

Registered pharmacy inspection report

Pharmacy Name: Doctor Care Pharmacy, 73 Golborne Road, London, W10 5NP

Pharmacy reference: 1041484

Type of pharmacy: Community

Date of inspection: 16/09/2024

Pharmacy context

This pharmacy is located within a parade of shops in a residential area of West London. The pharmacy mainly serves the local community as well as tourists visiting the area. It dispenses NHS prescriptions received electronically as well as private prescriptions generated by its own pharmacist independent prescriber. It also provides medication in multi-compartment compliance packs to people who live in their own homes and need help managing their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan; Statutory Enforcement

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	The pharmacy cannot adequately demonstrate that it had sufficiently considered the specific risks associated with its prescribing and aesthetic services. Consultation notes for these services lack basic information. And the pharmacy cannot demonstrate how information about medicines it prescribes is shared with people's regular prescriber. Taken together, these increase the risks to people using the service.
		1.2	Standard not met	The pharmacy cannot demonstrate that it routinely audits its prescribing service to ensure its processes are effective at keeping people safe.
		1.6	Standard not met	The pharmacy does not maintain appropriate records for its prescribing service.
		1.7	Standard not met	The pharmacy does not always keep people's personal information appropriately secure.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy cannot adequately demonstrate that its prescriber works within their competency when prescribing for some conditions.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy does not always provide its prescribing services safely. It cannot adequately demonstrate how prescribing decisions are made, or that people's regular prescribers are informed about prescribed medicines.
		4.3	Standard not met	The pharmacy does not always store its prescription-only medicines securely or ensure they are labelled appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy does not adequately manage the risks associated with its prescribing service. At the time of inspection, it did not have prescribing policies or risk assessments in place. And it does not carry out regular audits of its prescribing service. The pharmacy does not maintain sufficient records for its prescribing service. And it does not always protect people's personal information, which may increase the likelihood of sharing sensitive information. Other than the prescribing service, the pharmacy largely keeps the records it needs to by law. But it does not always keep its written procedures easily available or ensure team members are familiar with them. This could make it harder for staff to know what procedures they should follow.

Inspector's evidence

At the start of the inspection, the responsible pharmacist (RP) was not present. The pharmacy was open, and a trainee dispenser was covering the dispensary. The dispenser was able to describe the tasks they could and could not do in the absence of the RP. And in the absence of the RP, they were not seen doing tasks which would require an RP to be signed in. The trainee dispenser did not know what standard operating procedures (SOPs) were and could not locate them. The superintendent pharmacist (SI), who was also the RP for the day, arrived after the start of the inspection. The SI said that a new set of SOPs were being printed by another pharmacist who worked at another branch. The previous version was also not available at the pharmacy. Later in the inspection, a set of newly printed SOPs arrived from the other branch, but these had not been dated or signed by the SI or pharmacy team members.

The pharmacy was advertising aesthetic treatments such as antiwrinkle and filler injections. The pharmacy did not have any written procedures for the aesthetic service. The SI said that they did not provide this service for the time being. A record about the administration of antiwrinkle injections was found and was dated July 2023.

The SI was an independent prescriber and provided a private prescription service. The pharmacy did not have any prescribing policies or risk assessments for the prescribing service. The SI said that they had conducted a clinical audit about the service one year ago but could not locate it during the inspection. Following the inspection, the SI sent templates a prescribing SOP, a risk assessment, and a prescribing checklist. However these had not been signed off or dated and did not fully reflect the specific prescribing service being provided.

The trainee dispenser said that the SI highlighted any dispensing mistakes which were identified before the medicine had reached a person, or near misses, and discussed areas for improvement. The trainee dispenser did not know if these were recorded and was not involved in documenting their own near misses. The SI said that near misses had not been recorded recently and they mainly just discussed them with the rest of the team. The benefits of recording and reviewing near misses was discussed with the team. The trainee dispenser described being briefed about checking medicines against the prescription rather than the dispensing labels to help reduce dispensing mistakes. The SI said that dispensing errors, where a dispensing mistake had reached a person, would be documented on a specific form, and investigated. The SI said that the pharmacy had not had any dispensing errors.

The indemnity insurance certificate displayed at the pharmacy had expired. Following the inspection,

the SI sent evidence of an in-date certificate, however, it was not clear that independent prescribing was covered. The SI obtained confirmation from the insurance provider that this was a technical error, and that the pharmacy was covered for this service. The private prescription register generally contained the required information but it was difficult to find the original prescriptions generated by the SI as prescriptions were not filed in any order. The pharmacy provided a small number of emergency supplies and the records about them were generally in order. Controlled drug (CD) registers were generally completed in line with requirements, but the address of the wholesaler was not always recorded when entering stock received. The physical stock of a CD was checked and did not match the recorded balance. The SI confirmed that an entry had not yet been made on the morning of the inspection and updated the CD register accordingly.

