General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Osbon Pharmacy, 155 Essex Road, LONDON, N1 2SN

Pharmacy reference: 1040297

Type of pharmacy: Community

Date of inspection: 13/03/2023

Pharmacy context

This is a community pharmacy in North London, in a parade of shops on a busy road. The pharmacy changed ownership in April 2022. Its main activity is dispensing NHS prescriptions, and it delivers some medicines to people's homes. It dispenses medication in multi-compartment compliance packs to some people who need help taking their medicines. It offers supervised administration for a substance misuse service, and uses the Community Pharmacist Consultation Service (CPCS).

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not always ensure that its team members do the right accredited training for their roles.
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 identifies and manages the risks associated with its service. Team members know their own role and responsibilities, and are aware of the importance of protecting people's private information. The pharmacy largely keeps the records it needs to by law. And there are written procedures that staff can follow to help them know how to provide the pharmacy's services safely. But it is not always clear which version of these procedures is the current one, which could cause confusion.

Inspector's evidence

The pharmacy had three different sets of standard operating procedures (SOPs), and it was not initially clear which the current set was. None of the folders they were in indicated whether they were current or previous sets. The responsible pharmacist (RP) was initially unclear which set was currently in use, but team members were eventually able to identify the current SOPs in use. Team members explained they had read the SOPs relevant to their roles and had sometimes signed to indicate this, but not all team members had signed.

A sheet was available to record mistakes which were identified during the dispensing process, known as near misses. The sheet had not been filled in since January 2023, although the RP was not aware of any near misses that had happened since then. A near miss occurred during the inspection, and the RP was seen to discuss the mistake with the team member and fill in the near miss record. The RP and dispenser were unsure how a dispensing error would be recorded, where a dispensing mistake was made and the medicine had reached a person. They were not aware of any recent errors. The dispenser explained that the pharmacy computer system was relatively new, and he would check with the regular pharmacist how to record any errors. Some medicines which sounded similar had been highlighted on the shelves to help prevent picking errors.

The medicines counter assistant (MCA) could describe what she could and could not do if the pharmacist had not turned up in the morning. And she explained how she would deal with multiple requests for medicines that were liable to abuse.

There was a sign in the public area which explained to people how they could make a complaint, and provided contact details for the local Patient Advice and Liaison service. The name of the person to contact at the pharmacy was the previous owner, and this was highlighted with the team during the inspection. The pharmacy did not have a written complaints procedure, which could make it harder for team members to know what process to follow.

The pharmacy had current indemnity insurance. The right RP notice was displayed, and the RP record had largely been filled in correctly. There was a relatively large number of emergency supplies recorded as being made at the prescriber's request. This was queried with the staff, who explained that the pharmacy's computer was relatively new and they were still getting used to it. And that the records should have instead been put as emergency supplies at the request of the patient. The dispenser said that he would ensure the wider team was aware. Records of private prescriptions and unlicensed medicines dispensed appeared complete. Controlled drug (CD) registers seen had been filled in with the required information. A random stock check of a CD medicine showed that the recorded balance

matched the physical quantity.

No confidential information was readable from the public area. There were some bags of dispensed medicines which could be seen from the end of the pharmacy counter. Although the details on them could not be read from the public area, this was discussed with the pharmacist who said that they could be moved further into the dispensary. Staff used smartcards to access the NHS electronic systems and were aware of the importance of protecting people's confidentiality. Confidential waste was separated from general waste until it could be shredded.

The RP confirmed he had completed safeguarding training and thought he had done level 1 and level 2. The dispenser said he had also done training and could explain what he would do if he had any safeguarding concerns. There was a safeguarding SOP available for staff to consult, but it was not clear if staff had been through it as there were no signatures.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always ensure that its team members do the right accredited training for their roles. So it cannot demonstrate that they have the right skills and knowledge to provide the pharmacy's services safely. However, the team members are up to date with the pharmacy's workload, and they are comfortable about raising any concerns or making suggestions. They get some ongoing training, but it is not very structured. This could make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

During the inspection there was the RP (a locum pharmacist), a trained dispenser, and a trained MCA. There were also two team members working in the dispensary. One team member was dispensing prescriptions and had worked at the pharmacy for around four months. The other was dispensing multi-compartment compliance packs, which is a higher-risk activity, and had worked at the pharmacy for around five years. Neither team member had completed or were registered on the relevant accredited training.

