General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Clark's Chemist, 68 Broadway Market, LONDON, E8 4QJ

Pharmacy reference: 1040084

Type of pharmacy: Community

Date of inspection: 30/05/2023

Pharmacy context

The pharmacy is located within a parade of shops in a busy market. People who use the pharmacy are mainly from the local area. The pharmacy supplies medicines in multi-compartment compliance packs to people who need help managing their medicines. It also provides the Community Pharmacist Consultation Service, the New Medicine Service and seasonal flu vaccinations.

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
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's working practices are largely safe and effective. The pharmacy generally keeps the records it needs to by law so that medicines are supplied safely and legally. The pharmacy asks its customers for their views. Team members use the procedures in place to protect vulnerable people. And the pharmacy consistently records and reviews near misses which provides it with opportunities to learn and make the pharmacy’s services safer.

Inspector's evidence

Standard operating procedures (SOPs) were available and team members had read and signed SOPs which were relevant to their roles. In addition to this, the superintendent pharmacist (SI) also discussed key points from SOPs with the team. Some of the SOPs had not been reviewed for some time; the SI said he was due to review these soon.

Dispensing mistakes which were identified before the medicine was handed out (near misses) were corrected and discussed with the team members. A conversation was held with the team member involved in the mistake to discuss how it had happened and if it was due to the medicines 'looking-alike or sounding-alike.' Near misses were recorded on a log and these were reviewed by the SI. Following recent reviews, team members had been asked not to muti-task when dispensing and making sure their mobile phones were off. If team members brought any circumstance to the SI's attentions which could potentially result in them not being able to focus, they were asked if they wanted to take time off. Team members had also been asked to complete training and were asked to read the prescription before dispensing and attaching the label under the name and strength of the medication on the pack. The pharmacy recorded instances where a significant dispensing mistake had happened, and the medicine had been handed to a person (dispensing errors). However, the SI agreed to ensure all future dispensing errors were recorded. The SI would speak to the person as part of any follow-up to a dispensing error. As a result of past errors, medicines with similar names or appearances had been more clearly separated in the dispensing. These included atenolol and amitriptyline, and hydralazine and hydroxyzine. The pharmacy shared learnings from incidents and errors with local pharmacy networks and also between its two branches.

A dispensing SOP flow chart was displayed in the dispensary to remind team members about the correct dispensing process to follow. Prompts were also stuck on the workbenches reminding team members to attach the dispensing label under the name on the pack, to carry out a three-way check, and check expiry dates.

A 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 complaint procedure and team members had read the SOP for dealing with complaints. People usually provided verbal feedback to the team and some people left reviews online. Complaints were discussed with the team members. The SI would get involved if there was an abusive or aggressive incident.

Records about private prescriptions dispensed, RP records, unlicensed medicines and controlled drug (CD) registers were well maintained. CDs that people had returned were recorded on a form held with

the CD registers.

The pharmacy had an information governance policy. The SI said this had been updated with the new amendments, but he was due to review the policy. The information from the policy had been passed on to team members by the SI and team members had completed training on confidentiality and data protection. Relevant team members who accessed NHS systems had smartcards. The pharmacists had access to Summary Care Records (SCR); consent to access these was gained verbally from people. Assembled prescriptions were stored in the dispensary and people's private information was not visible to others using the pharmacy.

All team members including the pharmacists had completed safeguarding training. In addition, the pharmacists had also completed training about suicide awareness and vulnerable adults. Team members would refer any emergency hormonal contraception (EHC) requests particularly those in underage people to the RP. Details for local safeguarding contacts were available; if the SI was unsure, he would speak to the local council or other local pharmacy support contacts.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services it provides. And they do the right training for their roles. The pharmacy supports its team members with ongoing training to help them keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the team comprised of the SI, a second pharmacist who worked part-time, and was the responsible pharmacist (RP). There was also a trained dispenser, two trainee dispensers, a trained medicines counter assistant (MCA) and a trainee MCA. The SI felt that there was an adequate number of staff to cope with the pharmacy's workload.

The second pharmacist was in the process of completing independent prescriber training. The SI was considering offering a prescribing service in the future.

Staff performance was managed informally. Team members were provided with feedback on an ongoing basis and the SI would have a face-to-face conversation with individuals if needed. Team members came together and had a group chat each morning. Team members felt they were able to raise concerns or give feedback. Following feedback from the team, changes had been implemented about how prescriptions were dispensed and handed out and how the telephone was answered. Improvements had also been made in terms of recording near misses, and more space had been made in the dispensary by moving drinks and gluten-free products downstairs. The MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was aware of the maximum quantities of some medicines that could be sold over the counter.

Trainees enrolled on formal training courses were provided with set-aside study time. The SI was their supervisor and other more experienced colleagues also helped. Trainees were set timescales within which period their course needed to be completed. To keep up to date, training linked to NHS schemes and some services was completed. Team members also read through healthy living leaflets and completed quizzes on those. There were no targets set for services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an appropriate environment from which to deliver its services. And its premises are suitably clean and secure. People using the pharmacy can have conversations with team members in a private area.

Inspector's evidence

The dispensary comprised of two adjoining rooms. Space was limited but workbenches had been allocated for specific tasks and there was a designated checking bench. Workbenches were clear and organised. An allocated area had been created in the basement for managing and preparing multi-compartment compliance packs. Cleaning was done by team members. A clean sink was available for preparing medicines. The room temperature was adequate for providing pharmacy services and storing medicines. Air conditioning was available to help regulate the temperature. The premises were secure from unauthorised access.

