

# Registered pharmacy inspection report

**Pharmacy Name:** Eden Pharmacy, 79-85 Goodmayes Road, ILFORD,  
Essex, IG3 9UB

**Pharmacy reference:** 1031270

**Type of pharmacy:** Community

**Date of inspection:** 28/11/2022

## Pharmacy context

The pharmacy is located within a parade of shops on a main road close to a station. The pharmacy provides a range of services, including the New Medicine Service and flu vaccinations. It also supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. The pharmacy also provide the Covid vaccination service.

## Overall inspection outcome

✓ **Standards met**

**Required Action:** None

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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy's working practices are generally safe and effective. People who use the pharmacy can give feedback on its services. The pharmacy mainly keeps the records it needs to by law so that medicines are supplied safely and legally. And the pharmacy team knows how to help protect the welfare of vulnerable people. It protects people's personal information appropriately. Team members respond appropriately when mistakes happen during the dispensing process.

### Inspector's evidence

Standard operating procedures (SOPs) were available and team members had read and signed SOPs which were relevant to their roles. Team roles were defined within the SOPs. SOPs had not been reviewed for some time and the responsible pharmacist (RP) provided an assurance that she would ask the superintendent pharmacist (SI) to review these.

The pharmacy recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). All team members were required to initial the dispensed and checked by boxes on labels to ensure it was easy to identify who had been involved in the dispensing process. When a near miss was identified it was handed back to the dispenser who was asked to identify their mistake and correct this. A record was made on the near miss log. If the pharmacists spotted that people were making the same mistake or certain mistakes were happening repeatedly, they tried to separate items on the shelves and gave an example of having done this for the different strengths of Betmiga. Dispensing errors were investigated, and a root cause analysis was carried out. An incident report form was also completed. The RP said there had not been any reported dispensing incidents recently.

There were two RP notices displayed at the start of the inspection and both were incorrect. Both notices were removed, and a correct 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 complaint procedure. Where possible the RP tried to handle any complaints in store. Team members described that feedback was generally positive.

Records about private prescriptions, emergency supplies, controlled drug (CD) registers, unlicensed medicines dispensed, and RP records were generally well maintained. However, some pharmacists were not signing out of the RP record and some emergency supply records seen did not always have the reason for supply recorded. CDs that people had returned were recorded in a register as they were received. A random check of a CD medicine quantity complied with the balance recorded in the register.

Assembled prescriptions were stored in the dispensary and people's private information was not visible to others using the pharmacy. An information governance policy was available, and SOPs were available relating to patient confidentiality which team members had read and signed. Relevant team members who accessed NHS systems had smartcards. Pharmacists had access to Summary Care Records (SCR) and consent to access these was gained verbally. Confidential paperwork and dispensing labels were segregated in a separate basket and shredded.

Both pharmacists had completed the level three safeguarding training and most team members had also completed training about safeguarding. Team members were aware of where to refer concerns. The RP had the NHS safeguarding application downloaded on her phone.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough team members to dispense and supply its medicines safely, and they work effectively together and are supportive of one another. Team members are given some ongoing training to keep their knowledge and skills up to date.

### Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP, a trainee dispenser, a foundation trainee pharmacist and two medicines counter assistants (MCA). The SI who was not present at the inspection worked at the pharmacy regularly. The RP felt that there was an adequate number of staff. The team were up to date with their workload.

Previously, staff performance was managed through an appraisal system. It was now done more informally, and team members were provided with feedback on an ongoing basis. The team described that there was an 'open door policy' and they felt able to discuss matters as they arose as well as share concerns, feedback, or suggestions.

The RP planned to help the SI with training for team members. She was in the process of completing the training on inhaler technique for team members and once she had briefed them would ask them to complete the CPPE training module. Representatives from different manufacturers visited the pharmacy and provided team members with information on different products as well as leaving literature. The MCAs then briefed the rest of the team on what they had learnt. Team members completing formal training were provided with training time. The trainee pharmacist was enrolled on a structured training programme with a third-party provider as part of which she attended face-to-face or virtual training days. Team members would speak to one of the pharmacists if they needed help with any parts of their training.

As the team worked closely together there were no formal meetings and issues were discussed as they arose. There were no numerical targets for services provided.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises provide an appropriate environment to deliver its services from. And its premises are suitably clean and secure.

### Inspector's evidence

The pharmacy was clean and spacious. The dispensary was narrow but long. Workbench space ran along the length of the dispensary. This was generally clear and organised. Cleaning was carried out by team members in accordance with a rota. A clean sink was available for the preparation of medicines.

The pharmacy had a large clean consultation room which was easily accessible. The room allowed a conversation at a normal level of volume to take place inside and not be overheard. A film had been added to the glass windows and doors for privacy. The owners had renovated the room when they had taken over the business. The room temperature was adequate for providing pharmacy services and storing medicines safely. Air conditioning was available to help regulate the temperature. The premises were secure from unauthorised access.

