General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Primrose Pharmacy, 95 Regents Park Road, Primrose Hill, LONDON, NW1 8UR

Pharmacy reference: 1040553

Type of pharmacy: Community

Date of inspection: 14/06/2019

Pharmacy context

This is a community pharmacy located in Primrose Hill, on the Northern side of Regents Park in London. A diverse cross-section of the local population use the pharmacy's services. The pharmacy dispenses NHS and private prescriptions. It offers some services such as Medicines Use Reviews (MURs), minor ailments and Emergency Hormonal Contraception. And it supplies some people with their medicines inside multi-compartment compliance aids, if they find it difficult to take their medicines on time.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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

In general, the pharmacy manages most risks associated with its services appropriately. Pharmacy team members deal with their mistakes responsibly. But, they are not always formally reviewing them. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening. Whilst the pharmacy team has some understanding of data protection, the team is not trained on recent developments and the pharmacy doesn't tell people what it does with their personal information, as required by law. The pharmacy does not always maintain its records in accordance with the law. This means that team members may not have all the information they need if problems or queries arise.

Inspector's evidence

The pharmacy was in the final stages of being refurbished (see Principle 3). Staff explained that they processed one prescription at a time, worked at their own pace, they concentrated whilst dispensing and prescriptions were placed in an alphabetical order once they were processed. This helped locate them easily if needed. The dispensary and work spaces were kept clear of clutter and this helped reduce errors.

The team routinely recorded near misses, these were discussed and reviewed at the time. Staff described separating medicines that were involved or known to be commonly mistaken, such as sertraline and sumatriptan as well as ciprofloxacin and clarithromycin. To prevent distractions occurring, the responsible pharmacist (RP) explained that people were asked to step back away from the dispensary counter. There were no details documented about the review process.

Incidents were handled by the RP, his process involved checking details, apologising, rectifying the situation, placing a note on people's records, discussing with the team and documenting and completing an incident report. Previous details of documented incidents were not seen to verify the process. The pharmacist explained that no dispensing incidents had occurred. There were no details seen at the point of inspection, to inform people about the pharmacy's complaints procedure. This meant that people may not have been able to raise concerns easily and this was discussed during the inspection.

The team was aware to keep people's information confidential, this included staff in training, staff segregated confidential waste before it was shredded and dispensed prescriptions awaiting collection were, in general stored in an area where sensitive details could not be easily seen from the dispensary counter. The RP had accessed Summary Care Records for queries and he obtained people's consent to do this verbally.

Staff were not trained on the EU General Data Protection Regulation (GDPR) and there was no information on display about how the pharmacy maintained people's privacy. There was also no documented information seen about the pharmacy's Information Governance policy to provide guidance to the team.

Staff present at the inspection were not trained to identify signs of concern to safeguard vulnerable people but would refer to the RP in the first instance, after prompting. The RP stated that he was trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE). There were no relevant

contact details initially held at the pharmacy or an up-to-date standard operating procedure (SOP) for the team present. Evidence was provided that an SOP was subsequently implemented and staff received training about safeguarding.

Some documented SOPs at the inspection were dated from 2015 and not all members of the team had read and signed these. This was discussed at the time and evidence was provided that up-to-date versions of SOPs for the pharmacy were subsequently implemented. Trained members of the team understood their roles and responsibilities (see Principle 2 regarding other staff) and the correct RP notice was on display. This provided details of the pharmacist in charge of operational activities, on the day.

Records for the maximum and minimum temperature for the pharmacy fridge were kept daily to verify that medicines requiring cold storage were appropriately held. A record for returned CDs was maintained, although there were some gaps seen; details about their destruction were missing from some entries in 2017.

The RP record, most records of unlicensed medicines and emergency supplies were maintained in line with statutory requirements. However, the RP, had not signed in or recorded the time to state when his responsibility started on the day of the inspection, there were odd prescriber details missing in records of unlicensed medicines and odd records seen for the latter where the nature of the emergency was not documented, but instead recorded as “no comment”.

A sample of registers checked for Controlled Drugs (CDs) were in the main, held in line with the Regulations. Balances were described as checked with every transaction and initialled in the register when this occurred, some signatures were seen to verify this. On randomly selecting CDs held in the cabinet (MST, Oxynorm), quantities held, matched balances within corresponding registers.

