General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ronchetti Pharmacy, 617-619 Hertford Road, Enfield, EN3 6UP

Pharmacy reference: 9011200

Type of pharmacy: Community

Date of inspection: 18/11/2024

Pharmacy context

This pharmacy is located on a busy high street in the town of Enfield. It sells medicines over the counter. And it provides some NHS services such as the Pharmacy First service and the Flu and Covid Vaccination service. The pharmacy also provides a private travel vaccination service. It dispenses NHS and private prescriptions. And it supplies medicines in multi-compartment compliance packs for some people. The pharmacy provides a prescription delivery service for people who cannot get to the pharmacy.

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

Overall, the pharmacy manages risks associated with its services well. It has written procedures for team members to follow to help them work safely. And it protects people's confidential information. People can provide feedback or complain to the pharmacy. And it keeps the records it needs to by law. The pharmacy records mistakes it makes to try and learn from them. But it could do more to show what actions have been taken from the learnings.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs) for team members to follow. These were last reviewed in January 2024 by the superintendent pharmacist (SI). Team members had signed relevant SOPs for their role. And they were provided with time to go through the SOPs whenever they were updated to ensure they understood any changes. The team was clear on what activities it could and could not complete in the absence of the responsible pharmacist (RP).

Near misses (mistakes that were identified and corrected before being handed out) were recorded onto a paper log. The RP explained that the pharmacist who identified the mistake would make the record of it. This was then discussed with the team member who made the mistake to understand the root cause. The pharmacist explained that near misses were usually reviewed by the SI but he could not show any recent actions that had been taken. The pharmacist said he would review this going forward. The pharmacy had a recent dispensing error (a mistake which had been handed out). The second pharmacist, who also regularly worked as the RP, described the actions that were taken to rectify the mistake. And that team members had since reduced the number of baskets that were placed on the checking bench to reduce the risk of a similar mistake happening again.

The RP notice was displayed prominently and showed the details of the RP on duty at the time of the inspection. And the RP record was completed as required with start and finish times. The pharmacy had indemnity insurance to cover the services it provided. It kept private prescription records electronically; some records seen contained the incorrect prescriber. The RP and second pharmacist said they would ensure this was completed correctly going forward. Controlled drugs (CD) registers were kept in order and balance checks were completed regularly. A random balance check of two CDs showed no discrepancies between the physical quantity and the recorded balance in the register. The pharmacy kept records of patient-returned CDs and these CDs were disposed of appropriately. Records of supplies of unlicensed medicines were also kept with the required details.

The pharmacy had a complaints procedure. People could give feedback to the pharmacy in person or over the phone. The pharmacist explained they would try and resolve complaints locally but any complaints that required escalation would be referred to the SI who would take the necessary actions to resolve them. Confidential waste was kept separately and shredded. And assembled prescription bags awaiting collection were stored in the dispensary and so were not visible to people using the pharmacy. Team members had signed confidentiality agreements for the pharmacy.

Team members understood how to identify a vulnerable person who may need support. And both pharmacists present had completed level 2 training about safeguarding children and vulnerable adults. Details of the local safeguarding team and safeguarding policies were available in the SOP folder.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough appropriately trained team members to manage the pharmacy's services effectively. And they work well together to manage the pharmacy's workload. Team members feel comfortable about giving feedback or raising concerns they may have.

Inspector's evidence

There was the RP, a second pharmacist, five dispensing assistants, three medicines counter assistants (MCAs) and a work experience student present during the inspection. All permanent pharmacy team members had completed accredited training relevant to their roles. The pharmacy also had two delivery drivers who delivered prescriptions to people's homes. Team members were observed to be working well together and the pharmacist said the staffing was sufficient to manage the workload. No backlog of work was seen. The pharmacy usually operated with two pharmacists and there were enough team members to manage any absence. The MCAs were observed dealing with queries from people using the pharmacy appropriately. When asked, one MCA correctly described how she would make a safe sale of a medicine over the counter. And she was aware of the medicines which were liable to misuse. She said if she was concerned about a person repeatedly trying to purchase these medicines, she would refer them to the pharmacist for additional advice.

Team members did not get regular, formal training time. But one dispenser explained that team members were given time to read any updates provided by the SI. The pharmacy also received pharmacy publications which team members were able to look at to help keep their knowledge up to date. The RP and second pharmacist had completed the necessary training for the NHS services offered, such as the Pharmacy First service. And they had both completed training to be able to provide the private travel vaccination service.

Team members said they were comfortable about providing feedback or raising any concerns they may have. And they felt supported in their roles. Team members were not pressured to meet any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are kept secured from unauthorised access. And they are kept clean and tidy. The pharmacy has a suitable consultation room so people can have a conversation in private if needed.

Inspector's evidence

The pharmacy premises consisted of a spacious retail space and a relatively large dispensary. It projected a professional image and was kept clean by team members. It was bright and all fixtures and fittings were well maintained. And medicines were stored neatly on the shelves in the dispensary. Pharmacy-only medicines were stored behind the pharmacy counter. The lighting and temperature were adequate for working and storing medicines. And there was a clean sink in the dispensary with hot and cold running water.