Records for the prescribing service were minimal and did not always include information on the diagnosis and rationale, symptoms, differential diagnosis, person's medical history, or checks made in the case of higher-risk medicines. Some records only consisted of a dispensing label and a bag label attached to the prescription template. The SI said that they followed NICE guidance, however, there was evidence that this was not always the case. For example, they had prescribed amoxicillin for gum disease although NICE guidance indicated that antibiotics were not normally recommended and should only be prescribed on the advice of a specialist. The SI had not documented clear reasoning behind this decision. The SI had also recently prescribed Ozempic for weight loss despite the National Patient Safety Alert in October 2023 which informed pharmacies to prioritise this medication for those being treated for diabetes. The SI said that some people favoured this brand above brands that were licensed for weight loss.

The trainee dispenser described ways in which the pharmacy protected people's confidential information, including collecting confidential waste in separate bags. These were then collected by a recognised contractor. The trainee dispenser said they had been briefed about protecting people's confidentiality but had not completed formalised training. Other members of staff had signed a data protection clause within their employment contract. Screens faced away from people using the pharmacy, but NHS smartcards were seen to be shared. Team members said that they would apply for individual smartcards. Medicines awaiting collection were stored inside the dispensary, however, a number of multi-compartment compliance packs were seen to be stored in an unlocked consultation room, with confidential information clearly visible. The room could be accessed from the public area of the pharmacy. The SI said that the packs would be removed from the consultation room.

A complaint procedure was in place. People could give feedback verbally or via online platforms. A positive interaction was seen with a person who had visited the pharmacy and thanked the SI for their recommendations.

The SI had completed Level 2 training about safeguarding vulnerable groups. The trainee dispenser had not completed formalised training about safeguarding at the pharmacy but had received some training as part of an external (non-pharmacy) course. They could not locate the contact details of the local safeguarding team and said they would contact social services or the police. The SI said that other members of the team had not received training. The SI had arranged for an external company to provide a range of training modules, including one on safeguarding. There had not been any safeguarding concerns at the pharmacy. Following the inspection, the SI sent a safeguarding procedure.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy cannot adequately demonstrate that its prescriber prescribes within their area of competence. However, the pharmacy has enough staff to provide its services. Team members complete some training as and when possible, but there is limited structure to their training. This may mean that it is harder for them to keep their skills and knowledge up to date and relevant. And the pharmacy does not always ensure that members of the team are enrolled onto a suitable course in a timely manner.

Inspector's evidence

At the start of the inspection there was a trainee dispenser covering the pharmacy and the SI arrived later. The trainee dispenser said that the SI usually opened the pharmacy. The pharmacy also employed a qualified dispenser, a trainee medicine counter assistant (MCA), and an assistant. The assistant was involved in ordering repeat prescriptions and generating labels for multi-compartment compliance packs. The assistant had been working at the pharmacy for over three months but had not been enrolled onto a suitable course. Following the inspection, the SI sent confirmation of the assistant's enrolment onto a dispenser's course. Team members were up to date with their pharmacy tasks and said there was enough staff for the services provided.

The trainee MCA described asking several questions before referring to the pharmacist before selling a Pharmacy-only medicine (P-medicine). They were aware of the RP regulations and said that they would not hand out dispensed medicines or sell P-medicines in the absence of the RP.

The trainee dispenser completed their training modules either at work or at home and regularly discussed their progress with the SI. They said that they also completed research online and asked colleagues whenever they had a question about a medicine or a process. They had recently asked about how the supervised consumption service worked and how to enter CDs in the register.

The SI explained that their area of expertise was diabetes. They were an overseas vet and said they had previous experience in the medical field. They said that they followed NICE guidance when prescribing and kept up to date by researching online. The SI had completed aesthetics training with a training academy. They could not provide evidence of additional training they had completed to support their prescribing in areas outside of their expertise. Following the inspection, the SI sent an example of a CPD entry describing what they had done to update their knowledge on antibiotic prescribing. This did not include any evidence of the training that they had completed. Several prescriptions were found which had been issued by the SI for a range of conditions and medicines, for example, antibiotics, sleeping tablets, anxiolytics, anti-epileptics, pain relief, and dermatology medicines.

