General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dev's Chemist, 103a Dalston Lane, LONDON, E8 1NH

Pharmacy reference: 1040087

Type of pharmacy: Community

Date of inspection: 04/10/2024

Pharmacy context

This pharmacy is located in a residential area in East London. It dispenses both NHS and private prescriptions and provides a range of services. The services it provides include the New Medicines Service (NMS), flu vaccines, blood pressure monitoring service, supervised consumption, the Pharmacy First service and multi-compartment compliance packs for people needing help taking their medicines. It also offers a face-to-face prescribing service, but only a relatively small number of prescriptions are issued.

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 keep appropriate consultation notes about its prescribing service. And although it has a risk assessment, there is evidence that it does not follow it. Taken together, these increase the risks of the service.
		1.6	Standard not met	The pharmacy's consultation notes for its prescribing service do not always have the necessary information recorded.
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 not all met	4.3	Standard not met	The pharmacy does not have robust systems in place to always store its medicines securely and in accordance with legislation.
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 identify and manage the risks associated with its prescribing service. Although it has done a risk assessment, this is not specific to the prescribing service it provides and there is evidence that the pharmacy does not always follow it. And it does not always maintain appropriate consultation notes for this service. The pharmacy manages its other services safely and largely keeps the records it needs to by law. The team members know how to help protect the welfare of vulnerable people. But they do not make records of dispensing mistakes that have not gone out to patients, and this could make it harder for them to learn from these events and to make the pharmacy's services safer.

Inspector's evidence

There were a set of standard operating procedures (SOPs) available, and these were signed by team members. The responsible pharmacist (RP) was in the process of updating the SOPs. The SOPs covered a range of pharmacy activities, outlining the roles and responsibilities of the team. The RP said that he would be asking all team members to read and sign the new SOPs to confirm they had understood them. The name of the RP on duty during the inspection was displayed. The pharmacy had up-to-date professional indemnity insurance.

The pharmacy team did not record mistakes they made during the dispensing process, which were spotted before the medicine had been handed to a person (near misses). This meant team members might miss out on some opportunities to learn and make improvements to the pharmacy's services. The importance of recording and regularly reviewing near misses was discussed. The RP said they had not made dispensing mistakes that had been handed to a person (dispensing errors), but the team could explain what they would do if a dispensing error occurred. The RP said that changes were implemented in SOPs and systems were amended as incidents occurred. The trainee dispenser described how they would deal with a customer complaint. They referred to the pharmacist if a person wished to raise a complaint and the pharmacy had an SOP for dealing with complaints.

The pharmacy team maintained appropriate records about private prescriptions it had received and dispensed. Controlled drug (CD) records were generally well maintained. However, some entries where mistakes were made, were not amended in the correct way. The pharmacy completed running balances in all the CD registers but had not checked these recently. A random check of three CDs showed discrepancies between the physical stock and the recorded balances for two of the products. These were investigated and found to have been a result of duplicate entries. The importance of regularly checking the CD balances was discussed. The pharmacy did not have a patient returns CD register. The RP said they were not accepting CD returns due to limited space. The pharmacy did not have a record for emergency supplies and the RP said they had not made any. If a person required a medication urgently, the pharmacy contacted the GP or referred them to the NHS 111 service. The RP was a prescriber, so he sometimes prescribed the medication if he felt comfortable to do so. He said he sometimes prescribed for long-term conditions such as hypertension and diabetes. And explained that this was done in situations similar to an emergency supply and was provided for people who did not have access to local services and had run out of their regular medication. The RP record was largely well maintained, but there were a few occasions where the RP had not signed out. The importance of maintaining accurate records was discussed. The RP said they did not provide any unlicensed medicines.

The pharmacy offered a prescribing service run by the RP. The RP said that consultation notes were kept for the service, but notes were not found for several prescriptions which had been issued. He also said they had a SOP for the prescribing service, but it wasn't available during the inspection. After the inspection, the pharmacy provided some consultation notes for prescriptions from the past two months, a prescribing policy, and a risk assessment. The RP had issued three prescriptions in the last two months, which were all for antibiotics, one to treat a boil, one for a cough and one for forgotten medication abroad. The consultation notes lacked important details like medical history, observations taken, medical examinations, and red flags. The risk assessment was not specific to the prescribing service the pharmacy provided and did not provide an individualised framework for the service. It did not outline the specific training that had been completed, the medicines the pharmacy provided or the conditions it treated. There was evidence that the pharmacy did not follow the control measures in its own risk assessment, for example by not keeping comprehensive consultation notes.

The pharmacy had an SOP for confidentiality, and this was signed by team members. The pharmacy generally stored confidential information securely and separated confidential waste prior to disposal. Prescriptions waiting for collection were stored in a way that could not be seen by the public.

The pharmacist had completed level 3 safeguarding training. The pharmacy team members had completed level 2 safeguarding training. The trainee dispenser could recognise red flags and said they would report to the pharmacist if they had concerns. Following the inspection, the RP provided an SOP for safeguarding. This also contained contacts for local safeguarding boards.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an adequate number of staff to manage its workload. The team works well together and feels well-supported at work.

Inspector's evidence

At the time of the inspection, the team comprised of the RP, a trained dispenser, and a trainee dispenser. The team also included a trained MCA who was not in at the time. And the owner of the company was a pharmacist who supported when needed. Staff from a sister branch sometimes supported and the pharmacy was in the process of recruiting a dispenser. The pharmacy was up to date with its dispensing. And the RP felt he had enough staff to manage the workload.

