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: 23/11/2022

Pharmacy context

The pharmacy is in in Primrose Hill, near Regents Park in northwest London. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include substance misuse, community pharmacist consultation service (CPCS), new medicines service (NMS), travel clinic medicines and seasonal flu vaccinations.

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

Overall, the pharmacy's working practices are safe and effective. It has adequate standard operating procedures in place to manage risks and make sure its team members work safely. But these are due for review and may not reflect current best practice. The pharmacy team members maintain a dispensing audit trail so they can easily show who completed each step of the process if there is a query. The pharmacy generally keeps the records it needs to by law. Members of the pharmacy team protect people's private information, and they are appropriately trained in how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team discussed the mistakes they made when they were identified to learn from them and reduce the chances of them happening again. The responsible pharmacist (RP) explained that medicines involved in incidents, or were similar in some way, such as rivaroxaban and rosuvastatin tablets or different strengths of bisoprolol tablet were generally separated from each other in the dispensary to reduce the chance of mistakes in picking medicines for prescriptions. The RP completed a dispensing incident report if required and maintained a folder of interventions with a copy of the prescription.

Members of the pharmacy team responsible for making up people's prescriptions used baskets to keep each person's medication and prescriptions together and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were clinically, and final checked by the RP. Team members initialled the dispensing labels to identify who dispensed and checked the items on the prescription. The pharmacy team checked interactions between medicines prescribed for the same person with the RP. When a member of the team contacted the prescriber, the RP printed the email reply regarding an intervention, and it was filed and recorded on the patient medication record (PMR).

Team members highlighted prescriptions for medicines that the RP needed to discuss with the patients, so they had all the information they needed to take their medicines safely. For instance, they checked the allergy status of people being supplied an antibiotic. And dates of recent blood tests for medicines which required monitoring. And they endorsed controlled drug (CD) prescriptions with the date after which the prescription was no longer valid, and the CD could not be supplied. The pharmacy had a process for dealing with outstanding medicines which it had been unable to supply when dispensing a prescription. Pharmacy team members made sure the right medicines were given to the right person by asking people for their name, address and date of birth. And checking they matched the details on the prescription.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. Some SOPs required a review to update the information such as date of preparation, training records and to ensure the SOPs reflected current best practice. The pharmacy's SOPs included RP procedures and how to complain. Members of the pharmacy team were required to read the SOPs relevant to their roles and

sign training records to show they understood them. They knew what they could and could not do, what they were responsible for and when to seek help. A team member explained that they would not hand out prescriptions or sell pharmacy only (P) medicines if a pharmacist was not present. And a team member at the medicines counter described the protocol which they followed when recommending over-the-counter (OTC) medicines and specifically three higher risk OTC medicines. The pharmacy had a complaints procedure and displayed information on how people could comment or complain. A team member reported how they received good verbal feedback from people and via cards which were set out on a shelf in the dispensary.

The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. The pharmacy had fitted screens at the medicines counter, team members had access to fluid resistant face masks and only two people at a time could enter the pharmacy during the COVID-19 lockdown to help reduce the risk of infection with COVID. They regularly cleaned the pharmacy surfaces and applied hand sanitising gel.

The pharmacy team completed audits in line with the pharmacy quality scheme (PQS) to monitor how young people were using bronchodilators to manage a respiratory condition and the use of antibiotics. And they kept records of their findings. The pharmacy had a current business continuity plan to deal with systems failures and show how it could still provide some services.

The pharmacy had insurance arrangements in place, including professional indemnity, for services it provided. The pharmacy kept a record to show which pharmacist was the RP and displayed a notice that told people who the RP was. The pharmacy had an electronic controlled drug (CD) register. The RP explained how the team had colour coded the register to distinguish between different formulations of methadone. And the stock levels recorded in the CD register were checked regularly. A random check of the actual stock of a CD matched the recorded amount in the CD registers. The team recorded unwanted CDs returned to the pharmacy by people. The pharmacy kept electronic records of its supplies of unlicensed medicinal products, the emergency supplies it made and the private prescriptions it supplied. Records were generally in order.

The superintendent pharmacist (SI) administered flu vaccinations via the NHS and private patient group directions (PGDs) for the flu service. Records of administration of the flu vaccination were entered onto Sonar and the person's doctor's surgery was informed. The pharmacy completed a private flu vaccination record for people who were not eligible for the NHS flu vaccination service. Following the visit, the SI produced information about the vaccinations and medicines administered and supplied via PGDs to people attending the travel clinic. And the pharmacy was a registered yellow fever vaccination centre too. The SI completed a risk assessment form for each patient with a record of vaccines administered. Records were generally in order.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Members of the team had signed confidentiality agreements. They tried to make sure people's personal information could not be seen by other people and was disposed of securely. And they used their own NHS Smartcards. The pharmacy team had undertaken training in safeguarding procedures. And the RP was signposted to the NHS safeguarding App so members of the pharmacy team would have the current contact information to raise concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work well together to deliver services safely and manage their workload. The pharmacy supports them in completing appropriate training and they understand their roles and responsibilities. They are comfortable about providing feedback on how the pharmacy could improve its services.

