General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Northcote Pharmacy, 130 Northcote Road, Battersea, LONDON, SW11 6QZ

**Pharmacy reference:** 1041122

**Type of pharmacy:** Community

**Date of inspection:** 24/01/2023

## Pharmacy context

This NHS community pharmacy is set on a row of shops in a residential area of Battersea. The pharmacy is part of a small chain of pharmacies. It opens six days a week. It sells a range of over-the counter-medicines as well as health and beauty products. It dispenses people's prescriptions. And it delivers medicines to people who can't attend its premises in person. The pharmacy provides multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. It has a travel clinic and offers a chickenpox vaccination service. Its team can check a person's blood pressure. And people can get their flu vaccinations (jabs) at the pharmacy too.

## 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 | 1.2 | Good practice | The pharmacy continually monitors the safety of its services to protect people and further improve patient safety. |
| **2. Staff** | Good practice | 2.2 | Good practice | The pharmacy provides its team members with the training and support they need. And it actively encourages them to improve their skills. |
| | | 2.4 | Good practice | Members of the pharmacy team work well together and have a clear work culture of openness, honesty and learning. |
| **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 appropriately identifies and manages its risks. It has written instructions to help its team members work safely. It continually monitors the safety of its services to protect people and further improve patient safety. It mostly keeps the records it needs to by law. It has appropriate insurance to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy log and review the mistakes they make and learn from them to try and stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. And they understand their role in protecting vulnerable people.

### Inspector's evidence

The pharmacy had considered the risks of coronavirus. And, until recently, it had a screen on its counter to try and stop the spread of the virus. Members of the pharmacy team had the personal protective equipment they needed. And hand sanitising gel was available for people to use. The pharmacy had a business continuity plan. And this identified potential risks to its premises, its services and its team in the event of an emergency. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed periodically by the superintendent pharmacist. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to say they understood them and would follow them. The team members responsible for making up people's prescriptions used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP) who also initialled the dispensing label. The pharmacy had a small dispensing bench. And its team found it difficult to keep the dispensing workstations tidy all the time. So, the pharmacy reviewed its dispensing process and workflow. And most people's repeat prescriptions and compliance packs were now assembled offsite by one of the company's hub pharmacies. But only when people agreed to this happening first. This meant the mistakes made at the pharmacy had been reduced and members of the pharmacy team could spend more time talking to people about their medicines or prioritise other tasks. The pharmacy had robust procedures to deal with dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). And its team regularly audited the safety and the quality of its services. Members of the pharmacy highlighted and separated medicines which were similar in some way, such as medicines that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being selected. They discussed and documented individual learning points when they identified a mistake. They reviewed their mistakes regularly to help spot the cause of them and any trends. They met regularly to share learning from these reviews. So, they could try to stop the same types of mistakes happening again and improve the safety of the dispensing service they provide. And, for example, they recently reviewed and strengthened their dispensing process following a few mistakes where the wrong strength of a certain type of medicine had been picked.

The pharmacy had a notice that told people who the RP was at that time. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. But the pharmacy could do more to make sure the roles and responsibilities of its team were clearly defined within the SOPs. A team member explained that they couldn't hand out prescriptions or

sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints procedure. It had a notice which told people how they could complain about the pharmacy. People have shared their experiences of using the pharmacy and its services online. They were asked for their views and suggestions on how the pharmacy could do things better. And, for example, the pharmacy team tried to keep a person's preferred make of a prescription medicine in stock when it was asked to do so. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had an electronic controlled drug (CD) register which was in order. And the stock levels recorded in the CD register were checked regularly. The pharmacy had an electronic record to show which pharmacist was the RP and when. And it kept an appropriate record for the supplies of the unlicensed medicinal products it made. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But an appropriate entry wasn't always made when a prescription-only medicine was supplied to a person in an emergency under the CPCS. And sometimes the prescriber details were incorrect in the private prescription records.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy had a leaflet that told people how it gathered, used and shared their personal information. It had arrangements to make sure confidential information was stored and disposed of securely. And its team was asked to sign a confidentiality agreement and complete training on data security. The pharmacy had a safeguarding procedure. And its team was asked to do safeguarding training. Members of the pharmacy team knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person.

## Principle 2 - Staffing ✔ Good practice

### Summary findings

The pharmacy has enough team members to provide its services safely and effectively. And it encourages them to give feedback. Members of the pharmacy team work well together and have a work culture of openness, honesty and learning. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets. The pharmacy provides its team members with the training and support they need. It actively encourages them to improve their skills. And its team makes appropriate decisions about what is right for the people it cares for.

### Inspector's evidence

The pharmacy team consisted of a full-time pharmacy manager (the RP), a part-time pharmacist, a full-time trainee pharmacist, a full-time trainee pharmacy technician, a full-time medicines counter assistant (MCA), a part-time MCA and two full-time assistants who recently joined the pharmacy. The RP, the trainee pharmacist, the trainee pharmacy technician and the assistants were working at the time of the inspection. The pharmacy relied upon its team, team members from another branch or locum pharmacists to cover absences. Members of the pharmacy team were up to date with their workload. They worked well together and helped each other so people were served quickly, and prescriptions could be dispensed safely. The RP led by example. And they supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist.

