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: 31/07/2024

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 need help managing their medicines. The superintendent pharmacist (SI) is an independent prescriber and provides a private face-to-face prescribing service. This was a reinspection following an inspection in December 2023 where the pharmacy was found to have not met several standards.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan; Statutory Enforcement

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 follow its own prescribing procedure when providing its prescribing service. And it does not always follow the mitigation steps specified in its risk assessment. Its risk assessment is not comprehensive and does not identify all the relevant risks associated with the prescribing service.
		1.6	Standard not met	The pharmacy does not keep all the appropriate records necessary to demonstrate that its prescribing services are provided safely and effectively.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not always make the appropriate checks to ensure that its staff do the right training for their roles.
		2.2	Standard not met	The pharmacy's prescriber cannot adequately demonstrate that they are working within their competency for certain conditions, where prescriptions had been issued.
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 service safely. It prescribes some medicines liable to misuse and does not have the appropriate safeguards to show that it can supply them safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy's risk assessment for the prescribing service is not comprehensive, and it does not always follow it. And it does not always follow its own prescribing procedure. The pharmacy does not keep all the records it needs to, particularly in relation to its prescribing service. Taken together, these increase the risks to people using the prescribing service. However, the people using the pharmacy's services can easily provide feedback. Team members protect people's information well and have the relevant training to safeguard the welfare of people using their services. When a dispensing mistake happens, team members respond adequately. But they do not always record any mistakes, which could make it harder to review them and identify any patterns or trends. The pharmacy has written procedures to help team members understand their responsibilities and how to carry out activities. But some team members have not read them.

Inspector's evidence

Written standard operating procedures (SOPs) were in place and some team members had signed the ones relevant to their role to indicate that they had read them. On the day of the inspection the pharmacy was operating with two locum dispensers and a medicines counter assistant (MCA), all of whom had not read the SOPs. The SOPs had last been reviewed in 2023. Team members could explain their roles and knew when to refer to the responsible pharmacist (RP). When asked, team members knew what activities could and could not be done in the absence of a pharmacist. The superintendent pharmacist (SI) gave assurances that all staff who had not read the SOPs would be asked to read them and sign to confirm their understanding.

The pharmacy did not have its prescribing policy available during the inspection. So, it was not always available in the pharmacy to refer to if needed. A prescribing SOP was sent by the SI following the inspection. The prescribing SOP was lacking in detail and did not include information about the areas of prescribing, or details about which guidance was being followed. And the SOP said that detailed records should be maintained about consultations, prescriptions, and medication supplies. There was evidence that the prescribing SOP was not being followed. For example, training records were not always maintained for some medical conditions that the SI was prescribing for, and the pharmacy was not always maintaining detailed records of consultations with people.

The pharmacy could not produce the risk assessment for its prescribing service during the visit, and it was sent to the inspector following the inspection. The risk assessment did not adequately address some potential risks in detail such as how the pharmacy obtained consent, identity checks, keeping records of consultations, monitoring of parameters (if necessary), safeguarding for people prescribed medications with the potential for misuse, and counselling. The control measures for the risks that had been detailed in the risk assessment were not seen to be followed. For example, the pharmacy could not sufficiently demonstrate that prescribers were prescribing within their own competence, and improvements detailed in the clinical audit had not been implemented within 28 days of the audit findings. The SI had conducted a clinical audit following the previous inspection in March 2024, however they felt that they did not have sufficient records to complete a follow up review. They explained they were planning on conducting another audit at the end of the year. Although the numbers of prescriptions issued were relatively low, as described below there was a lack of detailed consultation records. And this may make it difficult for the pharmacy to complete a full audit and

identify areas for improvement.