The pharmacy team shared information on a group messaging app. The trainee dispenser said that they could easily contact the SI and felt supported by the pharmacy team. They regularly asked the SI for feedback about their progress and discussed ways in which to improve. Formalised performance reviews were not conducted. Targets were not set for the team.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are generally clean and maintained to a level of hygiene appropriate for the pharmacy's services. People can have a conversation with a team member in a private area. But space in the pharmacy is limited. And the pharmacy could do more to keep all areas tidy and free from unnecessary clutter.

Inspector's evidence

The pharmacy was relatively small and comprised of a small dispensary located on one side of the shop. There was sufficient workspace in the dispensary but several bags of medicines awaiting collection were stored on the dispensary floor. A small consultation room was located beside the dispensary, but this was cluttered with multi-compartment compliance packs. The room was not locked, and confidential information and prescription-only medicines (POMs) were accessible. There was a small retail area which had two chairs for people wanting to wait for a service.

There were several boxes of returned medicines just outside the consultation room, as well as several boxes on the stairway which posed potential tripping hazards. The SI said that those would be cleared. Several rooms were available in the basement. One room was fitted with a therapy bed and was used for aesthetic treatments and the phlebotomy service. The second room contained a single bed, and a third room was used as an office and storage space.

Staff facilities included a staff room with kitchenette, and a toilet. Cleaning tasks were shared by the team. The pharmacy was generally clean. The premises were secured from unauthorised external access.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy does not always provide its services safely. It does not keep appropriate consultation notes for its prescribing service, and it does not have robust processes in place for its prescribing service and for the supply of higher-risk medicines. The pharmacy does not always store its prescription-only medicines securely. It obtains its medicines from reputable suppliers. But it does not always ensure they are labelled appropriately. This may make it harder for the team to respond to product recalls.

Inspector's evidence

There was a small step into the pharmacy. The pharmacy team described serving people with mobility problems from the door. Some members of the team were multilingual and translated for people with language barriers. The SI said that team members from other branches were sometimes contacted to help translate for people. Services and opening times were clearly advertised.

The dispensed by and checked by boxes on the labels were not always used. This may make it difficult to identify who was involved in these processes. Prescriptions were not retained with dispensed medicines which meant that staff relied on bag labels when handing out dispensed medicines. Team members said they would review this.

The trainee dispenser was not aware of the valproate guidance and said that they had not read it. They said they would familiarise themselves with it. The SI was aware of the checks to make and the advice to provide to people in the 'at-risk' group. They said that they would provide valproate in its original pack, in line with guidance.

There was no documented evidence of sharing information with people's regular prescribers for any prescriptions issued by the SI. The SI said that they contacted GP surgeries by telephone to share information but could not provide evidence that this was happening. They added that, at times, people were provided with a copy of the prescription to take to their GP, but this meant that the SI relied on the person to share information. Completed records for the prescribing service did not include details of regular prescribers and there was no section to include this information. There was no evidence of any ID checks being made.

The pharmacy managed prescriptions for people receiving multi-compartment compliance packs. A log was used to keep track of when prescriptions were due. Once prescriptions were received, they were clinically checked by a pharmacist and checked against a master backing sheet. Any changes or missing items were queried with the GP, and the backing sheet was updated to reflect the changes. Packs were assembled in the small consultation room but there was limited space to dispense on. Team members involved in assembling the tray did not have access to the prescription and assembled the packs against a backing sheet. The risks of this practice were discussed. It also appeared to contradict the SI's previous advice on dispensing against prescriptions rather than labels.

The SI said that they had stopped providing aesthetic treatments since last year, except on rare occasions where they administered botulinum toxin. Consultation forms were completed by people accessing this service. The latest form found completed for botulinum toxin was dated July 2023. It did not contain information on the injection site, the product used, or the number of units used per site.

Pharmacy team members said that dispensary date checks were carried out at regular intervals, but records were not maintained. They said that they would document these checks in the future. Several medicines stored in amber medicines bottles were found on the shelves. Some were not labelled, and others were labelled with the medicine name but not expiry date or batch number. This may make it harder to identify a medicine or respond appropriately to batch recalls. One pack of ondansetron 8mg tablets with a label from another pharmacy was found on the dispensary shelf. The SI said that the pack should have been discarded and not placed on the shelf. Several boxes of medicines returned by people, including POMs, were found on the shop floor, just outside the consultation room, and not stored securely. The SI said that MHRA alerts and recalls were received electronically, actioned, and shared with other branches. They did not document any action taken in response to these but said that they would in the future.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

The pharmacy had several glass measures, with some used to measure certain liquids only. There was one small pharmaceutical fridge, and this was clean and suitable for the storage of medicines. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Members of the team had access to the internet and several up-to-date reference sources. The SI said that the stethoscope, blood pressure monitor, and blood glucose device were relatively new.

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.