General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dukes Pharmacy, 328-330 Muswell Hill Broadway, LONDON, N10 1DJ

Pharmacy reference: 1087867

Type of pharmacy: Community

Date of inspection: 29/05/2019

Pharmacy context

This is a pharmacy situated in a shopping parade next door to a surgery. It dispenses NHS prescriptions and offers a flu vaccination service. It supplies medicines in multi-compartment compliance packs to a number of people to help them take their medicines safely.

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 associated with its services. It keeps people's private information safe. And it asks its customers and staff for their views. The pharmacy generally maintains the records that it must keep by law. But some records are incomplete. So, it may not always be able to show exactly what happened if any problems arise. Team members understand their role in protecting vulnerable people.

Inspector's evidence

Up-to-date standard operating procedures were available which had been read by all team members except the locum dispenser. The responsible pharmacist (RP) said in future she would ensure that all locum staff had read through the SOPs relevant to their roles. Team members signed an overarching tracker. Team roles were defined within the SOPs.

Near misses were recorded on a log as they occurred. The RP said that she would have a chat with the dispenser when the near miss was identified, and a discussion was then held as to how this could be avoided. There were no near misses recorded since January or February 2019. The RP said that locum dispenser had been working at the pharmacy for six to seven weeks and did not make many mistakes. The previous dispenser had not worked at the pharmacy regularly. As a result of past near misses, the team had tided shelves so that stock was more visible.

Dispensing incidents were recorded on the National Pharmaceutical Association's (NPA) portal and an incident report form was also completed. The RP said that there had not been a reported incident for some time. In the event that an error was recorded the RP said that she would contact the prescriber and apologise to the patient. As a result of a past error escitalopram and esomeprazole were separated on the shelves.

The owner had arranged a meeting on a Sunday for all the group's pharmacists to discuss look-alike sound-alike medicines after there had been an article in the press about an error which had occurred with propranolol. The correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and also completed an annual patient satisfaction survey. Details of the complaint procedure were listed in the practice leaflet. Previous feedback had shown that people were least happy with the lack of lifestyle advise and signposting provided. The RP was looking at stocking a larger range of supplements and vitamins and tried to incorporate healthy living advice into consultations.

Records for emergency supplies, unlicensed specials, and RP records were well maintained. Prescriber details on private prescription records did not always match those on the prescriptions and some controlled drug (CD) register entries were missing the location of the wholesalers from where the stock was obtained.

CD balance checks were not carried out at regular intervals. The locum pharmacist had started the balance check at the weekend but not finished. The locum pharmacist had also found a discrepancy in one of the registers. At the time of the inspection this had not been investigated. Following the

inspection, the owner confirmed that the discrepancy had been resolved.

A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received. Assembled prescriptions were stored in the dispensary. Team members who could access the computers had smartcards. The RP had access to Summary Care Records and consent to access these was gained verbally from people. An information governance policy was available. Team members had read and signed the information governance workbook.

The RP had completed the level two safeguarding training and the medicines counter assistant (MCA) had completed the level one course. Details of the safeguarding contacts for the local area were displayed in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team generally manages the pharmacy's workload well. The pharmacy enrols staff who are training onto courses which are relevant to their role.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the RP, a locum dispenser and a medicines counter assistant (MCA). The regular dispenser had left in early March. The pharmacy had recruited another dispenser who was training at another branch and was due to start working at the pharmacy by the end of the month. Since March, the pharmacy had recruited locum dispensers. The owner also came in to support the RP when needed; he had come in to help with the checking on the day of the inspection.

The RP said that staffing had been an issue but when there were two full-time staff working the workload was manageable. As the dispensary was very small it would be difficult to fit in more staff. Travel vaccinations were provided on an appointment and walk in basis. However, the RP said that if anyone walked in when it was busy she would ask them to come back when it was quieter.

The MCA had just completed her course and was due to be enrolled on the dispenser course. As well as completing her formal training courses she had completed training for safeguarding, dementia friends, information governance and children's oral health. The RP said that as the MCA was still fairly new she verbally briefed her on information on new products and procedures such as for Viagra Connect.

Staff performance was managed informally by the managers and the owner also monitored how people were getting on. The RP gave team members feedback on the spot and trained them at the same time. The RP said that she could overhear conversations on the counter so would interrupt if needed.

The MCA counselled patients on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was also aware of the legal limits and age restrictions on the sale of certain medicines like pseudoephedrine and would always refer to the pharmacist if unsure or for any requests for multiple sales. She described handing out prescriptions in line with SOPs but was not aware of the validity period for some prescriptions.

Meetings were held for all the group's pharmacists from time to time. Pharmacists then relayed relevant information to the team. As the pharmacy team was small, issues were discussed as they arose. Team members were able to contact the owner via telephone or speak to him when he came into the pharmacy.

Locum dispensers were introduced to the rest of the team when they first started and briefed on the shelf layout. Locum dispensers had to complete certain courses as part of their agency requirement. There were no numerical targets in place. The RP said she knew that she had provide services; but that there was no pressure.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally provides a suitable environment for people to receive healthcare. But some areas are cluttered and not very tidy. And this detracts from the overall appearance of the pharmacy.

Inspector's evidence

The dispensary was small and it was in the main tidy. However, there was some rubbish on the floor, including a number of loose unidentified tablets. Cleaning was done by the team members. Workbench space was limited, and one of the workbenches had a number of baskets which the owner was in the process of checking. The dispensing workbench was clear and organised. Workbenches were roughly allocated and multi-compartment compliance packs were prepared upstairs in an allocated area. Medicines were held on shelves in the dispensary and upstairs. Medicines held in the main dispensary were arranged on shelves mostly in an organised manner. The new dispenser had started tidying shelves when she had first started. A sink was available.

