General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Norlington Chemist Ltd, 3 Broadway Market, LONDON, E8 4PH

Pharmacy reference: 1040083

Type of pharmacy: Community

Date of inspection: 04/12/2023

Pharmacy context

This pharmacy is located on a local high street in East London. The pharmacy mainly serves the local community and provides NHS services such as dispensing and the New Medicine Service. It also provides medication in multi-compartment compliance packs to people who live in their own homes and need help managing their medicines. And it provides a private face-to-face prescribing service.

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	1.1	Standard not met	The pharmacy does not always identify or manage the risks associated with all its services. It does not have suitable risk assessments for its prescribing service.
		1.2	Standard not met	The pharmacy does not properly review or monitor risks associated with its prescribing service.
		1.6	Standard not met	The pharmacy does not keep all the records it needs to correctly. This includes records for controlled drugs and the 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	Some pharmacy team members are not suitably trained or enrolled on training courses appropriate for their role.
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 services safely. It does not maintain clear records for its prescribing service and has limited processes in place to safely supply higher-risk medicines.
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 services, particularly its prescribing service and the management of its controlled drugs. The pharmacy's record keeping is poor. It does not ensure its records are kept up to date and accurate, including its controlled drug records. And it cannot demonstrate that it keeps appropriate consultation notes for its prescribing service. It cannot always produce private prescriptions it has dispensed. The pharmacy does not appropriately monitor the safety and quality of its prescribing service, for example by undertaking regular clinical audits. The pharmacy does not adequately protect people's personal information, which may increase the likelihood of sharing sensitive information.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which had been prepared in January 2023. Members of the team had not signed the relevant SOPs to confirm that they had read and understood them. A member of the team said she was currently in the process of reading them, although she had been working at the pharmacy for over a year. The locum dispenser had not read the SOPs although she had been covering shifts at the pharmacy since summer 2023.

A logbook was available to record dispensing mistakes identified before the medicine was handed to a person, known as near misses. The superintendent pharmacist (SI) said that the log was reviewed every few months. Team members said they were not always involved with the review process or informed of near misses unless they were involved in making them. Dispensing errors which had reached a person were documented on a paper form. The SI said that the pharmacy had separated two medicines with similar names on the shelves following a dispensing error. The SI was not aware of the 'Learning from Patient Safety Events' platform to report dispensing errors. She said that she would look into it.

The pharmacy had indemnity insurance in place. The responsible pharmacist (RP) notice was not visible to members of the public. Its location was changed during the inspection. The RP record was not always completed in line with requirements as the pharmacists were not routinely signing out of the RP record. Samples of the private prescription record were seen to have the incorrect prescriber details. Emergency supply records did not include the reason why an emergency supply had been made. The controlled drug (CD) registers were disorganised as several CDs had more than one open register running at the same time, making it difficult to find the relevant one. Some entries had not been made for some time and had not been made on the day or the following day, in line with the requirements. The address of the supplier was not recorded in the registers when entering stock in, and some information was obliterated either by crossing out or using correction fluid.

The SI and a second pharmacist were both present during the inspection. The second pharmacist was also a prescriber and provided a private prescription service. From the records seen, the number of prescriptions recently issued as part of this service was relatively low, around five to ten a month. A sample of private prescription records were checked, and they indicated that the pharmacist had prescribed zopiclone tablets and antibiotics to patients. The record also indicated that he had prescribed three medicines to a person in November 2023. The second pharmacist said that the incorrect prescriber had been selected on the record, but could not provide a copy of the prescription. And the pharmacy was unable to produce the prescription when asked to do so following the

inspection. The second pharmacist said that he followed local guidance as well as the Royal Free Hospital guidance when prescribing antibiotics, mainly for urinary tract infections. He explained that he also used the World Health Organisation pain ladder when initiating medication for neuropathic pain. The second pharmacist could not produce any consultation notes for the prescribing service. He added that he usually made notes on paper but would be changing to an electronic system in the near future. The second pharmacist confirmed that he had not conducted risk assessments or undertaken any audits about the prescribing service.

Team members said that they had received in-house training on information governance and protecting patient confidentiality. Some team members were not aware of the General Data Protection Regulation. The member of staff covering the medicines counter was observed asking people to write their name and date of birth when collecting their medicine. Medicines awaiting collection were stored close to the medicines counter and people's details were accessible and visible to members of the public. The second pharmacist said that a barrier was previously placed to keep people behind the counter, but this had been removed. Confidential waste was collected in a separate basket and shredded. Computers were password protected and smartcards were used to access the pharmacy's electronic records, but smartcards were seen to be shared. It had also been observed during a recent previous visit to the pharmacy that a person who didn't work for the pharmacy had entered the dispensary where people's personal information was visible.

The pharmacy previously conducted annual patient satisfaction questionnaires to seek feedback. People were able to give feedback or raise concerns verbally or online.

Some members of the support team had not completed training on safeguarding children and vulnerable adults and were not aware of the local safeguarding team. The assistant covering the medicines counter said she would raise any concerns to the pharmacist or SI. She described a safeguarding concern which had been raised with the person's GP.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always make sure that its staff do the appropriate training for their roles. Team members complete some training as and when possible, but there is limited structure to their training. This may make it harder for them to keep their skills and knowledge up to date and relevant.

