General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: DNR Ritz Healthcare Ltd, 43 Heath Street, LONDON, NW3 6UA

Pharmacy reference: 1040577

Type of pharmacy: Community

Date of inspection: 17/09/2024

Pharmacy context

The pharmacy is on the high street in northwest London. It dispenses NHS and private prescriptions and it supplies medicines in multi-compartment compliance packs for people who find it difficult to manage their medicines. It provides the NHS Pharmacy First service, flu and travel vaccination service.

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

The pharmacy generally identifies and manages the risks involved in providing its services. It has written instructions which are being updated to help its team members to work safely and effectively. And it monitors its services to improve their quality. Members of the team protect people's private information appropriately. People who use the pharmacy can leave feedback to help it do things better. The pharmacy keeps the records it needs to by law to show how it supplies its services and medicines safely. The pharmacy team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had systems in place to review dispensing errors and near misses. The responsible pharmacist (RP) was working alone at the time of the inspection. And she explained that she had created processes to help avoid errors. The RP printed the prescription first and then collected the medicines. She took a mental break and ticked the items off against the prescription. The RP checked the labelled medicines again before bagging them and transferring them to the person if they were waiting. The RP considered what actions she could take to minimise the risk of future mistakes. And she explained that she had recently commenced employment and had removed clutter to clear the dispensary benches and checked through the pharmacy’s stock removing obsolete medicines. Medicines involved in incidents, or were similar in some way, were generally separated from each other in the dispensary. Lookalike and soundalike (LASA) medicines were highlighted helping to reduce picking errors. The pharmacy had a process for dealing with dispensing incidents and a pharmacy incident form to complete if necessary. The RP was aware of reporting dispensing incidents to the NHS ‘Learning from patient safety events’ (LFPSE) service.

The RP described factors taken into consideration when risk-assessing the pharmacy prior to providing the flu vaccination service. Such as vaccine storage, clinical waste disposal and team training. She also risk-assessed the suitability of resources to offer NHS Pharmacy First Service and record keeping on PharmOutcomes, training to use the otoscope and locum pharmacist knowledge. As the RP had only recently taken up the role of superintendent pharmacist (SI) at the pharmacy, audits were still being planned. But she was aware of the clinical audit for people taking a valproate and updated guidance for dispensing valproates which had been extended to supplying topiramate too.

When members of the pharmacy team took in prescriptions at the medicines counter, they completed the legal check to make sure all the required sections of the prescription were completed. The RP used baskets to separate each person’s medication and to prioritise workflow. She referred to prescriptions when labelling and picking products. And initialled dispensing labels to show who dispensed and checked assembled prescriptions. Prescriptions were not handed out until they were clinically and accuracy checked by the RP including interactions between medicines prescribed for the same person. Sometimes the RP contacted the prescriber via phone or NHS email regarding interactions or availability of medicines and maintained an audit trail of significant interventions which were recorded on the patient medication record (PMR). Prescriptions with outstanding medicines were filed separately until stock was delivered and the remaining medicine was dispensed. Bagged prescriptions awaiting collection were stored on designated shelving until someone collected them. The RP highlighted high-risk prescriptions about which she needed to talk to the person or their representative. And the team

members checked the person's name and address before giving out prescriptions.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And the RP was in the process of reviewing the SOPs. The most recent SOPs were about controlled drugs (CDs) and their management and for providing the NHS Pharmacy First service. Members of the pharmacy team were required to read the SOPs relevant to their roles. Members of the team explained the questions they would ask when recommending medicines over-the-counter (OTC) and when they would refer to the RP. They understood what they could and could not do if the RP was absent. They explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar products, such as medicines people might abuse to a pharmacist. The pharmacy had a complaints procedure. People could leave feedback online or in person.

The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and when. It displayed a notice that told people who the RP was. The pharmacy maintained a CD register which was kept up to date and the stock levels recorded in the CD register were checked frequently. A random check of the actual stock of a CD matched the recorded amount in the register. The RP described the records required for supplying unlicensed ‘specials’ medicines. The private prescriptions records were generally in order. Records for treatments via the NHS Pharmacy First service were seen to be maintained electronically and shared with the person’s GP. The pharmacy supplied treatments in line with the patient group direction (PGD) pathways and referred people seeking treatment but who did not comply with the pathway in some way. And they were signposted to their regular GP or the Royal Free Hospital nearby.

The pharmacy was registered with the Information Commissioner’s Office. Members of the pharmacy had signed confidentiality agreements and they were aware of general data protection regulation (GDPR). The pharmacy team members 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 RP had completed the NHS data security and protection toolkit. The pharmacy computers were password protected. There was a privacy policy on the website. The pharmacy had a safeguarding SOP. And the RP had completed a level 3 safeguarding training course. Members of the pharmacy team knew who they would make aware if they had concerns about the safety of a child or a vulnerable person. The RP was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work well together to manage their workload effectively. The pharmacy provides ongoing training to help keep the team's skills and knowledge up to date. Team members are comfortable about providing feedback and suggestions which the pharmacy has acted on to improve its services.

Inspector's evidence

The pharmacy team consisted of one full-time pharmacist who was the superintendent pharmacist (and the RP), two part-time pharmacists who covered Friday and the weekend, three part-time or full-time dispensing and medicines counter assistants and a pharmacy student. Team members had completed or were enrolled on accredited training relevant to their roles. The RP had decided to wait until team members had completed their accredited training before they helped in the dispensary.