The pharmacy offered the Pharmacy First service, which the RP said he had completed training for but evidence for this was not seen at the time of the inspection. Following the inspection, the RP provided training certificates for this service. The pharmacy also offered a prescribing service, where the pharmacist prescribed antibiotics and occasionally blood pressure medicines and medicines for diabetes for people who did not have access to local services in instances similar to an emergency supply. Following the inspection, the pharmacist sent training certificates for his prescribing, which included training in consultation skills and legal prescribing. He also said he had completed antimicrobial and infection control training.

The trainee dispenser knew that there were restrictions on the sale of medicines liable to misuse such as co-codamol and referred to the pharmacist if unsure. The RP carried out weekly meetings to update the team on any changes or new services. Team members had direct access to the superintendent pharmacist and felt comfortable to raise concerns. They also felt supported in their roles and helped each other in their training.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area. But the pharmacy could do more to keep its workbenches free from unnecessary clutter.

Inspector's evidence

The dispensary was located towards the back of the shop and led into a large storage room. Pharmacy-only medicines were stored behind a medicines counter. There were chairs available for people waiting for prescriptions or services. There was enough work and storage space, but some workbenches were cluttered. Fittings had not been updated for some time; this detracted from the overall appearance of the pharmacy. A sink was available for preparing medicines. The room temperature and lighting were suitable for providing pharmacy services.

The premises were secure. A consultation room was available for private conversations and services. The door of the consultation room had some small gaps where sound may get through, but the room was not directly on the shop floor, so people did not stand close to the room. It was only accessible from behind the counter. The room was small and cluttered. A new consultation room was being prepared towards the front of the shop.

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

Summary findings

The pharmacy does not always keep its medicines secure or store them properly. However, it obtains its medicines from reputable sources and otherwise stores them properly. And people can access the pharmacy's services.

Inspector's evidence

The pharmacy had step-free access through the front of the shop. It had an established workflow for preparing prescriptions and multi-compartment compliance packs. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy supplied medicines daily to some people, as supervised and unsupervised doses.

The pharmacy supplied medicines in multi-compartment compliance packs to support people in taking their medicines. The trainee dispenser had a process to help track when the packs were due. The packs were provided with a backing sheet, which included details of the medicines and instructions about how to take them. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines. The backing sheets did not have the warnings required for certain medicines on the labels, but the RP said he would arrange with the software providers to have this added in. Team members highlighted any medicines containing fridge items. The pharmacy did not keep an audit trail of who had dispensed or checked the prescriptions. This would make it difficult to identify what has happened if an error were to occur. The importance of maintaining an audit trail was discussed.

The pharmacy supplied the pharmacy first service and flu vaccination service via patient group directions (PGDs). At the time of inspection, the pharmacy did not have the appropriate strength anaphylaxis pens available. The RP said they had just run out of the adult anaphylaxis pens, and new stock was due to arrive. He confirmed that he did not administer any vaccinations whilst there were no adult anaphylaxis pens in stock, and none were seen being administered during the inspection. The RP explained that he prescribed antibiotics and antimalarials after carrying out a consultation. The RP carried out clinical checks on prescriptions for high-risk medicines. He checked the yellow book for people taking warfarin. Methotrexate was ordered as blister packs rather than loose tablets to avoid staff handling cytotoxic medicines. The RP explained that for prescriptions of valproate, they would conduct the relevant clinical checks and always supply complete packs.

The pharmacy obtained medicines from licensed wholesalers and stored them on the shelves. The pharmacy had medicinal waste bins to store out-of-date stock and medicines people had returned. However, the pharmacy did not store all its medicines securely and in accordance with legislation. Loose medicine blisters, and tablets decanted into bottles with no expiry dates or batch numbers were found on the dispensary shelves. The loose medicine blisters were removed during the inspection. The pharmacist said the tablets in the bottles were not used for dispensing, and they were not kept with regular stock. Team members kept the tablets they removed from multi-compartment packs when changes were made and placed them in bottles for audit purposes. The pharmacist said these would be removed and disposed of after some time had passed.

A trained dispenser came in once a week to check expiry dates. However, two out-of-date medicines

were found during the inspection. The pharmacy had a date-checking matrix but there was no evidence that any recent checks had been made. Pharmacy team members monitored the minimum and maximum temperatures of the medicine's fridge daily and the temperatures recorded were within acceptable limits. The fridge temperatures during the inspection were within range.

Over-the-counter medicines were stored appropriately. Team members referred to the RP if they had concerns or were unsure. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The RP explained how they would action medicine recalls. The RP explained they would print the relevant alerts for the team to action and inform staff where needed. But there was no evidence found during the inspection of this being documented. This could make it harder for the pharmacy to show how they had protected people's health and wellbeing in the event of a product safety alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities to provide its services safely and to protect people's confidentiality.

Inspector's evidence

The pharmacy had a set of clean, well-maintained calibrated glass measures available for measuring liquids. This included separate measures for different medicines, to help avoid cross-contamination. The pharmacy computers were password protected and access to peoples' records was suitably restricted. The computer terminals were largely kept in secure areas of the pharmacy away from public view. One computer terminal was placed at the medicines counter in a way that risked being seen by the public. The RP said the screen was always locked when not in use and people were prevented from entering that section of the pharmacy. Team members had individual NHS smartcards to access prescriptions. The pharmacy had cordless phones so staff could move to more private areas for confidential conversations.

The fridge contained food in addition to the medicines. The food was removed during the inspection. The importance of not mixing food with medicines and not overfilling the fridge was discussed. Up-to-date reference sources were available including access to the internet.

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.