

Registered pharmacy inspection report

Pharmacy Name: Prince, 486 Harrow Road, LONDON, W9 3QA

Pharmacy reference: 1041476

Type of pharmacy: Community

Date of inspection: 12/12/2019

Pharmacy context

This is an independent retail pharmacy located on a main road in North West London. It has been under the same ownership since 1981. People who use the pharmacy live locally and many are elderly. The local area is culturally diverse. The pharmacy mainly supplies NHS prescriptions and sells a small range of retail products. It also sells a few over-the counter medicines via the pharmacy's website, and it offers a few other pharmacy services including flu vaccinations and substance misuse support. The regular pharmacist is a qualified chiropodist and offers chiropody services to some of their regular customers.

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 not all met	2.2	Standard not met	Some team members are not appropriately trained for the roles they undertake.
3. Premises	Standards not all met	3.1	Standard not met	The consultation room is untidy and unprofessional in appearance.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not store and manage all of its medicines appropriately. Medicine fridge temperatures are not properly monitored, CD management is lacking, stock medicines sometimes include mixed batches and off-cuts, and liquid medicines with a limited shelf-life are not consistently dated when opened.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

Team members understand their roles and responsibilities. They know how to protect people's private information and they have a basic knowledge of how to safeguard and support vulnerable people. The pharmacy has written procedures to make sure the team members work safely, but these are not necessarily followed in practice, so there may be occasions when they might not always work effectively. And the pharmacy does not always complete reviews when things go wrong, so team members may miss additional learning opportunities.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which covered the main tasks and activities. These were mostly dated indicating they had been implemented in 2014. The superintendent pharmacist said he usually reviewed them every year but there was no documentation confirming this. Training records indicated that current team members had read and signed the SOPs when they were first implemented or when they started working at the pharmacy. SOPs were not always followed in practice. For example, there was no dispensing audit trail in relation to prescription assembly and checking processes, and CD audits were not completed as frequently as indicated in the SOPs.

An RP notice was displayed and was visible from the retail area. Other team members' roles were not immediately clear, but they could explain their responsibilities and they worked under the supervision of the pharmacist during the inspection.

The pharmacist often worked alone in the dispensary and so frequently assembled and self-checked prescriptions. This introduced an element of risk, but the pharmacist usually tried to separate the two processes in order to mitigate this. There were no near miss reporting processes or formal patient safety reviews. The pharmacist said he would discuss near misses or errors with the dispenser involved. This might include considering look-alike-sound-alike medicines and making sure they were stored separately to avoid picking errors. If a dispensing error occurred, the pharmacist explained how he would resolve this, including contacting the person's doctor if they had taken any of the incorrect medication. He said he would also self-reflect on his dispensing and accuracy processes and make a record in a book used to record incidents and complaints, but no incidents had been documented recently.

Details of the pharmacy owner were displayed in the retail area. The superintendent pharmacist dealt with any concerns and issues raised by people using the services and these were usually resolved informally. The pharmacy sought feedback through annual NHS patient satisfaction surveys. The results of the most recent survey for 2018-19 were available on the www.NHS.uk website and they were generally positive. The team had received a few Christmas cards from regular customers complimenting the staff and thanking them for the service received throughout the year.

The pharmacy was indemnified by the NPA and a copy of the current insurance certificate was displayed in the dispensary. A recognised patient medication record (PMR) system was used to document prescription supplies and the team maintained all the records required by law, including RP logs, controlled drug (CD) registers, specials records, and private prescription and emergency supply records. Records checked were generally in order. However, CD running balances were not always

consistently maintained, which meant the pharmacy could not provide assurance that the stock was properly controlled. Private prescriptions were suitably filed and retained. One veterinary prescription for a human licensed medicine was noted which did not include the appropriate wording required according to the regulations, and the pharmacist was reminded of this.

Team members understood about data protection and the importance of maintaining patient confidentiality. There was an information governance folder containing the company's policies and staff confidentiality agreements which team members had signed. Most of them had signed a confidentiality clause. Confidential material was generally stored out of public view. Confidential paper waste was shredded. Pharmacists used individual NHS smartcards for accessing the NHS data. People provided signed consent for services such as flu vaccinations. A privacy notice was not displayed explaining how people's information was processed and safeguarded although this was explained on the pharmacy's website.