There were incomplete or incorrect prescriber details seen recorded within records of private prescriptions. The pharmacy held appropriate professional indemnity insurance, this was through the National Pharmacy Association (NPA) and due for renewal after 31 October 2019.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Trained staff understand their roles and responsibilities. And the pharmacy now ensures that all its team members are undertaking appropriate training for their roles. But, some members of the team lack some knowledge about the pharmacy's processes. And, once they have completed basic training, they are not provided with ongoing training in a structured way, to help keep their knowledge and skills up to date. This could affect how well they care for people and the advice they give.

Inspector's evidence

The pharmacy dispensed 5 – 6,000 prescription items every month and 40 people received their medicines inside Monitored Dosage Systems (MDS). At the inspection, staff present included the regular and superintendent pharmacist, the pharmacy manager who was a trained medicines counter assistant MCA), a trainee MCA who was enrolled onto accredited training with Buttercups and a trained dispensing assistant. There was also a member of staff who was initially described as a new starter but had worked in the pharmacy for the past year and served in the shop. This included selling medicines and a second person who had also worked in the pharmacy for longer than three months, was putting pharmacy stock away.

At the point of inspection, the latter two members of staff were not enrolled onto accredited training to support this activity. This was not in line with the GPhC's minimum training requirements which specifies that any assistant given delegated authority to carry out certain activities should have undertaken or be undertaking an accredited course relevant to their duties within three months of commencing their role. This situation was discussed at the time and following the inspection, evidence was received to verify that both were subsequently enrolled onto the appropriate training with the NPA.

Certificates for some of the team's qualifications were seen. The MCA who was enrolled in accredited training, stated that in the absence of the RP, dispensed medicines would not be handed out, but some Pharmacy medicines could be sold, provided they ran this past the manager first. In addition, before this MCA sold over-the-counter (OTC) medicines, they asked if the person had used/taken this before and if it was for them only, then no further questions were asked. If the person stated no, then they asked the RP or the pharmacy manager. The full range of questions to ensure safe supply of OTC medicines were not asked.

At the inspection, this member of staff was being supervised by the pharmacy manager and held some knowledge about OTC medicines. The pharmacy manager confirmed that he routinely supervised all transactions for this member of staff.

Appraisals were described as occurring informally and when required for the team. To help staff with ongoing training, they described taking instruction from the RP, reading emails and trade magazine, they were provided with information about medicines that were switched from prescription-only to Pharmacy and described receiving literature in the post. As they were a small team, staff communicated verbally and regularly discussed details. There were no formal or commercial targets set to complete services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable and professional environment to deliver its services.

Inspector's evidence

The pharmacy premises consisted of a spacious sized retail space and open plan dispensary with an extended basement area. The latter was very cluttered, this included the way returned medicines were stored (see Principle 4). The former two areas were kept free of clutter.

The pharmacy was suitably bright, areas that faced the public were professional in appearance and the pharmacy was appropriately ventilated. Pharmacy (P) medicines were stored behind the front counter, staff were always present or within the vicinity and there was a barrier here to restrict people accessing these medicines by self-selection. One side of the dispensary was open, which meant that people could enter this area, however, the RP explained that a barrier was due to be installed, this was still work in progress and people rarely came to this end of the pharmacy.

The premises were being refurbished and although most areas were complete, some areas were still in the process of being finished. This included the consultation room. At the point of inspection, this was not signposted to indicate that a room was available for services and private conversations, it contained a medical fridge with prescription-only medicines (POMs) and as the room was being used to accuracy-check MDS trays, several MDS trays were present that included people's private information. The door was open, kept unlocked and as it was unfinished, there was no way to lock this. The glass panel in the centre of the door was also missing.

The RP stated that trays here were moved when the room was used or that it wasn't being used for services at present. However, the pharmacy's only seat for people waiting for prescriptions was placed directly outside this door, and as the door was unfinished, this meant that unauthorised access to POMs or confidential information was possible. This was discussed at the time with the RP and evidence was provided that a lock was placed on the door and the panel implemented.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains medicines from reputable suppliers and stores most of them appropriately. Members of the pharmacy team make some checks to ensure that medicines are not supplied beyond their expiry date. But, the pharmacy has no up-to-date written details to demonstrate this. So, the team may not always be able to show that all stock is safe to supply. In general, the pharmacy's services are delivered in a suitable manner. But, team members do not always identify prescriptions that require extra advice. This makes it difficult for them to show that appropriate advice has been provided when these medicines are supplied.