There was a small room at the rear of the dispensary used for storing excess stock. And there was a small kitchen area for staff use. There was also a clean WC with handwashing facilities.

The pharmacy’s consultation room was accessed from the retail area. It was large and there was enough space to provide pharmacy services safely. The pharmacy was using part of the room to store medicines waste and pharmacy consumables, but the contents of the boxes could not be seen by people using the consultation room. No confidential information was visible in the room. And it was sufficiently private so conversations could not be heard from outside.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people with different needs. And it provides its services safely and effectively. It obtains its medicines from licensed wholesalers and stores them appropriately. Team members ensure medicines are suitable for supply including by actioning drug alerts and recalls. The pharmacy does not always highlight higher-risk medicines on prescriptions so it may miss opportunities to provide additional information to people receiving these medicines.

Inspector's evidence

The pharmacy had step-free access from the pavement. And it displayed its opening times and services clearly in the window. There was enough space for wheelchair users or those with pushchairs to enter the pharmacy to access its services. And there was seating available for people wanting to wait. The pharmacy was able to print larger font labels people who were visually impaired. And there were leaflets providing information about a range of health conditions available for people to read and take away.

Team members used baskets to dispense prescriptions into. This helped to prevent medicines from being mixed up. Larger baskets were available for prescriptions containing a larger number of items. There were separate areas in the dispensary for dispensing and checking prescriptions. Dispensing labels on assembled prescriptions were seen to contain the initials of the dispenser and checker to maintain a clear audit trail. A separate workbench to the back of the dispensary was used to dispense multi-compartment compliance packs. These were prepared within the week of them being required. One pharmacy team member was generally responsible for ordering the prescriptions for these and liaising with the surgery if there were any queries. Once all queries were resolved, another dispenser would prepare the packs. Prepared packs were checked by the pharmacist as soon as they were ready and then sealed. Labels were seen to contain the required warnings and drug descriptions to help people identify their medicines. And patient information leaflets were supplied with the packs monthly.

Medicines that required delivery were recorded onto a log. Deliveries containing fridge items or CDs were highlighted. The driver would record the time the deliveries were made, and this could be seen by the pharmacy on the system. The driver would obtain a signature for the delivery of a CD on a template provided by the pharmacy. Any failed deliveries would be brought back to the pharmacy and a note would be left for the person. The pharmacist explained they would usually attempt delivery a couple more times before contacting the person.

The pharmacy had the required signed patient group directions (PGDs) to safely provide the NHS Pharmacy First service and the flu and Covid vaccination services. And valid PGDs were seen for the other private services the pharmacy provided, such as travel vaccinations. Consultation records were maintained appropriately.

The pharmacy obtained its medicines from several licensed wholesalers. And it stored medicines in a tidy and organised way on the shelves. The team carried out date checking regularly, and records were seen to show this. Short-dated stock was labelled with a highlighted sticker showing the expiry date. A random check of stock on the shelves showed no expired stock amongst in-date stock. Medicines requiring cold storage were kept in two large fridges. And fridge temperature checks were carried daily

and were seen to be maintained in the required range. Medicines waste was stored separately awaiting collection for safe disposal.

Team members did not always highlight prescriptions containing higher-risk medicines such as lithium and warfarin. The pharmacist explained they would highlight prescriptions if people were taking these medicines for the first time, so they were given appropriate advice to take their medicine safely. And sometimes the dispensing system would print an additional 'high-risk medicine' label. But if they had been taking these medicines regularly, the pharmacy would not usually provide any additional advice to people. He said he would review this going forward. The team was aware of the guidance about supplying medicines containing valproate. Team members would ensure these medicines were supplied in their original packs and dispensing labels did not cover important safety information on the box. The pharmacy did supply some people valproate-containing medicines in multi-compartment compliance packs. The pharmacist was unsure whether risk assessments had been carried out for this but said he would check and ensure these were completed. The pharmacy received drug alerts and recalls via email to the pharmacy's shared mailbox. These were seen to be printed off and signed by team members once they had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. Team members maintain the equipment so it is safe to use. And they use it in a way which protects people's personal information.

Inspector's evidence

The pharmacy had several computers in the dispensary and one in the consultation room. All computers were password protected to prevent unauthorised access. And they were positioned so sensitive information on the screens was not visible to people using the pharmacy. Team members could access online resources, such as the British National Formulary (BNF) if needed. The pharmacy had two large fridges which had enough space for storing medicines requiring cold storage. And the CD cupboards were secured. The pharmacy had cordless phones so phone calls could be taken in private if required.

The pharmacy had suitable clean, glass, calibrated measures in various sizes for preparing liquid medicines. And there were clean tablet counting triangles available. The pharmacy had the necessary equipment for providing the NHS Pharmacy First service, such as an otoscope and tongue depressors.

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.