Inspector's evidence

At the time of inspection, the pharmacy was initiallty staffed by the SI, an assistant and a locum dispenser. A second, regular pharmacist, joined the inspection later. A medicine counter assistant (MCA), a trainee MCA and a dispenser were on unplanned absence on the day of the inspection. Team members said that annual and emergency leave was usually covered by locum staff, though not on this occasion.

The assistant, who was covering the counter, had started working at the pharmacy over one year ago. She was involved in selling Pharmacy-only medicines (P-medicines), dispensing prescriptions, assembling multi-compartment compliance packs, carrying out expiry date checks and handing out dispensed medication. She had not been enrolled onto a suitable training course. She was still in the process of reading the current SOPs although they were dated January 2023. The locum dispenser had been working a few days a week since the summer. She was mainly involved in dispensing walk-in and repeat prescriptions. She was also in the process of reading the pharmacy’s SOPs.

The second pharmacist explained that his prescribing area of expertise was pain and mental health and said that he would generally initiate medication for these conditions. He had specialised in pain management when completing his Pharmacist Independent Prescriber course. When asked for evidence of additional training, he provided a CPPE certificate for a 'consulting with people with mental health' training module.

The assistant asked several questions before selling P-medicines, for example, she checked if person suffered from asthma or was taking any other medicines before selling anti-inflammatory tablets. She said that she had received some in-house training and had been provided with training books belonging to previous team members. She added that team members were informed of any updates,

for example, product recalls or changes to medicine classification.

Informal one-to-one performance reviews were conducted with the pharmacist. Team members said that they were asked for feedback during team meetings which were generally held every two to three months. As a result, some changes had been implemented, for example, the prescription filing system had been changed. Sales targets were set for the team, but they did not feel these affected their professional judgment in any way.

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 took up one shop unit. It had a clean and tidy retail area. A cushioned bench was available at the centre of the retail area for people wanting to wait for a service. A spacious consultation room was available with two doors, one leading to the medicines counter and another to the retail area. The dispensary was located to the back of the shop and was relatively small, with limited workspace. Workbenches were cluttered with paperwork and part-dispensed prescriptions but there was just enough clear space to dispense medicines. A staff room with kitchenette was located beside the dispensary. There was an office and spacious storage area in the basement. The premises were cleaned daily by a cleaner. A cleaning log was displayed but it was not filled in.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always provide its services safely. It does not always label its dispensed medicines in line with legal requirements. And as described under Principle 1, there are risks with the pharmacy's prescribing service which are not being appropriately managed. The pharmacy does not always highlight prescriptions for some controlled drugs, which could increase the chance of the medicines being handed out when the prescription is no longer valid. The pharmacy obtains its medicines from reputable suppliers but it does not always store them securely. People with a range of needs can access the pharmacy's services.

Inspector's evidence

Access into the pharmacy was step-free and team members said they helped people in when needed. Some members of the team were multilingual, and described using a translation application to help provide information to people who did not speak English. There were several posters on the window as well as a television screen to promote services.

Instalment supplies for certain CDs were supplied in bottles with labels handwritten by the SI. But the labels did not include all the required information and the writing on them was not clear. The SI explained that they would enter the prescription onto the patient medication record (PMR) system after supplying the instalment with the handwritten label. The risks of this practice had been discussed with the SI during a visit to the pharmacy the previous week but the SI had not implemented any changes to ensure that instalments were labelled in line with requirements.

The assistant, who was involved in dispensing, said that she had been informed about the MHRA guidance on sodium valproate, but had not read it. She said she would always refer prescriptions for this medicine to the pharmacist. She was not aware of the need to dispense valproate in its original pack and all members of the team, including both pharmacists, could not describe the 'at-risk' group accurately. The assistant was not aware of the updated guidance for Isotretinoin or how she could access it.

The multi-compartment compliance pack service was generally well managed. The pharmacy used the PMR system to keep track of repeat prescription orders to help ensure they were ordered in a timely manner. Team members checked prescriptions against backing sheets before assembling the packs. Drug descriptions were provided on the backing sheets, but patient information leaflets were not routinely supplied. This meant that people or their carers did not access to up-to-date information about their medicine. Assembled packs were bagged and stored in the basement. However, prescriptions were not retained with the bags, which meant that team members were relying solely on bag labels when handing these out.

Higher-risk medicines awaiting collection, such as Schedule 3 and 4 CDs, were not highlighted in any way. A prescription for Gabapentin, dated September 2023 and therefore expired, was still on the shelf awaiting collection. Pregabalin capsules, which had been labelled in July 2023, were also on the shelf, without a prescription attached. The assistant, who was involved in handing out dispensed medication, did not know how long prescriptions for these medicines were valid for.

Medicines were generally stored appropriately. But there were some dispensed medicines in bags which were awaiting collection which were stored on shelves. And these bags were easily accessible from the public area. Expiry date checks of stock medicines were carried out by members of the dispensing team as well as the assistant. A record was displayed in the dispensary and showed that expiry date checks had been conducted in June 2023 and October 2023, however, several date-expired medicines were found on the shelves, including a medicine that had expired in May 2023. Previous date checking records could not be supplied during the inspection. The fridge temperature was monitored and recorded daily. The pharmacist said that alerts and recalls were received from the MHRA electronically and actioned, but records were not maintained to confirm this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had two plastic measures and a tablet counter. The SI said she would order glass measures. Computers were password protected and were out of view of people. There was one fridge in the dispensary though it was packed with stock. Waste medicine bins were used to dispose of waste medicines and were stored appropriately. Staff had access to up-to-date reference sources.

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.