General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Eclipse Pharmacy, 413 Hoe Street, Walthamstow, LONDON, E17 9AP

Pharmacy reference: 1040216

Type of pharmacy: Community

Date of inspection: 11/08/2022

Pharmacy context

The pharmacy is situated in a parade of shops in a busy shopping area. It mainly dispenses NHS prescriptions. And supplies some medicines in multi-compartment compliance packs to people who need help managing their medicines. It also supplies medicines to some people living in care homes. The pharmacy offers a number of private services including travel 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. Team members respond appropriately when mistakes happen during the dispensing process. They use these as an opportunity 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. The team had been routinely ensuring infection control measures were in place.

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). The responsible pharmacist (RP) brought mistakes to the team members attention and had recently asked them to start recording all near misses. Near misses were consistently seen to be recorded. The RP had a discussion with colleagues about the repercussions if the wrong medication was supplied and taken by someone. Dispensing errors would be brought to the RP's attention and he described the steps he would take which included speaking to the person, resolving and rectifying the error and completing an investigating to find out what had gone wrong. The RP was unsure as to where the error would be recorded and he explained that he had ordered a book for recording dispensing errors. To the RP's knowledge there had not been any reported errors recently.

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. People also left reviews online and the pharmacy tried to respond to feedback within 48 hours. The RP explained that people also provided feedback verbally and the pharmacy were part of a mystery shopper scheme. As a result of customer service feedback, the RP had advised team members to look more approachable and friendly. The RP also had tried to increase the number of private consultations with people and to ask people if they wanted to speak in private as he felt people wanted to speak to a healthcare professional. There had also been some feedback that team members did not have enough knowledge on some over the counter products, the RP had provided them with additional training sources to help.

Records for emergency supplies and unlicensed medicines dispensed were well maintained. Private prescription records were generally in line with requirements but the prescriber details were missing from some entries. RP records were well maintained but the RP had signed out ahead of time, which could make the records less able to be relied upon. Controlled drug (CD) registers had some missing headers and some entries had not been made but they largely complied with requirements.

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 team members had been briefed. Relevant team members who accessed NHS systems had smartcards and the SI was in the process of arranging smartcards for some team members. Pharmacists had access to Summary Care

Records (SCR) and consent to access these was gained verbally. Confidential paperwork and dispensing labels were segregated and shredded. Three empty returned compliance packs were seen in the general waste bin. Both the RP and pharmacy manager were surprised to see these. The pharmacy manager explained that the new team member had been asked to remove the confidential information and discard the empty packs but had misunderstood. The packs were removed during the visit. The RP provided assurance that he would rebrief team members on what was confidential information.

The RP had completed the level two safeguarding training. The RP was aware of where to locate the contact details for safeguarding boards. The RP explained that someone had visited the pharmacy from the local community outreach for vulnerable woman and children and briefed the team. The team had completed some training as part of this.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services provided, and they do the right training for their roles. They work effectively together and are supportive of one another. The pharmacy supports its team members with ongoing training. This helps them keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the RP who was the regular pharmacist. The RP had completed his pre-registration training at the pharmacy and worked at the pharmacy since qualifying. Other staff included two trained dispensers, a trainee pharmacist and a trainee medicines counter assistant and a new member of staff who would be enrolled on a suitable course. The RP felt that there were an adequate number of staff and explained that ensuring the pharmacy and rota were organised and tasks were completed on time meant that things ran smoothly. One of the dispensers was the pharmacy manager and managed holidays and sickness. Where possible, cover was obtained from the sister branch or team members were asked to work overtime.

Staff performance was managed informally. The RP provided staff with feedback and he described how team members also provided him with feedback and discussed how he could improve. Team meetings were held every couple of months to discuss how the team were getting on. The team discussed what had gone well and what could be improved. In between meetings things were discussed as they arose.

The trainee MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. He was aware of the maximum quantities of certain medicines which could be sold over the counter and would refer to the RP before selling certain medicines.

The trainee MCA preferred to complete his training at home. He was well supported in his training by the owner and RP. To keep the team up to date the RP briefed the team on any training he has completed. Pharmacy magazines and literature was shared with team members. People from different companies also came in and briefed the team on products. The trainee pharmacist had been signed up to complete training with a training provider. The RP had enquired about flu vaccination training for her and based on his pre-registration experience was trying to ensure she had the best experience. Targets were set by the owner for the services provided. The RP explained that there was no pressure to meet the targets and the targets did not affect his professional judgement in any way.