The consultation room was accessed from behind the medicines counter; access into the basement was from this room. The RP explained that the door leading to the basement was closed when the room was being used. The room allowed a conversation at a normal level of volume to take place inside and not be overheard.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes its services accessible for people. It gets its medicines and medical devices from appropriate sources and generally stores them properly. Team members make the necessary checks to ensure that the pharmacy's medicines and medical devices are safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacy had a small step at the entrance and team members would help people requiring assistance. Some people preferred to wait outside and be served from outside. The SI explained that due to the location the pharmacy was not able to have a ramp. If needed, people were signposted to two or three other local pharmacies. Aisles were clear with easy access to the medicines counter. Services were appropriately advertised to patients. Team members spoke a range of languages. Team members all received emails on their personal NHS accounts of local services, updates from local councils and local support groups and could use this information to help people. Posters were also displayed for local support groups and team members could signpost people to other services such as counselling, diabetic clinic, or to the nearby GP surgery. The pharmacy had the ability to produce large print labels.

The SI expressed the view that the repeat dispensing service benefitted local people the most. He explained that people wanted a service where they did not have to wait, and this service meant prescriptions could be prepared in advance and people would come in and collect.

The pharmacy was a healthy living centre and provided information about different conditions each month. Information leaflets were printed with a quiz at the end. Team members were required to read through these at the start of the month so that they could talk to people confidently. At the time of the inspection the leaflet had information about hearing loss. The pharmacy also played health-related messages and clips on a display screen.

The pharmacy had an established workflow for dispensing prescriptions. People called before collecting their medication, team members checked on the system and the SI explained that the NHS tracker activated immediately on the system. Prescriptions were labelled by one of the team members and then either dispensed by them or another colleague. These were then checked by the pharmacist. As a final step, when a person waited for their prescriptions, the MCA showed them their medicines before placing into a bag. But medicines of a sensitive nature were bagged first on the side. On some occasions pharmacists had to self-check; the SI said this was usually rare but had happened more frequently during the pandemic. Team members recorded and attached any special precautions and notes to the prescription form, such as if the person needed a review or if one of the items was not dispensed. CD stickers were attached to all prescriptions with CDs. Dispensed and checked-by boxes were available on labels, and these were routinely used to create an audit trail showing who had carried out each of these tasks. Baskets were used to separate prescriptions, preventing transfer of items between people.

Prescriptions for sodium valproate were dispensed as per the routine workflow. Team members alerted the pharmacist when these were dispensed and were aware of the labelling requirements. The pharmacists were aware of the guidance for dispensing sodium valproate and the associated Pregnancy

Prevention Programme (PPP). People who were not part of the PPP were referred back to their GP. For people who used the pharmacy regularly the pharmacists checked if they had their reviews and for someone using the pharmacy for the first-time additional checks and counselling was provided. Generic prescriptions were not dispensed until the person came in to collect.

Additional checks were carried out when people collected medicines which required ongoing monitoring. The pharmacists checked that the person had their card/booklet and were following the instructions within these and were aware of side-effects and the symptoms to look out for. The SI said they no longer dispensed 10mg methotrexate tablets following a local alert and the pharmacy had requested all prescriptions to be changed to the 2.5mg strength.

Some people's medicines were supplied in multi-compartment compliance packs. Each person on the service had a master sheet with a record of all their medication; this was used to check all new prescriptions and any changes or omissions were brought to the RP's attention and queried with the surgery. Each person's records and medicines were stored in clear, sealable, labelled bags. Packs were prepared by the dispenser and sealed straightaway. These were then checked by the RP. The pharmacy had purchased a machine to deblister tablets to help team members. Hospitals usually called when people were admitted and prescriptions were put on hold until discharge information was received. Assembled multi-compartment compliance packs seen were labelled with product details and mandatory warnings. Information leaflets were supplied monthly.

Deliveries were carried out by the SI or team members. Signatures were obtained for CDs or when delivering to a multiple occupied location such as a nursing home. Team members were asked to take a photograph of the door or of them handing over medicines when they delivered. If someone was not available when the medicines were delivered, the medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and were organised on shelves in a tidy manner. Fridge temperatures were monitored and recorded daily. These were seen to be within the required range for storing medicines. CDs were held securely. Expiry date checks were carried out by team members, but the pharmacy had not kept any records about this activity since the pandemic. Short-dated stock was marked with stickers. All children's medicines and injectables were checked every three months. One date-expired medicine was found on the shelves spot checked. Dates were checked as part of the dispensing and checking process. Out-of-date and other waste medicines were kept separate from stock and were stored securely and then collected by licensed waste collectors. Drug recalls were received via email. These were actioned straightaway, then printed, stamped and kept for audit. Team members remembered the recall for pholcodine.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had calibrated glass measures. Separate measures were available for liquid CD preparations to avoid cross contamination. Tablet counting equipment was available. Equipment was clean and ready for use. Two medical fridges were available. A portable blood pressure monitor was used for some services, and it was replaced on a regular basis. The pharmacy also had a static blood pressure monitor in the shop area which was supplied by a third party. The SI said this had not been calibrated by the company since the pandemic, but the machine was not used for any clinical services. 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. Confidential waste was 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.