General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chana Chemist, 70 Chapel Market, Islington, LONDON, N1 9ER

Pharmacy reference: 1040287

Type of pharmacy: Community

Date of inspection: 05/05/2021

Pharmacy context

This pharmacy is located within a parade of shops near a street market. The pharmacy serves people of all age ranges and receives most of its prescriptions electronically. It provides 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. The inspection took place during the Covid-19 pandemic.

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	1.6	Standard not met	The pharmacy does not use robust systems to keep its controlled drug registers up to date.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is disorganised and cluttered. It has limited clear space to be able to dispense and check medicines safely. There are items on the dispensary floor which are tripping hazards for staff. The consultation room is untidy, and not all items inside are stored securely.
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 not all met**

Summary findings

The pharmacy does not keep its controlled drug registers up to date as required by law. But overall, it otherwise manages the risks associated with its services adequately. And the records it needs to keep by law otherwise largely comply with requirements. People who use the pharmacy can provide feedback. When a dispensing mistake occurs, team members generally react appropriately. But they do not always make a record of dispensing mistakes. So, they might be missing opportunities to learn and make the services safer.

Inspector's evidence

Standard operating procedures (SOPs) were in place, but they were stored in a disorganised manner in a file. SOPs were reviewed every two years, most recently in 2019. The superintendent pharmacist (SI) and dispenser had read and signed the relevant SOPs.

The pharmacy had made some changes as a result of the Covid-19 pandemic. Team members wore face masks and disposable aprons at all times. The premises, including door handles and chairs, were cleaned several times a day and hand sanitizer was available. A plastic screen had been fitted at the front counter and several boxes had been placed in front of the medicine counter to create a safe distance between people using the pharmacy and team members.

The SI said that near misses (where a dispensing mistake was identified before the medicine was handed to a person) were discussed with the dispenser but they were not always documented. Some near misses were seen to have been recorded in 2019. There did not appear to be a review process for near misses, but the SI described making some changes to help minimise dispensing mistakes, for example, separating gliclazide 30mg and 60mg tablets. He also describing taking a short mental break before checking items, if he had dispensed the prescription.

A procedure was in place for dealing with dispensing mistakes which had reached a person (dispensing errors). But the SI could not find previous records of dispensing errors. He described an error where zopiclone 3.75mg tablets had been supplied instead of 7.5mg. The SI had contacted the patient to inform her of the error and had advised her to take two tablets instead of one. He had also informed his indemnity insurance provider.

The correct Responsible Pharmacist (RP) sign was displayed. The dispenser understood her role and responsibilities, however, she said she would hand out dispensed medicines in the absence of the RP. This was discussed with the dispenser at the time, and the SI was advised to review the RP SOPs with the dispenser.

The pharmacy had a complaints procedure. The pharmacy normally conducted annual surveys but had not done one the previous year due to the pandemic. The SI said that he took customer feedback on board and had introduced a ‘£1 section’ as a result of people's feedback.

The pharmacy had current indemnity insurance cover. Records for the supply of unlicensed medicines, private prescription and emergency supplies were generally in order. The RP record was kept electronically. The SI was not routinely signing out of the RP record but he was the only pharmacist working at the pharmacy over the past few months. Controlled drug (CD) registers were not always maintained in accordance with requirements. Some entries had not been made within the required time limit. In some cases, entries had not been made for several months. Following the inspection, the SI provided evidence that the entries had been brought up to date. CD running balance checks were not conducted regularly for all CDs. Headers were missing in some registers which could increase the risk of making incorrect entries. Random stock checks of CDs did not always agree with the recorded balance. Following the inspection, the SI provided evidence that these discrepancies had been rectified.

Prescriptions awaiting collection were stored behind the medicines counter and were not visible to people. Confidential information was collected in a basket and shredded on site. However, not all confidential information was stored securely (see Principle 3). An information governance policy was in place and both the SI and dispenser had completed training on the General Data Protection Regulation.

The SI had completed the Centre for Pharmacy Postgraduate Education training on Safeguarding children and vulnerable adults. The dispenser could not remember if she had completed any training. She was able to describe signs of abuse but not of neglect. The SI said he would provide the dispenser with additional training on safeguarding. The contact details of the local safeguarding team were available, and the SI also described using the NHS telephone application for guidance and contact details.

Principle 2 - Staffing ✔ Standards met

Summary findings

Team members feel able to raise concerns if necessary. Overall, the pharmacy has sufficient team members to manage its workload but there is a backlog of administrative tasks which need to be addressed. While there is some informal ongoing training, the pharmacy could provide better support to help team members complete it.

Inspector's evidence

The pharmacy team comprised of the SI and a dispenser. The dispenser had completed an accredited course. Both had good rapport with patients, knowing most on a first-name basis. Regular locum pharmacists also helped cover some shifts as and when needed. The dispenser covered both the medicines counter and dispensary.

The pharmacy was relatively quiet throughout the inspection. However, it was clear that the SI had struggled to manage the workload over some period of time as the dispensary, consultation room and medicines counter were extremely cluttered with paperwork. The SI could not find a number of documents as they were stored amongst the many piles. He accepted that he needed some support to help clear the administrative backlog.