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. But the pharmacy could do more to keep its dispensary tidy and organised to reduce the risk of things going wrong.

Inspector's evidence

The retail area of the pharmacy was clean. The dispensary was untidy and disorganised in places. There was ample workbench space which was allocated for certain tasks. A number of baskets containing prescriptions waiting to be checked were stored on the floor. The RP provided an assurance that he would work with the team to create space to store the baskets. A sink was available for the preparation of medicines. Some pharmacy only medicines (P) were stored in a glass cabinet on the shop floor. Team members accessed the medicines from this cabinet. Cleaning was carried out by the team.

The pharmacy had a large 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. The room temperature was adequate for the provision of pharmacy services and the safe storage of medicines. Air conditioning was available to help regulate the temperature. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy's entrance was at street level and was easily accessible. Team members helped people who required assistance. There was easy access to the medicines counter. Services were appropriately advertised to patients. Team members knew what services were available and described signposting people to other providers where needed. Most team members were multilingual and spoke languages spoken locally. The pharmacy had the ability to produce large print labels.

The RP felt that electronic prescriptions had the most impact on people as it allowed people to get their medication without having to come into the pharmacy.

The pharmacy had an established workflow in place. Prescriptions were dispensed by the dispensers and left for the pharmacists to check. People were notified once their prescription was ready to collect. It was very rare that the pharmacists had to self-check. Dispensed and checked-by boxes were available on labels which were observed to be used. Baskets were used to separate prescriptions, preventing transfer of items between people.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. In most cases sodium valproate was dispensed in its original pack. The RP had briefed the team on label placement to ensure information was not covered. Additional checks were carried out when people collected medicines which required ongoing monitoring. Methotrexate was stored separately on the shelves and team members had been briefed on the importance of dispensing the same brands for some medicines such as lithium, carbamazepine and phenytoin. The RP encouraged people to bring in their yellow books when collecting prescriptions for warfarin.

Some people's medicines were supplied in multi-compartment compliance packs. Prescriptions were requested by the pharmacy in advance to allow time to prepare packs. Prescriptions were checked against previous copies of backing sheets and the repeat slip. Any changes were queried with the surgery. Dispensers obtained a second check on the stock they had picked before preparing packs. These were then checked and sealed by the pharmacists. Assembled packs were labelled with product descriptions. Patient information leaflets (PILs) were supplied monthly. Mandatory warnings were not included on the backing sheets and the team provided an assurance that they would speak to the systems helpdesk and have this amended. Following an incident with compliance packs in the past, the pharmacy stored all prepared packs in clear plastic bags and bag labels were no longer attached to the bag but were stuck on individual packs at the point of preparation. Prescription forms were also stored with all prepared packs.

The pharmacy also supplied medicines to people residing in care homes. Prescriptions were ordered by the pharmacy. These were checked and processed by the RP and dispenser. Medication Administration

Records (MAR charts) were prepared by the RP. PILs were attached to the MAR charts.

Deliveries were carried out by a designated driver. The driver kept an audit sheet and marked deliveries as they were completed. Signatures were no longer obtained when medicines were delivered and this was to help infection control. In the event that someone was not available medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored and recorded. Records seen showed that the temperature were within the required range for the storage of medicines. CDs were held securely. Date checking was previously completed at least every three months. The RP felt that leaving a large gap in between checks was risky and now tried to complete checks more frequently. Short-dated stock was marked. No date-expired medicines were found on the shelves checked. Out-of-date and other waste medicines were kept separate from stock, stored securely and then collected by licensed waste collectors. Drug recalls were received via email. The RP saved all actioned alerts in an electronic folder.

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. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had calibrated glass measures for liquid CDs, however other measures were plastic. The RP provided an assurance that he would order glass measures. Tablet counting equipment was available. Equipment was clean and ready for use. Separate measures were used for liquid CDs and separate tablet counting triangles were used for cytotoxic medicines to avoid contamination. A medical fridge of adequate size was available. A blood pressure monitor was used for services provided and it was fairly new. 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.

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.