General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Essex Chemist & Optician, 41 Essex Road, Islington, LONDON, N1 2SF

Pharmacy reference: 1040295

Type of pharmacy: Community

Date of inspection: 02/09/2020

Pharmacy context

This pharmacy is located off a busy main road, and is surrounded by shops, offices and residential blocks. The pharmacy previously had an optician within the same premises, but this no longer exists. The pharmacy dispenses medicines predominantly to people residing locally. The pharmacy provides Medicines Use Reviews and New Medicine Service checks to people. And it offers an emergency hormonal contraception service. This inspection was undertaken during the Covid-19 pandemic.

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 generally manages the risks associated with providing its services. Overall, it keeps the records it needs to by law, to show that medicines are supplied safely and legally. People who use the pharmacy can provide feedback and raise concerns. And the pharmacy team have received training to help protect the welfare of vulnerable people. The pharmacy does not always record mistakes that occur during the dispensing process. This may mean that staff are less able to spot patterns in mistakes and take action to prevent similar mistakes in the future. It has written procedures which staff can refer to. But it is not clear if the procedures have been reviewed recently to ensure they reflect current practices. Although the pharmacy protects people's personal information adequately, it could do more to ensure that the information is protected at all times.

Inspector's evidence

The pharmacy had a new set of standard operating procedures (SOPs) available, however, these were not filled in with details of when they were prepared and when they were due to be reviewed. So, it was not clear how long they had been in place. Current team members had not signed the SOP's relevant to their roles to confirm that they had read and understood them. The superintendent pharmacist (SI) said that the she would be reading the SOPs alongside the trainee dispenser.

The pharmacist had carried out a staff risk assessment in response to Covid-19. The pharmacy was restricting the number of people into the pharmacy to help minimise cross-infection. Staff temperatures were checked at least once a week to check for signs of infection. Personal Protective Equipment, including masks, face visors, aprons and gloves were available for the team. The SI was aware of the need to report relevant Covid-19 infections at the workplace to the Health and Safety Executive.

The SI said she would record dispensing mistakes which were identified before reaching people (near misses) in a small book. But the book was empty. The SI could not recall any near misses but said that some had occured.

The SI said she would record mistakes that had reached people (dispensing errors) on the pharmacy's electronic record system, in the patient notes section. However, this may make it difficult to find records without remembering people's details. She was not aware of the need to report dispensing errors on the National Reporting and Learning System and was shown how to access the online form by the inspector. The SI described an error where allopurinol had been supplied instead of amlodipine. She said that stock had been separated as a result of the mistake to help prevent its reoccurrence. She also confirmed dispensed medicines with people, during handing out.

The correct responsible pharmacist (RP) notice was displayed. There was an RP record but the RP did not always sign out when their responsibility ended. And this could make it harder to identify who the pharmacist was if there was a future query. The SI said that she had always been the responsible pharmacist. Private prescription records did not always have the correct prescriber details recorded. Emergency supply records were maintained electronically but the nature of the emergency was not recorded for several entries checked. So, it may not be possible to know why a supply was made, if there was a query. The SI said that the pharmacy had not supplied any unlicensed medicines for some time. But she described attaching a copy of the bag label and dispensing label on the certificate of

conformity for an unlicensed product. Samples of controlled drug (CD) registers examined were in order. Random checks of CD medicines complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received.

The pharmacy had current professional indemnity insurance. Feedback from people accessing services was sought via annual questionnaires. There was a complaints procedure in place. The trainee dispenser said she would refer complaints to the pharmacist or ask the person to put the complaint in writing.

The pharmacy had an information governance policy in place. The trainee dispenser was able to describe ways in which the pharmacy protected people's confidentiality, for example, by never sharing sensitive information over the telephone and only accessing Summary Care Records after consent was obtained. Only the SI had an NHS smartcard to access NHS systems. Some prescriptions were found in the unlocked consultation room, and although the room was no longer being used due to the pandemic, they were not stored securely. They were moved during the inspection.

The RP had completed level two safeguarding training. The trainee dispenser was previously a nurse and had completed training on the subject with her previous employer. She described taking her time to reassure a dementia patient who often visited the pharmacy asking for her medicines.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services. And they do the right training for their roles. They complete ongoing training to keep their skills and knowledge up to date.

Inspector's evidence

At the time of inspection, the pharmacy team comprised of the SI and a trainee dispenser. The trainee dispenser previously worked as a nurse. The SI said she had advertised for another position at the pharmacy but was still in the process of looking through all the applications. She said there was currently enough cover, but additional staff were needed to cover the medicines counter as it could get busy at times. The SI said she would also arrange for locum pharmacists to help during the flu season, as she would be busier when providing flu vaccinations.

The trainee dispenser, who was currently enrolled onto a dispensing course, mainly covered the medicines counter. She asked appropriate questions before selling pharmacy-only medicines and provided additional advice to people. She completed her course modules at work and accessed learning material online, for example, on the National Pharmaceutical Association (NPA) website. She also read pharmacy magazines and had recently read up on allergies and Covid-19. Records of ongoing training were not maintained.