Inspector's evidence

Entry into the pharmacy was via a step from a wide, front door and staff explained that they attended people with wheelchairs or with restricted mobility at the door. There was one seat available for people waiting for prescriptions. Staff provided verbal information or physical assistance to people who were visually impaired, they stood closer to and faced people who were partially deaf so that they could easily lip-read and described taking them to a quieter area to discuss details.

The team used online information or their own knowledge to signpost people to places where other local services were provided, if required. Baskets were used during the dispensing process to hold prescriptions and medicines, this helped to prevent any inadvertent transfer. The team's involvement in processes was apparent through a dispensing audit trail that was used. This was through a facility on generated labels.

Staff were aware of risks associated with valproate. They had read information about this, relevant literature was available to provide to people upon supply of this medicine and no females at risk had been seen, according to the team. People prescribed high-risk medicines were not frequently identified, counselled, relevant parameters checked, or details documented. This included the International Normalised Ratio (INR) levels for people prescribed warfarin. The pharmacist explained that INR levels for people were sent directly to the person's GP surgery and the team was not informed about this. He also described the pharmacy team being vigilant when other medicines that were responsible for high hospital admission rates were prescribed.

The initial setup for MDS trays involved the person's GP initiating and assessing suitability. Prescriptions were ordered by the pharmacy and cross-checked against records on the pharmacy system. If changes were identified, staff confirmed them with the prescriber and documented details on records. Descriptions of medicines within trays were provided and trays were not left unsealed overnight. All medicines were de-blistered into trays with none left within their outer packaging and Patient Information Leaflets (PILs) were routinely supplied. Mid-cycle changes involved retrieving the old trays, amending, re-checking and re-supplying.

Licensed wholesalers were used to obtain medicines and medical devices, this included Alliance Healthcare, Sigma and AAH. Unlicensed medicines were obtained through Avicenna and Alliance. Staff were aware of the process involved with the European Falsified Medicines Directive (FMD). The pharmacy was registered with SecurMed, there was relevant equipment present at the point of inspection and the team had seen guidance information from the RP about the process. However, the pharmacy was not yet complying with the process.

Other than returned medicines (see below), the pharmacy stored its medicines in an organised way. There were no date-expired medicines or mixed batches seen. Short dated medicines on POMs were identified, and these medicines were described as date-checked for expiry every few weeks. However, there was no schedule or matrix being used to demonstrate that the process had occurred. For OTC medicines, staff stated that they checked expiry dates before they sold medicines but there was no method being used to readily identify these medicines, when they were approaching expiry and no schedule to demonstrate when date-checks had occurred. A more robust method of ensuring stock was managed appropriately, was discussed during the inspection.

Dispensed medicines awaiting collection were stored with prescriptions attached, the team could identify fridge items and CDs (Schedules 2-3) as these details were written on or a stamp was used to highlight this. Staff stated that they removed uncollected items every month. Schedule 4 CDs were not routinely identified, and some team members were unaware of how long prescriptions were valid for.

The pharmacy held appropriate containers to hold medicines that were brought back by people for disposal, however, these medicines were seen stored in a very haphazard and disorganised manner in the basement. The team was instructed to clear this at the time and evidence received that this had been disposed of, appropriately. People bringing back sharps to be disposed of, were referred to the local council. Returned CDs were brought to the attention of the RP, details were entered into the CD returns register, they were then segregated and stored in the cabinet prior to destruction. Drug alerts were received via email, staff checked stock and acted as necessary. An audit trail was available to verify the process.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities it needs.

Inspector's evidence

The pharmacy was equipped with current reference sources and the team had access to relevant equipment to provide pharmacy services. This included counting triangles, and clean, crown stamped, conical measures for liquid medicines. However, plastic measures were also present and ensuring these were not used, due to the lack of accuracy was discussed at the time.

The dispensary sink used to reconstitute medicines was clean. Hot and cold running water was available with hand wash present. Medicines requiring cold storage were stored at the appropriate temperatures within the medical fridge. The CD cabinets were secured in line with legal requirements.

Computer terminals were positioned in a manner that prevented unauthorised access. A shredder disposed of confidential waste and the team used their own individual NHS smart cards to access electronic prescriptions. These were taken home overnight.

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.