Inspector's evidence

The pharmacy team consisted of the SI who was RP two days per week, and two part-time regular locum pharmacists who covered two days each per week, three full-time accredited or trainee dispensing and medicine counter assistants and a part-time trainee dispensing and medicines counter assistant. The pharmacy relied upon its team to cover absences.

Members of the pharmacy team worked well together. So, people were served quickly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an OTC sales and self-care SOP for its team to follow. This described the questions the team members needed to ask people when making OTC recommendations. And when they should refer requests to a pharmacist. They knew who they should raise a concern with if they had one. Members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. They worked with the SI two days per week, and they could have an informal meeting and had suggested changing how the private prescriptions were separated and filed after they were dispensed. The pharmacy team shared messages and information via their WhatsApp group.

A member of the team described training in new pharmacy products via My Learning which included how the product worked and a quiz to assess knowledge of the product. The team member completed the training topics at work when it was quiet. The locum pharmacist said they were supported to organise their own training and the local pharmaceutical committee (LPC) sent emails about training events and webinars to attend. For example, there was a CD webinar planned for the new year.

In line with PQS requirements in previous years, members of the team had learnt about risk assessment, sepsis, suicide awareness and infection control. And the SI had undertaken the required training to complete the declaration of competence to deliver the flu vaccination and travel clinic service. The SI had a 'certificate of online travel training' document showing he had successfully completed online training and assessment for the supply and administration of the vaccines listed. The team members were signposted to the GPhC Knowledge Hub.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, bright, secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe and people's private information is protected.

Inspector's evidence

The registered pharmacy premises were bright and clean. And steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a spacious retail area, a medicines counter along one side of the retail area. The layout of the dispensary had been altered since the previous visit. There was a large storeroom. The pharmacy had a consulting room which was signposted so people could have a private conversation with a team member. The worksurfaces in the dispensary were kept clear and clean when the pharmacy was busy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. People with different needs can easily access the services it offers. The pharmacy obtains its medicines from reputable suppliers and stores them securely at the right temperature, so they are safe to use. The pharmacy team members identify people using high-risk medicines and make sure they have the information they need to use their medicines safely. Team members know what to do in response to alerts and product recalls and return any medicines or devices to the suppliers.

Inspector's evidence

The pharmacy did not have an automated door. And its entrance was not level with the outside pavement. But it had a ramp which could be fitted at the entrance to make it easier to enter the building for people who found it difficult to climb stairs, such as someone who used a wheelchair. The pharmacy team tried to make sure these people could use the pharmacy services. The pharmacy had a notice that told people when it was open. And other notices in its window told people about some of the other services the pharmacy offered. Members of the pharmacy team were helpful and could speak or understand Hungarian, French, Gujarati and Hindi to help people whose first language was not English. And they signposted people to another provider if a service was not available at the pharmacy such as the local chiropodist and NHS 111.

The pharmacy only provided a limited delivery service to people in a nearby residential home who could not attend its premises in person. The pharmacy used a disposable multi-compartment compliance aid for people who had difficulty managing their medicines and when to take them. Members of the pharmacy team prepared the compliance aids in the consultation room which had more available bench space. The completed compliance aids were stored in the consultation room, but the team members said that people were not left alone in the room. The dispensing bench was on the far side of the consultation room and the compliance aids were stored so that the person's details were not visible.

They managed re-ordering prescriptions on behalf of people and checked the prescriptions for changes before preparing the compliance aids. And they checked the discharge letters for changes after a hospital stay. They endorsed the printed electronic prescription tokens with any interventions. And they mostly supplied high-risk medicines in their original packaging and not in the compliance aids. The pharmacy provided a brief description of each medicine contained within the compliance aids along with patient information leaflets for each medicine. So, people had the information they needed to make sure they took their medicines safely.

Members of the pharmacy team could identify which of them prepared a prescription and they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added. They were aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. They knew the dispensing label should not be attached to the dispensing carton so the educational information was covered and that these people

should be given a patient card and be reviewed annually by a specialist. The pharmacy received referrals for emergency supplies or treating minor ailments for the community pharmacist consultation service (CPCS) via PharmOutcomes. The pharmacy also provided the new medicines service (NMS) to help people get the most from their new medicines by resolving issues such as side effects. The prescription with the new medicine was retained with the person's contact details and notes about monitoring recorded on the pharmacy computer.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices in their original manufacturer's packaging. The dispensary was generally tidy and clean. The pharmacy team checked and recorded the expiry dates of medicines stock and marked short-dated items. And it generally recorded when it had done a date-check. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. The medicines fridge was in the consultation room, so vaccines stock was easily accessible for the travel clinic service. And it stored its CDs securely in line with safe custody requirements. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock. And the RP described the actions they took and demonstrated what paper records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately and keeps people's private information safe.

Inspector's evidence

The pharmacy had a plastic screen on its counter to help protect against COVID infection. The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had a few glass measures for use with liquids, and some were used only with certain liquids. The pharmacy team had access to up-to-date reference sources. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the refrigerator. The pharmacy team collected confidential wastepaper for secure disposal. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure they used their own NHS smartcards when they were working. Following the visit, the SI provided details of arrangements for safe disposal of clinical waste from the vaccination services. And detailed the adrenaline devices available to deal with anaphylactic shock following a vaccination. The team were aware of the location of the nearest defibrillator.

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.