

Registered pharmacy inspection report

Pharmacy Name: Browns Pharmacy, 195 Shirland Road, LONDON, W9 2EU

Pharmacy reference: 1041480

Type of pharmacy: Community

Date of inspection: 17/11/2021

Pharmacy context

This traditional community pharmacy is located alongside other local shops in a residential area of North West London. Most people who use the pharmacy are from the local area. The pharmacy mainly supplies NHS prescriptions, and it sells a range of over-the-counter medicines. It supplies some medicines in multi compartment compliance packs, to help make sure people take them at the correct time. The pharmacy also offers a substance misuse service and the NHS Community Pharmacist Consultation Service (CPCS). The inspection was completed during the COVID-19 pandemic.

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 not all met	1.6	Standard not met	The pharmacy does not keep accurate records. The responsible pharmacist record is not completed correctly and controlled drugs registers are not properly maintained.
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 not all met

Summary findings

Overall, the pharmacy's working practices are generally safe and effective. But it does not keep accurate records so it cannot clearly demonstrate how it manages its services safely. It has written procedures explaining how it operates, but some of these procedures have not been reviewed for several years, so they may not always be relevant to current practice. Members of the team keep people's information safe and they understand their role in protecting vulnerable people. They discuss any errors so they can learn from them. But they don't usually record their mistakes so they may miss some opportunities to improve.

Inspector's evidence

A range of standard operating procedures (SOPs) were available which covered the main activities of the pharmacy. Roles and responsibilities were highlighted within the SOPs and signature sheets were used to record training. The pharmacy technician and dispenser had both read and signed the SOPs, but the trainee dispenser had not. She was aware of the intended purpose of the SOPs but explained that most of her training had consisted of performing tasks under guidance. Most of the SOPs had not been reviewed or updated for several years so they may not always reflect current practice or the most recent requirements.

The pharmacy was owned by a company and one of the directors worked at the pharmacy full time and he managed the day-to-day running of the pharmacy. Dispensing activities and sales of medicines were supervised by the pharmacist. Team members could clearly explain their individual roles and responsibilities.

Dispensing labels included an audit trail which identified which team member were involved in the assembly and checking process when prescription medicines were supplied. The pharmacist explained how they discussed any errors as a team. The previous day a near miss error where the wrong strength of naproxen had been labelled had led to a team discussion. But near misses were not recorded so they could not be reviewed for trends which means the team might miss further opportunities to learn and improve. The pharmacist could not recollect any dispensing incidents being reported to him and no records could be found. A notice was displayed in the retail area explaining the pharmacy's complaints procedure. Complaints were usually handled by the pharmacy owner with input from the pharmacist or superintendent if needed.

A current certificate of professional indemnity insurance was available. The pharmacy used a standard patient medication record (PMR) system to record and label prescriptions supplies. A responsible pharmacist (RP) notice was not displayed at the start of the inspection although this was quickly rectified when the pharmacist was alerted. The RP log was kept electronically, but there were only nine entries relating to the last two months. This meant the pharmacy could not produce an accurate record to show which pharmacist was responsible on a specific date and time, as required by law. Controlled drug (CD) registers were not always well organised as headings were often missing and running balances were not accurately maintained. Private prescription records were kept electronically; they were generally in order although prescriber details were sometimes incomplete. Appropriate records were kept when unlicensed medicines were supplied on prescription.

The team members confirmed they had received training on confidentiality and information governance, and they each had their own NHS smartcard. Confidential waste was segregated and shredded. A privacy notice was not displayed in the retail area, so people might not be easily able to access information about how the pharmacy handles their personal data.

Members of the team were aware of their safeguarding responsibilities and would speak to the pharmacist if they had any concerns. The pharmacist had completed level 2 safeguarding training so knew what signs to look for and how to escalate a concern. A safeguarding policy could not be located.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to effectively manage the workload. The pharmacy team members receive the appropriate training for their roles. They work well together, and they use their professional judgement in the interests of patients. But the pharmacy does not provide structured ongoing training or formal reviews, so the team may miss additional opportunities to learn.

Inspector's evidence

Two or three regular locum pharmacists covered the core opening hours of the pharmacy, and the superintendent pharmacist worked on Sundays. A locum pharmacist who worked three regular days a week was on duty at the time of the inspection. The pharmacy manager, a pharmacy technician, a dispenser and a trainee dispenser were working alongside the pharmacist. They worked well as a team and managed the workload effectively. A medicines counter assistant also worked part-time at the pharmacy but was not present.

Some training certificates were displayed in the dispensary. The trainee dispenser was enthusiastic about her role; she had completed her MCA training and had progressed and was now enrolled on a dispensing course. The dispenser confirmed she had completed her training at the pharmacy, and she had access to pharmacy publications which included training materials, so she used these to keep their knowledge up to date. But she did not have a copy of her certificate and detailed training records were not available at the pharmacy.

The trainee dispenser described which sort of queries and requests for over-the-counter medicines she would refer to the pharmacist. She was aware that some medicines were prone to abuse and alerted the pharmacist if people were buying these medicines repeatedly. The pharmacy did not normally sell codeine linctus because of its potential for misuse.