Logs were available to record dispensing mistakes that were identified before reaching a person (near misses), however the last entry was from March 2024. The previous superintendent who was a non-practicing pharmacist said that near misses were usually recorded by the pharmacists when checking prescriptions and discussed with the team member who dispensed the medication at the time the mistake occurred. But they explained that only the mistakes deemed serious were recorded. The last review of near misses was completed in August 2023. There had been some reported dispensing mistakes which had reached the person (dispensing errors), with the last recorded error being in September 2023. The non-practicing pharmacist described the steps that the team would take in the event that a dispensing error occurred, which included identifying the cause and speaking to the person who had received the error. An incident form was also completed, however, the pharmacy did not report these to the NHS 'learn from patient safety events' (LFPSE) service. The non-practicing pharmacist said that the team would report a dispensing error to a person's GP if they had taken the wrong medication or dose.

The SI was the RP on the day of inspection and the correct RP notice was visible to the public. The RP record was held electronically, it was mostly completed correctly but finish times were not always recorded. Records about unlicenced medicine supplies contained the required information. Records about emergency supplies and private prescription records did not always have the appropriate details recorded. And this may mean that this information is harder to find out if there was a query.

A random physical check of two controlled drugs (CDs) matched the balance recorded in the register. The SI was aware of the need to obtain authorisation from the controlled drugs accountable officer (CDAO) to destroy expired medications. And these medications were separated in a different CD cupboard.

According to the prescribing software that the pharmacy used, the SI had issued eight private prescriptions since February 2024. The clinical records about the prescriptions the SI had issued were largely incomplete and lacking in important details. Most of the records seen did not include information about the symptoms, differential diagnosis, medical history, or advice and counselling provided. On the previous inspection the pharmacy could not produce any consultation notes for the prescribing service, demonstrating that sufficent improvements had not been made.

There were additional entries in the private prescription record with the SI as noted as the prescriber. There were no corresponding prescriptions found. And the SI was not able to offer an explanation as to why those entries had been made. The SI could not provide any clinical records for these additional entries found in the private prescription record.

The SI said that they had prescribed hormones on three occasions on the advice of a hormone replacement clinic. They could not recall the clinic name and said that they had received blood tests results and information on the person's symptoms from the clinic by email. They said that reviews were carried out by the clinic. However, the SI did not have access to these reviews. This information was not included in the SI's clinical notes and there was no record about the clinical reasoning for supplying the medicine. The SI was asked to send evidence of information received from the hormone clinic for all such prescriptions issued by them. Following the inspection, the SI sent a copy of the blood test results for two people.

After inspecting a sample of CD registers, it was found that the SI had issued a prescription for a Schedule 2 CD. The SI had not made any clinical records for this supply. They said that they had prescribed this medicine on an FP10PCD form which had since been sent to the relevant NHS body.

They explained that the person had been prescribed a different strength of the same medicine and brand by their GP, but that the medicine had been in short supply. They had therefore prescribed an alternative strength privately as the person was travelling. None of this information was documented. The SI reported it was usual practice for the pharmacy to take copies of the private prescriptions supplied, however a photocopy of the prescription in question was not available.

The indemnity insurance certificate was in date. Feedback or complaints from people using the pharmacy's services could be received verbally in person, by telephone or through the online contact form on the pharmacy's website. If a complaint was received, team members had an SOP to refer to and they could escalate issues to the SI. Annual customer surveys were collected through a third-party company and collated to provide the pharmacy with data for improving services.

Computers were password protected meaning that confidential electronic information was stored securely. Confidential paper waste collected by an external contractor and destroyed appropriately. And patient-returned medicines that were to be sent for destruction had patient details removed. Checked medications that were awaiting collection were stored appropriately to ensure that people's information was not visible from the counter, this was an improvement from the last inspection. The SI said that all team members had completed information governance training and a certificate for the completion of the NHS Data Security and Protection Toolkit (DSPTK) was seen after the inspection, alongside signatures of staff who had completed training under the DSPTK pharmacy policy.

The pharmacy team members understood safeguarding requirements and were able to describe some of the signs to look for and the actions they would take to safeguard a vulnerable person. The SI and one of the locum dispensers had completed level 2 safeguarding training, and other members of the team had completed level 1. The training had been done through either the Centre for Pharmacy Postgraduate Education (CPPE) or elearning for healthcare (e-lfh).

