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: 01/12/2021

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. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed. The pharmacy was inspected during the COVID-19 pandemic. Not all standards were inspected on this occasion.

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 pharmacy's cleaning routines are not adequate for the safe provision of its services.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy doesn't always store its medicines correctly. Its stock medicines are not appropriately packaged or labelled.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Members of the pharmacy team usually work to professional standards to identify and manage risks effectively. They record or discuss mistakes they make during the dispensing process with the regular pharmacist. And they try to learn from these to avoid problems being repeated. Its team members understand how they can help to protect the welfare of vulnerable people. And the pharmacy team members keep people's private information safe.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The pharmacy had assessed each team member to identify their personal risk of catching the virus and the steps needed to support social distancing and infection control. The pharmacy had a pandemic control standard operating procedure (SOP). The team members had access to personal protective equipment (PPE) and wore face masks during the inspection. Throughout the inspection the team members mostly worked at separate stations in the dispensary which provided some level of social distancing. The pharmacy had COVID-19 information posters at the entrance, and it displayed separate posters reminding people to wear face coverings. Markings on the floor directed people where to stand to maintain social distancing requirements. The team kept a hand sanitiser on the pharmacy counter for people to use.

The pharmacist said that she only supplied codeine linctus against a prescription. There was no codeine linctus found in the shop, or on the dispensary shelves. The counter assistant was observed attempting to sell a packet of Paramol to someone on request after asking who it was for. But they did not ask any other questions to establish if it was appropriate for the person to take. However, the pharmacist intervened in the sale, asking suitable questions to make sure the medicines were appropriate for the person. The assistant was then asked about selling other medicines and said that he would usually ask for additional information from people. He said that he knew the customer who had requested Paramol and knew he had had it before, occasionally.

Some mistakes made during the dispensing process, but before reaching the patient (near misses), were recorded and discussed within the team. The pharmacy had highlighted some medicines with similar names on the shelves to try to prevent the team picking and supplying the wrong item to people.

The pharmacy conspicuously displayed the responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly.

The pharmacist and the team had undertaken formal training about safeguarding vulnerable children and adults and had access to the local telephone contacts for the safeguarding team. The team members were 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 its services safely. And the pharmacy provides its team members with some ongoing training to help keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy was run with one pharmacist who worked a regular five-and-a-half-day week. This was the same as the opening hours of the pharmacy. There was a part-time dispenser and a full-time medicines counter assistant. Both had completed the formal training required for their roles. There was also a post office worker, who had no role in the pharmacy business.

Once the staff had completed their formal training, they were provided with access to pharmacy magazines and on-line training. Following the previous inspection, the counter assistant had completed a number of refresher courses on topics which included sepsis and safeguarding. He was also refreshing his counter assistant training using the Avicenna training modules.

The management team visited the pharmacy regularly and the staff were able to discuss issues with them. The pharmacist was not set targets set by the owner. More formal appraisals for staff were being introduced.

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

Summary findings

The cleanliness of some of the public spaces, especially where invasive services are provided, is not adequate. And the consultation room does not present a professional image. But the premises provides a secure and generally suitable environment for people to receive healthcare. The pharmacy team members could do more to keep some areas tidier.

Inspector's evidence

The pharmacy staff said that there was a general clean down in the pharmacy once or twice a week but there were many touch points which appeared to be dirty. And no special measures were in place for the COVID-19 pandemic, especially the touch points such as door handles. The shop area and dispensary were generally clean and tidy but the area behind the counter had some deliveries piled up in boxes. Pharmacy team members prepared multi-compartment compliance packs on a separate bench, 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. The room was grubby, especially the doors where people touched the paint work. The paintwork was matt and not easily cleaned. The table had markings on it which made it look dirty and unprofessional. The room was also used to store post office bags and other paraphernalia which also detracted from the professional image of the consultation room. A flu vaccination service was being provided from this room at the time of the inspection. The pharmacist said that the room was cleaned once or twice a week.

To the rear was a storeroom which was quite cluttered, although slightly less so than on the previous inspection. This was reported to be a warehouse used to store medicines for other shops in the group. Medicines were often ordered by the pharmacy but transferred to other pharmacies in the group.

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

Summary findings

The pharmacy mostly manages and delivers its services safely and effectively. But it does not always keep medicines in suitable or appropriately labelled containers.. This increases the risk of people receiving medicines which are not of a suitable quality. However, generally, the pharmacy dispenses people's medicines safely. But it cannot always show who was involved in dispensing each item. So it may be harder for the pharmacy to review mistakes and learn from them.

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 had 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 the baskets provided which were intended to ensure that prescription items were kept together and were easy to move from one area of the dispensary to another. So the risk of people's medicines being mixed up was increased.

A large number of people were being supplied their medicines in multi-compartment compliance packs. These packs were labelled with the information the person needed to take their medicines in the correct way. The packs also had tablet descriptions to identify the individual medicines. There was a list of packs to be dispensed each week, with each person having a summary sheet showing any changes to their medicines and where the medicines were to be placed in the packs. However, there were a few packs on the draining board which had been dispensed up to three months prior to the inspection which were marked "on hold to be changed if the patient comes out of hospital". It should be noted that medicines removed from the manufacturer's packaging may have a much-shortened shelf life when put into multi-compartment compliance packs. And medicines which have been mixed together in a pack will be cross-contaminated and should not be re-used for other people even if they have not left the pharmacy.

The pharmacy got its medicines from licensed wholesalers and generally stored them on shelves in a tidy way. But there were many bottles containing loose medicines labelled with only the name and strength of the medicine. These were not in their licensed state and were disposed of. Regular date-checking was done for other medicines. There were coloured dots on some boxes to indicate items which were short dated. Drug alerts were received, actioned and filed appropriately to help show how the pharmacy prevented recalled medicines from finding 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. But the use of plastic, uncalibrated measures may lead to inaccurate volumes being supplied.

Inspector's evidence

There were various sizes measures, but they were made of plastic and not calibrated. 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 team also 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.