Members worked well together. So, people were served quickly, and their prescriptions were processed safely. The RP was responsible for managing the pharmacy team, supervising the supply of medicines and advice given by the pharmacy team. The pharmacy had a sales protocol and self-care SOP which its team followed. This described the questions the team members needed to ask people when making over-the-counter (OTC) recommendations. And when they should refer requests to a pharmacist. The RP held informal training sessions when the team came into work slightly early and discussed topics such as selling OTC anti-inflammatory medicines. The team members had trained to promote flu vaccinations and make appointments.

The RP conducted informal appraisals to establish what team members had achieved and what they would like to achieve. They were comfortable about making suggestions on how to improve the pharmacy and its services. And they had suggested an alternative method of filing prescriptions waiting to be collected which made them easier to find and better use of space. They knew who they should raise a concern with if they had one. And their feedback led to a plastic screen being installed on the pharmacy counter.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, bright and secure and it provides a suitable environment to deliver healthcare services. The premises are suitably equipped to protect the pharmacy's medicines stock and people's private information when the business is closed.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. And steps were taken to make sure the pharmacy and its team did not get too warm. The pharmacy had a large retail area, a medicines counter, a small dispensary at a higher level with a view of the retail area. And there was a storeroom. The pharmacy had a small consulting room. So, people wanting to have a private conversation with a team member. The dispensary had limited workspace and storage available. So, items were sometimes stored on the floor. And worksurfaces in the dispensary could become cluttered when the pharmacy was busy. The pharmacy had a sink. And it had a supply of hot and cold water. Members of the pharmacy team were responsible for keeping the pharmacy's premises clean and tidy according to a rota. The consultation room was small and located a few level steps from the dispensary.

The pharmacy website did not sell any products and it did not prominently display all the required information such as owner, registration and superintendent pharmacist details. But it did have useful information about the pharmacy and its services. And contact details for the pharmacy and other organisations. People could re-order their repeat prescriptions and download consent forms.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy and its services are easily accessible to people with different needs. Its working practices are safe and effective. The pharmacy obtains its medicines from reputable sources and stores them securely at the correct temperature to help ensure they are fit for purpose. The pharmacy team members know what to do when they receive medicine alerts and recalls. And they carry out appropriate checks for affected stock. To make sure people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy had a wide, manually operated door at its entrance which was not level with the outside pavement. So team members could go to the door and fit a ramp to help people who found steps difficult, such as someone who used a wheelchair. They tried to make sure people could use the pharmacy's services and they could speak or understand languages such as Somali, Dutch, Hindi, Gujarati and Punjabi to help people whose first language was not English. The pharmacy had a neon sign in the window that told people when it was open and about services the pharmacy offered. The pharmacy had seating for people to use if they wanted to wait. Members of the pharmacy team signposted people to another provider if a service was not available at the pharmacy. There were other nearby pharmacies and the Royal Free Hospital.

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. The RP counselled people taking a valproate and explained the pregnancy prevention programme making sure they had educational information such as a patient card and patient information leaflet (PIL). She was aware of updated guidance for dispensing valproates which had been extended to supplying topiramate too. The RP gave examples of counselling and therapeutic monitoring for other medicines. For instance, checking the person's yellow book for the most recent INR and blood test dates for people who took warfarin.

The pharmacy used a disposable multi-compartment compliance pack to supply medicines to people who had difficulty managing their medicines. The RP re-ordered prescriptions for people and checked them for changes before dispensing. High-risk medicines were mostly supplied separately. Prescriptions for CDs were dispensed and supplied within the period that the prescription was valid. The RP generally provided a brief description of each medicine contained in the compliance packs and always provided patient information leaflets. 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.

The pharmacy had prepared to provide the flu vaccination service to people on a walk-in and appointment basis at set times daily. The RP had allocated time slots to manage the routine daily workload. Vaccines were stored in a separate vaccines fridge and clinical waste bin. The service risk assessment had included making sure people could access the consultation room safely. The adrenaline injection devices to treat anaphylaxis were in date. The business continuity plan included contacting the

local surgery to ask them to issue FP10 prescriptions instead of sending the electronic prescribing service (EPS) prescriptions. People could take FP10 prescriptions to any pharmacy. An additional team member had been trained to support in the dispensary putting away the medicines deliveries and dispensing. The team cleaned the premises on a rota basis. The pharmacy provided this service to staff at a local organisation. The pharmacy also promoted the NHS Pharmacy First service. The RP had completed training to offer treatment for the conditions covered by the patient group directions (PGDs) and reported that the most common ailments had been sore throat and skin infection. The pharmacy offered a prescribing service one day per week when the pharmacist independent prescriber who covered Sundays was RP.

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. Since taking up the position, the RP had gradually checked all the existing medicines stock to tidy the dispensary and remove obsolete medicines. And she recorded when she had completed a date-check. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. Waste medicines were kept separate from stock in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took and demonstrated what records they kept when the pharmacy received a concern about a product. People were contacted if necessary if they had previously been supplied a medicine which was now affected by the alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And its team makes sure the equipment protects private information.

Inspector's evidence

The pharmacy team had access to up-to-date reference sources online. The pharmacy had measures for use with liquids. The pharmacy had a fridge to store pharmaceutical stock requiring refrigeration. Team members regularly checked the maximum and minimum temperatures. The pharmacy had CD destruction kits to denature obsolete CDs and render them without value. They disposed of confidential waste appropriately. 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. They used their own NHS smartcards. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team.

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.