The pharmacist was level 2 safeguarding accredited and a copy of his certificate was provided. The team had access local safeguarding contacts. The pharmacist said he would usually discuss concerns about people's welfare with their doctor in the first instance. Team members had not received any formal safeguarding training so, they may be less confident identifying issues or raising any concerns. But said they would refer any concerns about patients' welfare to the pharmacist.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy has enough staff to provide its services but it would benefit from additional dispensing support. Staff work under the supervision of a pharmacist and can raise concerns if needed. But the lack of formal staff training means that some team members might not always have all the skills they need and there may be gaps in their knowledge.

Inspector's evidence

The superintendent worked as the regular responsible pharmacist six days a week. Very occasionally, locums provided cover when the superintendent was on holiday. At the time of the inspection the pharmacist was supported by two counter assistants. The team greeted the steady flow of customers promptly and managed the workload without any major issues during the inspection. Most patients were regular and known to the team. The pharmacist said prescriptions were generally received and processed on the same day. Walk-in prescriptions were usually supplied without a significant wait.

The pharmacy employed one of the superintendent's daughters as a part-time dispenser, but the pharmacist often worked alone in the dispensary so was responsible for managing the busy dispensing workload. His other daughter was a qualified pharmacist and she did not work regularly at the pharmacy, but she managed the pharmacy's website remotely. Neither of them was present during the inspection. The pharmacy did not have comprehensive records or documentation relating to staff training, although the dispenser's accredited NVQ2 training certificate was provided. One of the counter assistants had worked at the pharmacy for around three years. She had been enrolled on a Buttercups accredited healthcare course some time ago but not managed to complete it. She said she read occasional training updates and she understood the difference between General Sales List (GSL) and Pharmacy only (P) medicines and knew what types of query should be referred to the pharmacist. The other assistant had worked at the pharmacy for many years. The superintendent said she had been signed off under the RPSGB grandparent's clause whilst working at another pharmacy, but no proof of this could be provided. The pharmacist produced his chiropody qualification certificate and he was accredited to provide MURs and flu vaccinations under patient group directions (PGDs), although copies of these could not be located.

Team members spoke openly about their work and felt confident raising issues with the pharmacist. But there was no formal appraisal process or whistleblowing policy in place, so they may be less confident raising formal concerns. No specific targets were set for the team, so team members were able to use their professional judgement without feeling influenced.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy provides has enough space for the delivery of healthcare services. But the generally tired appearance and poorly presented consultation room detract from the overall professional image.

Inspector's evidence

The pharmacy was situated in an older traditional retail unit. It has a spacious retail area and the medicines counter was situated at the rear next to a small open plan dispensary. Work areas were reasonably clear, but the dispensary had less than two metres of bench space, so it was quite cramped which made the working environment challenging.

A small basic consultation room was located next to the dispensary. It was used was used to administer flu vaccinations and for chiropody consultations. But it was also used for storage and it was cluttered, untidy and unprofessional in appearance. Lighting was adequate but the pharmacy's décor and fittings were old, worn and tired in appearance. The carpet tiles were stained and loose in places.

The pharmacy has a large basement accessed by stairs from the retail area. It had staff rest and WC facilities, as well as storage and office space. Access the to this area was restricted to staff only.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy generally sources and supplies medicines in an appropriate manner. But working procedures are sometimes unclear, which makes it difficult for the pharmacy team to demonstrate that it manages all aspects of the services safely. And some stock medicines are not stored or managed correctly, so there is a risk that these might not always be fit to supply.

Inspector's evidence

The pharmacy was open from 9am until 6pm Monday to Saturday. There was a non-automated door at the entrance and a slightly ramped entrance, so access to the pharmacy was reasonably unrestricted. The pharmacy's services and contact details were available on the pharmacy website www.princechemist.co.uk. The team were able to signpost to other healthcare providers in the locality. Most people ordered their own repeat prescriptions and they could nominate the pharmacy to receive their electronic NHS prescriptions. The pharmacy offered to fax prescription requests to local surgeries on behalf of some of their regular patients. The pharmacist provided ad-hoc home deliveries for a few housebound patients.