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

Summary findings

The pharmacy does not always undertake the appropriate checks to make sure that its staff do the right training for their roles or that its prescribers work within their competency. Team members have the opportunity to raise concerns if needed. They 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 staffed by the SI, a non-practicing pharmacist, a locum MCA and two locum dispensers. Some regular team members including an MCA, a dispenser and a pre-registration pharmacy technician were on leave. The SI said that staff absences had put pressure on the team. During the inspection, team members were seen to be managing the day-to-day workload of the pharmacy effectively, and there was no significant backlog of work.

The locum MCA had been working at the pharmacy since April 2024 and had not yet completed an accredited training course. They were covering the counter at the time of inspection and were supported by the non-practicing pharmacist in selling pharmacy-only medicines and providing advice. The SI provided evidence following the inspection that this team member was now enrolled on an accredited course. The MCA was able to demonstrate an awareness of medicines with the potential for misuse and could identify people making repeat purchases. They knew the questions to ask when selling medicines or providing advice and knew when to refer to the pharmacist.

The dispenser, not present on the day of inspection, had been working at the pharmacy as a dispenser since December 2022 and had not yet completed an accredited training course for this role. Following the inspection, the SI had been in discussions with this team member around enrolment on an accredited course, however this had not yet been actioned. On the previous inspection the pharmacy had a member of staff who was not appropriately trained. This indicates that the pharmacy did not use a robust system to check that its staff do the right training for their roles.

The SI's explained that their area of prescribing competence was in pain and mental health. They said that they followed NICE guidance when prescribing for these conditions. When asked, they could not provide examples of any additional training they had completed to support their prescribing for hormone replacement or attention deficit hyperactivity disorder. The only evidence the SI provided about additional training they had undertaken was that they had completed a training module about antibiotic stewardship via e-lfh. This training however does not demonstrate sufficient training to prescribe antibiotics.

Informal one-to-one performance reviews were conducted annually where staff were given feedback and were given the opportunity to raise ideas and concerns. Team members that were asked said that they usually kept up to date with new information by looking through the packaging information or leaflet provided with products. But there was no formal structured process for ongoing development of the team. The SI also said that staff had access to the e-lfh resources which they could access in work hours, however there was not regular designated training time.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and generally tidy, with adequate space for providing its services safely. It keeps its premises safe and people visiting the pharmacy can have a conversation with a team member in private. The premises are secure from unauthorised access when closed.

Inspector's evidence

The pharmacy had single door access large enough for people with wheelchairs and pushchairs. It had a clean and tidy retail area, and a cushioned bench was available at the centre of the retail area for people wanting to wait for a service. Pharmacy-only medicines were kept behind the counter. And medications awaiting collection were kept to the side of the medicines counter, with patient identifiable information turned away so that it could not be seen by people in the retail area. The counter had a belt barrier in place to prevent unauthorised access. A suitably sized consultation room was available for providing services, which was accessible from behind the medicines counter and the retail area.

The dispensary was located to the rear of the premises and was relatively small, with limited workspace, but there was just enough clear space to dispense medicines. A staff kitchenette was located beside the dispensary. There was an office and spacious storage area in the basement. The premises were well-lit, and there was air conditioning and small fans available to maintain a suitable temperature for the storage of medicines. Handwashing facilities were available in the dispensary and kitchenette, and a staff toilet with separate handwashing facilities was available in the basement. The pharmacy's website was easy to navigate, with information on the services provided and health advice available.

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

Summary findings

The pharmacy does not always provide its services safely. As described under Principle 1, there are risks with the pharmacy's prescribing service which are not being appropriately managed. And the pharmacy cannot demonstrate that it communicates with people's regular prescribers when prescribing medicines which require additional safeguards. Or makes clear records setting out the justification for prescribing. However, since the last inspection, the pharmacy has improved the way it labels certain medicines. 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

The pharmacy had step-free access which made it accessible to a wide range of people. Large-print labels were available on request. Some team members were multi-lingual and were observed helping people in different languages.