Staff performance was managed informally. The SI said he regularly discussed areas for improvement with the dispenser and also asked her for feedback. The dispenser was happy to raise concerns directly to the SI.

The dispenser said she had attended some training sessions, for example, on smoking cessation, the repeat dispensing service and obesity, but this was some time back. She did not have set study time and did not maintain a record of her ongoing training.

The dispenser was observed selling over-the-counter medication. She asked a number of questions and referred to the pharmacist at times, for example, before selling chloramphenicol eye drops for an eye infection. There were no targets set for team members.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is untidy and there is only a small amount of clear space for dispensing and checking medicines. And this could increase the risk of dispensing mistakes. There is a room where people can have private conversations with a team member, but the room is untidy. And not all the items in the room are stored securely. There are tripping hazards in the dispensary which present a risk to the staff. Otherwise, the premises themselves are generally adequate for the services the pharmacy provides. And the premises are secure from unauthorised access.

Inspector's evidence

The dispensary was located at the back of the shop and was relatively small and narrow. It was cluttered and untidy. There were items on the floor which presented tripping hazards for staff. Workbenches were cluttered with paperwork, part-dispensed prescriptions, and packs of medicines. There was only a small amount of clear space to dispense and check prescriptions. This could increase the risk of dispensing errors. Some parts of the dispensary were also dusty, and the dispensary sink was not clean. The retail area was spacious and generally tidy.

A large screen was fitted at the medicines counter to help prevent the spread of infection during the pandemic. A small staff area was located behind the medicines counter; this contained a fridge, microwave and electric kettle. The area was filled with paperwork and stock, stored in a disorganised manner.

A spacious consultation room was available, but this was cluttered with boxes, paperwork and empty pharmaceutical waste bins. It did not present a professional image to people using the room. And not all items inside the room were stored securely. A sink was fitted in the room, but this was covered under piles of paper. Some confidential information was stored in the room.

The premises were secure from unauthorised access. The ambient temperature and lighting were adequate for the provision of pharmacy services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely. And it orders its medicines from reputable sources and largely stores them properly. But it does not always remove expired medications from shelves. This could increase the chance of supplying date-expired medicines.

Inspector's evidence

The pharmacy offered a limited range of services which were adequately promoted. Team members described signposting people to other service providers, such as GPs and dentists as well as the NHS website.

There was step-free access into the pharmacy. The door was kept open and a doorbell was fitted should a person need assistance from the team. The pharmacist and dispenser were multilingual.

The premises were registered with the General Pharmaceutical Council as Chana Chemist, and this also appeared on the pharmacy's dispensing labels. The pharmacy had changed ownership in 2015 and new signage had been put outside for 'Angel City Pharmacy'. The mismatch in names could cause confusion for people using the pharmacy.

Dispensed and checked-by boxes were generally used by team members to ensure that there were dispensing audit trails. Baskets were used to separate prescriptions and prevent transfer between patients, however, there was limited space to dispense on as benches were very cluttered.

Medicines were dispensed into multi-compartment compliance packs for people who needed help managing their medicines. Prepared packs observed were labelled with product descriptions and mandatory warnings. But there was no audit trail in place to show who had prepared and checked the packs, which could make it harder to know who had done these tasks if there was a query. Patient information leaflets were supplied regularly. Individual charts were available for each person to help ensure the correct number of medicines were supplied in the correct time slots.

The pharmacy offered a delivery service to people's homes with deliveries carried out by the pharmacist and dispenser. Records were maintained but people were no longer being asked to sign the records due to the pandemic. Medicines were returned to the pharmacy if a person was not available.

Prescriptions were not always attached to dispensed and bagged medicines. And this could make it harder for staff to refer to this information when handing the medicines out. And it may also increase the risk of supplying medicines past the valid date on the prescription.

The dispenser was not aware of the checks and labelling requirements when dispensing sodium valproate to women in the at-risk group. Warning cards and labels were not available. The SI said that he would order additional supplies of information leaflets and warning cards and ensure that the dispenser completed additional training.

Medicines were obtained from licensed wholesalers and generally stored appropriately. The fridge temperature was monitored and recorded daily. The SI said that stock was date checked on a regular

basis. Short-dated stock was marked with a coloured sticker. Two date-expired medicine were found in with stock and were removed for destruction. The date-checking matrix could not be found during the inspection, but the SI sent a copy following the inspection. This showed that the date checking was last recorded in September 2019.

Waste medicine was disposed of in appropriate containers. These were kept in the dispensary and collected by a licensed waste carrier.

The SI said that drug alerts and recalls were printed out, actioned and filed away. One alert, which had been printed and signed, was found amongst the piles of paper.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment and facilities it needs to provide its services safely. But it could do more to ensure that its equipment is appropriately maintained.

Inspector's evidence

Several glass measuring cylinders were available but were some required cleaning. Measures were placed on top of the CD cabinet on kitchen towels which were discoloured and dirty. The SI said he would replace the kitchen towels more frequently. There were tablet and capsule counters, including a separate counter for cytotoxic medicines.

A fridge was fitted in the dispensary for medicines requiring cold storage. However, it required cleaning. The CD cabinet was fitted securely.

The blood pressure monitor had been replaced 2-3 years ago and was currently not in use. Computers were password protected and were out of view of people. A shredder was available to destroy confidential waste. 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.