Medicines were suitably labelled, and patient information leaflets were usually supplied. Owing slips were available, but these were not consistently utilised. The pharmacy dispensed some medicines in multicompartiment compliance packs for some of their more vulnerable patients. Packs were usually requested by the doctor and most were supplied a week at a time to prevent patients becoming confused. Compliance pack assembly was managed by the pharmacist, but processes were unclear and there were no supporting records or documentation which would enable packs to be safely assembled in his absence. Packs were labelled in accordance with the regulations, but they did not include medication descriptions and patient information leaflets were not usually supplied, so people might not always get all the information they need.

The pharmacist was aware of the risks of supplying valproate-based medicines and that patients should be counselled. He was not aware of any regular patients in the at-risk group. The appropriate patient literature could not be located at the time of the inspection, which meant it may not be possible to supply the necessary information if valproate was dispensed. The pharmacist was able to access Summary Care Records and had completed the relevant training to administer flu vaccinations under PGDs. The pharmacist made occasional interventions, for example a recent private script for lorazepam 2.5mg tablets had been refused as the patient was also prescribed lorazepam 1mg by their NHS doctor. But the pharmacist had not informed the patient's GP or taken additional steps to verify if the prescription was genuine, however he agreed to follow this up.

Pharmacy medicines were stored behind the counter, so sales could be supervised. The counter assistant understood the restrictions on selling codeine-based medicines. The pharmacist could easily supervise and intervene as the dispensary and counter were in close proximity.

Occasional OTC medicines were supplied via the pharmacy's website www.princechemist.co.uk, including GSL and P medicines. A few high-risk lines such as painkillers containing codeine were listed. The website had the MHRA EU logo and all the necessary company details. Requests for medicines were reviewed by the pharmacist and dispatched by Royal Mail. There were no online questionnaires and sales were conducted by email or by telephone, which enabled the pharmacist to ask relevant

questions. There was no in-built system to pick up repeat requests and so it was reliant on the pharmacist's vigilance. Some previous requests had been refused, for example frequent requests for Nytol. But there was no supporting documentation indicating how sales were conducted or when supplies had been refused or indicating patients had been effectively counselled.

Stock medicines were sourced through a range of licensed wholesalers. There was no clear stock control system and the pharmacy was not currently compliant with the requirements of the European Falsified Medicines Directive (FMD). Stock medicines were stored on open shelves in the dispensary and these were untidy in places. A random check of the shelves found no expired items. But some mixed batches and off-cuts with no batch number or expiry date were seen amongst stock, and liquid medicines with a limited shelf-life such as Oramorph and Haldol were not always dated when opened, which means these medicines might not be fit for supply. Some medicines which had been put aside for use in compliance packs had been left in baskets in the consultation room which risked unauthorised access.

The pharmacy fridge had a manual maximum and minimum thermometer. The actual temperature on the day was within the acceptable range but the thermometer was difficult to read. Daily temperature records were captured on the PMR, but the pharmacist confirmed these were estimated rather than actual readings, and they did not always monitor the fridge temperature. So, the pharmacy could not demonstrate that it stored these medicines at the correct temperature.

The majority of the pharmacy's CD stock was stored in a cabinet located in the basement. Obsolete CDS were segregated. The pharmacy had a CD destruction register for patient returns but the last entry was in 2011, which suggested these were not always documented. CD stock balances were not regularly audited. Other expired, patient returned medicines and used sharps were placed in appropriate designated waste containers, prior to collection by waste contractors.

Alerts and recalls for faulty medicines and medical devices were received via email. These were checked by the pharmacist and actioned if necessary. Recent alerts had been received and the pharmacist explained how they had quarantined and returned affected ranitidine stock, although documentation relating to this was not readily available.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services and the team uses the equipment in a way that protects people's privacy.

Inspector's evidence

The pharmacy had disposable medicine containers, calibrated glass measures and counting equipment for dispensing medicines. The team could access to the internet and suitable reference sources such as the British National Formularies and Drug Tariff.

Computer terminals were suitably located so they were not visible to the public and the PMR system was password protected. Telephone calls could be taken out of earshot of the counter if needed. The pharmacy had a large CD cabinet and a domestic fridge was used for storing medicines. Basic anaphylaxis and chiropody equipment for use alongside services was available.

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.