## Principle 4 - Services ✓ Standards met

### Summary findings

People can access the pharmacy's services. The pharmacy has some systems in place for making sure that its services are organised. It orders its medicines from reputable sources and largely manages them properly. However, team members do not always refer to the prescription when they are assembling compliance packs. And this could increase the chance that a mistake is made.

### Inspector's evidence

The pharmacy was easily accessible; there was a ramp outside, and the pharmacy had double doors. Aisles were wide and allowed easy access to the medicines counter. Services were appropriately advertised to the public. Team members knew what services were available and described signposting people to other providers where needed. The pharmacy previously received lots of queries about travel vaccinations and Covid vaccinations before it had started providing these. And the team had referred people to other nearby pharmacies that provided those services. The pharmacy team members were able to produce large print labels if needed. The local area was diverse, and most members of the team were multilingual and between them spoke the languages mainly spoken locally.

The RP felt that when the minor ailments service had been available it was very useful and had been used widely as there were many people locally who were eligible for free treatment. With the new Community Pharmacy Consultation service (CPCS), although the team was able to recommend products, people would often go back to their GP for a prescription as they would not have to pay. The emergency contraception service was useful for the younger population. The Covid vaccination service had not really taken off at the pharmacy.

There was an established workflow for dispensing prescriptions. Prescriptions were taken in at the counter by the MCAs and left in a designated area; they also notified the dispensers when prescriptions were placed there. Prescriptions were then dispensed by the dispenser or trainee pharmacist and checked by the pharmacist on the designated checking bench. More prescriptions were now received electronically, and MCAs asked people their names and date of birth and this was recorded and left in the waiting area. The RP mentioned that dates of birth were always taken as there were several people locally with similar names. It was rare that the RP had to self-check. Dispensed and checked-by boxes were available on labels, and these were used routinely to create an audit trail. Baskets were used to separate prescriptions, preventing transfer of items between people.

The RP was aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. Ensuring warning signs were not covered was discussed with the team. Additional checks were carried out when people collected medicines which required ongoing monitoring. People's yellow books were checked when they collected their warfarin, but this information was not recorded.

Some people's medicines were supplied in multi-compartment compliance packs. The pharmacy had a table which was used to track when people were due their medication. The dispenser usually ordered prescriptions a week in advance and stock was ordered at the same time. Packs were usually prepared in advance of receiving the prescription. Paper records were checked against the electronic record before the packs were prepared. Once prepared they were left unsealed until the prescription was

received, and the RP could check. If there were any changes these were made, and a new backing sheet was prepared. The dispenser agreed to speak to the surgery to request if prescriptions could be ordered earlier to ensure prescriptions were available in advance of packs being prepared. The team also provided assurance that packs would be sealed as soon as they were prepared. If someone was admitted into hospital, the pharmacy usually received a call from the hospital pharmacist. A note was made on the record to notify other team members. Discharge summaries were not usually received unless the person brought their copy in. Assembled packs were labelled with product descriptions and mandatory warnings. Patient information leaflets (PILs) were not routinely supplied; the dispenser agreed to ensure these were provided monthly.

Covid vaccinations were provided by either the RP or SI. The pharmacy used the national protocol to provide the service. The pharmacy had been able to provide the service for two weeks prior to the inspection but had not yet vaccinated anyone. The pharmacy had originally planned to provide vaccinations on an appointment basis, but it had recently been added to the 'Grab-a-jab' list and could also provide vaccinations on a walk-in basis. Information about this service was displayed outside the pharmacy to inform people.

Deliveries were carried out by one of the MCAs. Signatures were not obtained when medicines were delivered, and this was to help infection control. Schedule 2 or 3 CDs were not delivered. If someone was not available, medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers. Medicines were organised on shelves in a tidy manner. Some tablets in loose foil blisters and not in an outer container were seen stored on shelves and some medicines were stored in brown bottles without any indication of expiry dates or batch numbers. The RP provided an assurance that these would not be used, and she would brief the team about storing stock correctly. Fridge temperatures were monitored daily and recorded and records seen showed that the temperatures were within the required range for storing medicines. CDs were held securely.

Expiry date checks were carried out monthly by team members. Short-dated stock was highlighted. No date-expired medicines were found on the shelves checked. Out-of-date and other waste medicines were kept separate from stock and were generally stored securely and then collected by licensed waste collectors. Drug recalls were received via email. Drug recalls were actioned, and the alert was then printed and filed to create an audit..



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean.

### Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment. However, plastic measures were also available. The RP provided an assurance that these would not be used in future. Separate labelled measures were used for liquid CDs to avoid contamination. Equipment was clean and ready for use. A medical fridge of adequate size was available. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. There was a machine on the shopfloor which could be used by people to measure their height, weight, and blood pressure. This was provided by an external company who also maintained and calibrated the machine.

### 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.