The SI said that they had refused to issue prescriptions in the past but could not provide records about any examples. They explained that face-to-face consultations had been carried out for the prescriptions issued, but said they may consider conducting virtual consultations in the future. Identification checks were not routinely obtained from people unless they were from abroad. The SI said they would consider making these checks to make sure that the person was who they were claiming to be.

The SI said that consent to share information with the person's regular prescriber was obtained, but they did not maintain records of this. A few records were seen on the prescribing system where prescriptions for medicines liable to misuse had been prescribed by the SI. The SI could not provide any examples of when information about medicines he had prescribed had been shared with the person's regular prescriber. And there were not clear records made about the justification for prescribing or not prescribing. The SI said that they obtained verbal consent to check the person's Summary Care Record (SCR) but did not include any information obtained from the SCR to justify their prescribing.

Medicines were sourced from licensed suppliers. The pharmacy team members said that they checked the expiry dates of medicines at regular intervals but did not keep clear records about this. Two medicines expiring at the end of July 2024 were found still on the shelves. Temperature records for the pharmaceutical fridge were completed daily and showed no deviations in temperature outside of the required range of between 2 and 8 degrees Celsius. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier. Drug alerts and recalls were received electronically but the pharmacy did not maintain records of action taken in response to them. So, this could make it harder for the pharmacy to show what it had done in response. The dispenser said that they had actioned a recent alert for atomoxetine capsules.

Team members were observed following the SOP for dispensing prescriptions and baskets were used to keep items for different people separate. Dispensing labels included 'dispensed by' and 'checked by' boxes to indicate who had carried out those tasks. The pharmacy dispensed some medicines in multi-compartment compliance packs for people who needed help to manage their medicines. Packs were assembled, checked and stored in the basement, in a designated area to avoid distractions. 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. A brief description of each tablet or capsule was written inside the compliance pack, alongside any medicine warnings, and patient information leaflets were supplied every month.

Since the last inspection, instalment supplies for certain CDs were supplied with labels generated from the patient medication record (PMR) system. This was an improvement to the handwritten labels that the pharmacy was previously using, and the labels seen on this inspection included all the required information. The dispenser said that for prescriptions that were only valid for 28 days, the pharmacist checking the prescription circled the date. This ensured that the team member handing out these prescriptions was aware of the validity.

Team members were aware of the risks involved when supplying valproate products to people who could become pregnant. They also knew about the guidance to supply these products in complete original manufacturer's packs, and to ensure they didn't cover any of the warnings with dispensing labels. One of the dispensers explained that prescriptions for other high-risk medicines were highlighted on the patient's medication record (PMR), which prompted team members to ask about relevant blood test results, however test results were not recorded on the system.

The pharmacy offered the Pharmacy First service under patient group directions (PGDs). These were printed in a folder for reference along with other supporting resources, all PGDs were in date and signed by the SI who provided the service.

The pharmacy delivered some medicines to a few people who lived close by. There was not a designated delivery driver and team members delivered these within the pharmacy opening hours. They were not required to obtain a signature for receipt of items and medicines were returned to the pharmacy if a person was not home. They did not deliver any Schedule 2 or 3 CDs. There was an audit trail about deliveries made on the PMR system, which showed which people had received deliveries.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use.

Inspector's evidence

The pharmacy used suitable standardised conical measures for measuring liquids and clean triangle tablet counters were available for dispensing loose medication. Separate conical measures and triangle counters were available for certain substances that were marked to avoid contamination. A new otoscope with disposable specula covers was available for providing the Pharmacy First services. There was a blood pressure monitor in the consultation room, the SI said that this was replaced annually, along with the 24-hour ambulatory blood pressure monitors. An in-date adrenaline auto-injector (AAI) and sharps bin were available in the consultation room. A portable telephone helped the team to ensure conversations were kept private where necessary. All computers were password protected to safeguard information, however staff were seen to be using a smartcard which belonged to a team member who was on leave, this was removed when highlighted to the team. A fire extinguisher was available in the kitchenette.

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.