The pharmacy had an induction training programme for its team. And this included the trainee pharmacist and the assistants who recently started at the pharmacy. The trainee pharmacist confirmed that the RP was their designated supervisor. And there was a training plan in place for their foundation training year. The trainee pharmacist felt supported. They were encouraged to improve their skills and attend regular training events with other trainee pharmacists. They had regular discussions and reviews with the RP. And they received time to study. People who worked at the pharmacy needed to complete mandatory training during their employment. They were required to undertake accredited training relevant to their roles after completing a probationary period. They regularly discussed how they were doing and their development needs with their line manager. And they helped each other to learn. Members of the pharmacy team were encouraged to ask questions and familiarise themselves with new products. They kept their knowledge up to date by completing training. And they had time set aside while they were at work to train and support their development. The pharmacy team didn’t feel the targets set for the pharmacy stopped it from making decisions that kept people safe. The pharmacy had a culture that encouraged its team to be open and honest about the mistakes people made and share learning at meetings or one-to-one discussions. This meant it could improve the safety of the services it offered. Team members were comfortable about sharing their views and making suggestions on how to improve the pharmacy and its services. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback led to them strengthening their process to tell people when their prescriptions were ready to collect.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy provides a professional environment to deliver it services from. And people can receive services in private when they need to. But members of the pharmacy team sometimes don’t have the space they need to work in when it’s busy.

### Inspector's evidence

The pharmacy was air-conditioned, bright, clean and modern. It was professionally presented throughout. But its dispensary was small. It had limited workbench and storage space available. Its dispensing worksurfaces could become cluttered when it was busy. And sometimes bulky prescriptions needed to be stored on the floor. The pharmacy had a consulting room for the services it offered that required one and if someone needed to speak to a team member in private. The consulting room was locked when it wasn’t being used. So, its contents were kept secure. And people’s conversations in it couldn’t be overheard outside of it. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water. But the tap in the dispensary was loose. Members of the pharmacy team were responsible for keeping the premises clean and tidy. And they wiped and disinfected the surfaces they and other people touched.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides services that people can access easily. Its working practices are safe and effective. And it delivers medicines to people's homes and keeps adequate records to show that it has delivered the right medicine to the right person. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely. People who work at the pharmacy are friendly and helpful. They dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

### Inspector's evidence

The pharmacy didn't have an automated door. But its entrance was level with the outside pavement. And members of the pharmacy team remained alert to make sure they could help people who couldn't open the door easily, such as people with pushchairs or wheelchairs, access the pharmacy. The pharmacy had a notice that told people when it was open. It had a digital display in one of its windows that told people about its products and the services it delivered. And it had a small seating area for people to use when they wanted to wait in the pharmacy. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. The pharmacy dealt with CPCS referrals. People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses. Members of the pharmacy team were friendly and helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. And it kept an electronic record to show when it delivered someone their medication. The pharmacy provided winter a travel clinic and chickenpox vaccinations. People were asked to book an appointment for these paid-for services. This helped the pharmacy better manage its workload and make sure it had the people it needed to deliver the services safely. The pharmacy offered a walk-in flu jab service. But people could also book an appointment for their flu jab. The pharmacy had the anaphylaxis resources and the patient group directions it needed for its vaccination services. And the RP was appropriately trained to vaccinate people. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The RP asked another appropriately trained team member to check they had chosen the correct vaccine before administering it. The pharmacy team made sure the sharps bin was kept securely when not in use. The pharmacy used a hub pharmacy to assemble most of its repeat prescriptions. It also used another hub pharmacy to assemble people's medicines in disposable and tamper-evident compliance packs. And the assembled prescriptions were returned to the pharmacy for the team to hand out or deliver. The pharmacy team checked whether a medicine was suitable to be re-packaged into a compliance pack. And it usually assessed requests for the service to make sure compliance packs were appropriate for the patient. The pharmacy kept an audit trail of the people involved in the assembly of each compliance pack. It routinely provided patient information leaflets. And a brief description and a photograph of each medicine contained within a compliance pack was printed next to the medicine's name. This made it easier for people to tell what medicine they were taking. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the

person collecting the prescription to see what was being supplied and query any items. The pharmacy used reminder stickers to alert its team when these items needed to be added or if extra counselling was needed. And assembled CD prescriptions awaiting collection were generally marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully. Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And the pharmacy had the resources it needed when its team dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team marked containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. And they marked products which were soon to expire. These steps helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy team recorded the destruction of the CDs that people returned to it. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in an appropriate pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And a team member described the actions they took and demonstrated what records they made when a drug alert was received.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's personal information is kept secure. And its team makes sure the equipment it uses is clean.

### Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team generally checked each refrigerator's maximum and minimum temperatures. But the team had forgotten to record these temperatures on a few occasions recently. Members of the pharmacy team could check a person's blood pressure when asked. And the monitor they used to do this was recently changed. 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 put its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were stored securely when they weren't working.

## 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. |