The signposted consultation room was easily accessible. And it was kept unlocked when not in use. The room was used to hold records, folders and records in lockable cabinets. These were locked by the RP during the course of the inspection. Adrenaline pens and some patches were found in the room in a basket. These were brought into the dispensary by the RP. Following the inspection, the owner confirmed that he had found a key for the consultation room and said that the room would be locked when it was not in use.

The room temperature was suitable for the storage of medicines. There was good lighting throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally delivers its services in a safe and effective manner. The pharmacy obtains medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use.

Inspector's evidence

The pharmacy was easily accessible with step-free access from the street. Team members would assist people depending on their needs. Some team members were multilingual and some people came in with friends or family members who spoke English. Pharmacy services available were appropriately advertised. People were signposted to other services where appropriate. The team were familiar with local services or used the internet to find details of other services.

The RP said that the delivery service and flu vaccination service had an impact on the local population. The pharmacy had provided over 300 vaccines. The RP said that the local surgery had provided vaccinations on one or two Saturdays. And the pharmacy had been able to offer vaccinations at other times, so as to be more convenient for people to access. This had also helped to reduce the GP's workload. As part of being a Healthy Living Pharmacy the RP said people were given advice in relation to smoking cessation, diet and lifestyle. People were also signposted to other services.

Approximately 70% of prescriptions were received electronically. These were printed out and filed alphabetically and dispensed when people came to collect due to the restricted amount of space available. Prescriptions were dispensed by the dispenser and checked by the RP. The RP tried not to self-check, but in the event that she did she described taking a mental break after dispensing.

Dispensed and checked by boxes were available on the labels to help maintain an audit trail. These were initialled by the pharmacist's when they checked prescriptions but not routinely by the locum dispensers. This could make it harder for the pharmacy to show who had done this activity if there was a query. The pharmacy team also used baskets for prescriptions to ensure that people's prescriptions were separated and to reduce the risk of errors.

Both pharmacists were aware of the change in guidance for dispensing sodium valproate. The RP said that there was one person who collected their medicines from the pharmacy and fell in the at-risk group. The RP had spoken to her parents. The RP was not aware of the need to use the warning stickers when sodium valproate was not dispensed in its original pack. This means that people may not always have all the information they need to take their medicines safely.

When people presented with a prescription for warfarin the RP said she asked for the yellow book and checked the INR; occasionally making a record on the electronic patient medication record. The RP said that the pharmacy was in the process of registering to provide the yellow fever vaccination service.

The pharmacy had a list of people who were supplied their medicines in multi-compartment compliance packs. Prescriptions for the packs were ordered by the pharmacy a week in advance. Once the prescription was received it was printed and labelled. Individual charts were in place for each person. Packs were assembled upstairs. Missing items and changes were confirmed with the pharmacist at the surgery. Any changes were annotated on the individual's chart. The hospital called when

someone was admitted and emailed a copy of the discharge summary both to the pharmacy and surgery. The surgery then issued a new prescription. Trays were prepared by the dispenser and checked by the pharmacist. Trays were either checked by the pharmacist upstairs or brought down to be checked and were sealed by the pharmacist once they have been checked.

There were unsealed assembled packs for six people which the dispenser said she had prepared some the day before the inspection. The RP said that she would start asking dispensers to seal trays as soon as they were prepared to avoid the risk of contamination of tablets becoming misplaced as they were transported downstairs.

Assembled packs observed were labelled with product descriptions and mandatory warnings. Patient information leaflets were handed out monthly and there was an audit trail in place to show who had prepared and checked the packs.

Deliveries were carried out by a designated driver. Signatures were obtained for CDs delivered but not for other medicines; the owner said that there had not been any disputes to date. But it could make it harder for the pharmacy to show that the medicines were safely delivered. In the event that someone was not available medicines were returned to the pharmacy and the RP called the person to reschedule the delivery.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as CDs. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of medicines. CDs were kept securely.

Date checking was done by the dispenser every three months. Short-dated stock was marked and a date checking matrix was in place. One date expired medicine was found on the shelves sampled. The pharmacy was not compliant with the Falsified Medicines Directive (FMD). The owner said that a week prior to the inspection the pharmacy had upgraded the computers. The owner was speaking to a few companies about the equipment for FMD and said that the pharmacy would be compliant within a month.

Out-of-date and other waste medicines were segregated away from stock and then collected by licensed waste collectors. Drug recalls were received by the RP from the MHRA; the owner said that he was usually around so if the RP was not there he would check for recalls or would ask the superintendent pharmacist to cascade it to all the branches. The last actioned recall was for co-amoxiclav suspension.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had one glass calibrated measure. The owner ordered a backup during the course of the inspection. Tablet counting triangles were also available. The owner said that cytotoxic medicines were ordered in blisters as it helped the risk of contamination and meant that team members did not have to handle the tablets. This had been discussed at the groups meeting.

A blood pressure monitor was available and was relatively new. The date of first use had been annotated on the box and the monitor was to be replaced in two years. Empty amber glass bottles were stored uncapped in the dispensary. This could increase the risk of the bottles becoming contaminated.

A fridge of adequate size was available; food was stored in this fridge in close proximity to medication. The fridge was also dirty in places. Following the inspection, the owner confirmed that this had been cleaned. A range of up-to-date reference sources was available. Computers were password protected and were not visible to people using the pharmacy. Confidential waste was segregated in a box and shredded.

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.