Members of the pharmacy team communicated openly and were responsive to customers' queries. They could raise issues informally with the pharmacy owner and contact the superintendent if needed. The pharmacy did not have any specific performance targets relating to professional activities.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean, bright and professional in appearance. The pharmacy provides a suitable environment for healthcare services and a consultation room is available to protect people's privacy.

Inspector's evidence

The pharmacy had been recently redecorated and fitted with a new frontage, flooring and lighting so it was professional in appearance. A small consultation room had also been installed in the retail area. It was suitably equipped with a sink, table and two chairs.

The pharmacy was generally clean and tidy. The dispensary was small with a limited amount of bench space considering the volume and nature of the workload. The lack of space for assembly of compliance packs meant these had to be stacked prior to checking and sealing. But the dispensary was reasonably well organised with separate areas allocated to different activities, and there was a dispensary sink.

A Perspex screen had been fitted to the medicines counter to help prevent the spread of covid infection. But most team members did not wear face masks when working which could contribute to transmission amongst the team. The retail area was spacious enough to allow social distancing and the pharmacy aimed to limit access to two or three people at a time.

Stairs led to a basement which was used mainly for storage. There was a staff toilet and separate sink in the toilet for handwashing. A flood earlier in the year had caused damage in the basement area which was being managed and had mostly resolved. The pharmacy did not have air conditioning, but the room temperature was appropriate. The pharmacy was suitably secured overnight.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are easy to access, and they are generally well managed, so that people receive their medicines safely. But pharmacy team members could do more to make sure they provide enough information to people receiving high risk medicines and compliance packs. The pharmacy sources and stores medicines safely and the team carries out some checks to help make sure that they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy was open 9am to 6pm Monday to Friday, 9am to 5pm Saturday and 10.30am to 1pm on Sunday. There was a small step at the pharmacy's entrance and a manual door but the staff could offer assistance if needed. Opening times and covid notices were displayed. The pharmacy offered an occasional ad-hoc delivery service to mainly housebound patients.

Dispensing baskets were used to keep individual prescriptions separate to prevent these being mixed up during dispensing. Dispensed medicines awaiting collection were bagged and kept in the dispensary. Prescription forms were filed separately in alphabetical order so that they could be retrieved when the medicines were handed out. The team members were aware of the types of medicines which would be considered high-risk. But there was no clear system used to flag these medicines to allow additional counselling at the handout stage. The team member knew about the risks associated with the use of valproate during pregnancy. All stock packs of valproate contained suitable warning cards, and the pharmacy had additional supplies of educational material so these could be provided if needed.

People were usually asked to confirm their name and address before prescription medicines were handed out, to make sure the correct prescription had been selected. If any medicines could not be immediately supplied, the prescription form was filed until the person returned to collect it, but there was no clear audit trail so these could be properly tracked.

The pharmacy supplied medicines in multi-compartment compliance pack for a large number of people. The dispenser managed these and had introduced systems and audit trails so these could be managed efficiently. Records of regular medication, any changes and discharge information were kept for each patient. Packs were prepared in advance and they were clearly labelled. But labelling did not include descriptions of medicines so that individual medicines could be identified, and patient leaflets were not always supplied, so people may not have all the information they need to take their medicines safely. Formal assessments were not completed prior to initiating compliance packs so there was a possibility that they may not be suitable for some of the people who used them. But most people were referred by their doctor or recommended following discharge from hospital. Packs could be supplied on a monthly or weekly basis depending on which was more suitable for the patient.

The pharmacy supported a number of substance misuse patients. The pharmacist managed the substance misuse service. Take away doses were prepared in advance. Supervised doses were prepared when the patient presented. The pharmacist explained they were in daily contact with the local drug and alcohol team and confirmed that any concerns or more than three missed doses were reported to the key worker.

Stock medicines were obtained from licensed wholesalers and suppliers. Medicines were stored in a reasonably well organised manner in the dispensary. Excess stock was stored in the basement. Expiry date checks were completed periodically, and a random check of the shelves found no expired items. A fridge in the basement was used to store cold chain medicines. Fridge maximum and minimum temperatures were checked daily and recorded.

Controlled drugs were stored in appropriate cabinets. Obsolete CDS were segregated but these had accumulated, and an authorised destruction was needed. There was a system for recording the receipt and storage of patient returned CDs but there were no recent entries, so it was unclear if this system was being used effectively. Other waste medicines were disposed of in dedicated bins that were kept in the basement and collected periodically by a waste contractor. Drug alerts were received by e-mail and checked by the pharmacy owner who notified the team of there was anything relevant. But there was no audit trail to show when these had been reviewed or actioned, so the pharmacy could not clearly demonstrate this.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities necessary for the services it provides. Equipment is appropriately maintained so that it is safe to use, and it is used in a way that protects people's privacy.

Inspector's evidence

The pharmacy team members had access to the most recent versions of the BNF, and they could access the internet for general information. Clean glass crown stamped measures were used to measure liquids. Other counting equipment, containers and cartons were available for dispensing purposes. Disposable compliance packs were used.

The dispensary was not accessible to the public. Telephone calls could be made without being overheard. There were two computer terminals from which the PMR system could be accessed. The system was password protected. Electrical equipment appeared to be in working order, however the team reported issues with the PMR system frequently crashing and this was due to be upgraded.

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.