for people if they needed help. The pharmacy's 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 generally used but a few items looked at did not show 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.

Some people were supplied with medicines in multi-compartment compliance packs. These packs 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 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 were dispensed. People receiving packs who were also on higher-risk medicines were not always asked for monitoring information. The pharmacy had yet to review people receiving these packs to assess if they were still required.

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 sometimes asked about any recent blood tests or their current dose. This usually happened if the pharmacist handed out the prescription, but not if another member of staff did so.

People in the at-risk group who were receiving prescriptions for valproate were usually counselled about pregnancy prevention. There were warning stickers and cards available for use.

The pharmacy got its medicines from licensed wholesalers, and stored them on shelves in a tidy way. There were coloured dots on some boxes to indicate items which were short dated. Regular date-checking was done. The pharmacy had paid for the software and equipment to comply with the requirements of the Falsified Medicines Directive, but was not able to use it due to technical issues. The superintendent pharmacist was trying to resolve the issue with the provider. Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. 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. This meant that people could receive information which reflected current practice.

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.