To keep up to date and as part of her revalidation, the SI carried out independent reading from pharmaceutical magazines. She also kept up to date by accessing a number of websites and reading emails from the NPA, the Pharmaceutical Services Negotiating Committee and the Local Pharmaceutical committee. She said she would be completing online training on the Sonar platform for her flu vaccine accreditation.

The SI had contacted the NPA to query about whistleblowing as she was not entirely sure what procedures to have in place at the pharmacy. She said that members of the team would have access to the NPA or PSNC if they wanted to raise any concerns. She would also be creating a new SOP to cover whistleblowing.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are mostly clean. People can have a conversation with a team member in a private area. But the pharmacy could do more to make sure that it keeps its consultation room tidy and free from clutter.

Inspector's evidence

This was a small pharmacy; the dispensary was located at the back of the shop and had limited work and storage space. Workbenches were relatively clean and tidy. The fittings in the pharmacy had not been updated for some time and some shelves were dusty. There was a sink in the dispensary which was used for the preparation of medicines and hand washing. The sink was cluttered with cups and cutlery. The SI said the premises were regularly cleaned and that she would work on improving cleaning procedures.

A small consultation room was available, but it was cluttered. The SI said that it would be cleared, and a new, smaller desk would be placed inside, creating more space to provide vaccine services. A second room, located behind the consultation room, was previously used by an osteopath. The room was now being used by the pharmacy to store excess medicines and other items. The room was clean and well organised.

The trainee dispenser said she disinfected the worktops, door handles and sanitizing station at least twice a day. A plastic screen had been fitted at the medicines counter, but this was removed as the team did not feel comfortable with it.

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

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are generally delivered in a safe and effective manner. The pharmacy gets its medicines from reputable suppliers and stores them securely. But it does not highlight prescriptions for higher-risk medicines. And this could mean that it is missing out on opportunities to speak with people when they collect these medicines.

Inspector's evidence

Access into the pharmacy was via a step; team members helped people who required assistance. The pharmacy's services were advertised on the NHS UK website.

The SI self-checked all dispensed medicines and described taking a mental break between dispensing and checking. She also went through people's medicines with them, before handing them out. This acted as a third check. Dispensing audit trails were not always maintained to help identify who had dispensed and checked a medicine, in case there was a query in future. There was limited workspace, but benches were generally kept tidy. Baskets were also used during the dispensing process to prevent the mixing of people's prescriptions. Prescriptions were now being attached to medicines awaiting collection which meant the pharmacy team were no longer relying on bag labels to conduct checks at hand out. Owings slips were now generated to help the pharmacist keep track of owed items. These slips were filed in alphabetical order and stock was ordered and kept aside for the person. A slip was provided to the person to remind them that they were owed medicines.

There was no system in place to highlight prescriptions for higher-risk medicines. And this could mean that the pharmacy misses out on oppurtunities to speak with people when they collect these medicines. The SI said she asked about INR levels for people taking warfarin but did not record the values for reference. The SI had read the valproate guidance and said she would check if there was risk of pregnancy when dispensing this medicine to women. She said she would provide the information cards; these were available at the pharmacy. She did not know how to label valproate removed from its original pack. The inspector informed her of the requirements. The pharmacy did not have anyone who fell in the at-risk group who collected valproate on a regular basis.

Prescriptions for Schedule 4 CDs were not highlighted in any way. This may increase the chance of them being handed out past the valid date of the prescription.

Prescriptions for people receiving their medicines in multi-compartment compliance packs were either received automatically or managed by the pharmacy. Repeat slips were annotated with due date and filed accordingly; these were then sent electronically to the GP surgery. Prescriptions were cross-checked with individual record sheets and the patient medication record (PMR) system to confirm all items ordered had been prescribed and to identify any changes. Medicine descriptions were provided for medicines placed in the packs to help people identify their medicines. The SI said that patient information leaflets (PILs) were routinely supplied.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and recorded; these were observed to be within the required range for the storage of medicines. Some medicines were seen to be stored loosely in blisters on the shelf outside of their original packs. Some of these had no indication of batch number or expiry date. An original pack which had mixed batches

inside was also found. These were removed during the inspection. CDs were stored securely.

Expiry-date checks were recorded but the last check had been conducted in December 2019. The SI said there had been delays in carrying these checks out due to the pandemic. A medicine was found on the shelf which had expired in December 2018. Several packs of another medicine were due to expire at the end of September 2020, and although they were still in date at the time of inspection, they were not marked in any way to indicate their short expiry date. Out-of-date and other waste medicines which had been identified by team members were segregated from stock and then collected by licensed waste collectors. The SI said she would be conducting a date check of all dispensary stock.

The SI had spoken to the patient medication record supplier about the Falsified Medicines Directive and had set up the monthly subscription needed to access their software.

The RP received drug alerts and recalls electronically but did not keep a record of action taken in response to these. This could make it harder for the pharmacy to show what action it had taken in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

The pharmacy had clean glass measures, and tablet counting equipment. Equipment was clean and ready for use. A separate tablet counting triangle was used for cytotoxic medicines and separate measures were used for certain liquids to avoid contamination. A medical fridge of adequate size was also available.

Up-to-date reference sources were available including access to the internet. The computer in the dispensary was password protected and out of view of 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.