The pharmacy was sometimes busy during the inspection, but team members were up to date with their workload. They felt comfortable about raising any concerns or making suggestions. The pharmacy had a regular pharmacist, but they were on a day off. Team members did not receive any structured ongoing training, but they said that they did get occasional updates from the pharmacist about new products or services. And they received information leaflets from wholesalers and products manufacturers sometimes. The MCA said that she had completed training about 'Strep throat' in the past. The RP felt able to take professional decisions. And staff were not set any numerical targets by the company.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are adequate for its services, and team members generally keep them clean and tidy. People can have a conversation with a team member in a private area. And the premises are secure from unauthorised access. The pharmacy could do more to ensure that its floors are kept clear from unnecessary clutter.

Inspector's evidence

The premises were generally clean and tidy. The dispensary was not large, and storage space was limited, but it was just about adequate, with enough clear workspace. Lighting was generally good throughout. There were some baskets of stock on the floor, but these had been pushed to the side to help minimise the risk of tripping. This was discussed with the team during the inspection.

The pharmacy had a consultation room which was signposted from the public area. The room was of an adequate size and allowed a conversation at a normal level of volume to take place inside and not be overheard. The premises were secure from unauthorised access and the room temperature was suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its safely and manages them adequately. Its services are accessible to people with a range of needs, and staff know to signpost people to other local services where needed. Team members take the right action in response to drug alerts and recalls, so that people get medicines and medical devices that are safe to use. The pharmacy gets its medicines from reputable sources and largely stores them properly. But it could take more care to ensure that waste medicines are always disposed of appropriately.

Inspector's evidence

There was step-free access from the street via a small steep ramp which was around 10cm tall. The door was powered to assist people coming in, but this feature was currently faulty and the staff had reported it for fixing. Team members were aware of the local health facilities such as sexual health and drug and alcohol services and said they often signposted people. Some staff were multilingual, and described how they had use translation applications in the past to assist people

Dispensing baskets were used to help prevent different people's medicines becoming mixed up. There was limited space in the dispensary, but there was a clear workflow and one specific area was used for checking prescriptions.

Prescriptions for higher-risk medicines such as methotrexate or lithium were not routinely highlighted, which could mean that staff missed out on opportunities to talk with people when they collected these medicines. Prescriptions for CDs were highlighted, but this was not done consistently. Staff were aware of the shorter prescription validity date for Schedule 3 and 4 CDs.

Team members were aware of the guidance about pregnancy prevention for people taking medicines containing valproate. The RP was not aware of anyone in the at-risk group who was taking these medicines. He could describe what he would do if someone in the at-risk group was prescribed these medicines and was not already registered on a Pregnancy Prevention Programme. The pharmacy had spare warning cards and stickers for use with these medicines.

Dispensed multi-compartment compliance packs were labelled with a description of the medicines inside. But there was no audit trail to indicate who had dispensed and checked the packs. There was a box containing part-dispensed packs where the medicines had been put into the packs but the packs had not yet been labelled. Separate bags were used for each person's medicines which also contained the prescriptions. The dispenser said that these packs were checked by the pharmacist, then the labels were generated and attached, then the packs were checked again. Patient information leaflets were not routinely supplied with the medicines, which could make it harder for people to have up-to-date information about their medicines. The dispenser said that the regular pharmacist generally checked the completed packs, but he would check ones that the pharmacist had labelled.

The pharmacy delivered medicines to some people in their own homes and kept an audit trail for this. Signatures from recipients were not obtained to help with infection control. And the delivery driver explained that many people had given consent for the pharmacy to use their keycode locks to deliver the medicines.

The pharmacy ordered its medicines from licensed wholesale dealers and specials suppliers, and generally stored them in a tidy way in the dispensary. Team members regularly date-checked the stock, and this activity was recorded. A random check of medicines on the shelves did not find any medicines which were past their expiry dates. The fridge temperatures were checked and recorded regularly. And previous records seen indicated that the fridge had remained within the appropriate temperature range. Drug alerts and recalls were received via email and the dispenser described the action the pharmacy took in response, which included checking the currently held stock. He was unsure if a record was retained of the action taken.

In a general waste bin in the dispensary, some full packs of prescription-only medicines were found. A team member explained that they had taken them off the shelf as they were approaching their expiry dates and had put them in the general waste bin. And said that it was the first time that they had taken the medicines off the shelves like this. The medicines were retrieved and put into the designated sacks. Other medicines for destruction were seen to have been separated from stock and placed into designated sacks in the basement.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It uses its equipment to help protect people's personal information. But it is not always clear that the equipment the pharmacy uses is appropriately maintained, and this could mean that people are less able to rely on the readings from them.

Inspector's evidence

Dispensing equipment such as glass measures and tablet and capsule counters was clean. Staff said that the blood pressure machine would be replaced rather than recalibrated but were unsure how often this happened. The phone was cordless and could be moved to a more private area to help protect people's personal information. There was a shredder in the consultation room which was used to shred confidential waste. A weighing scale was in the shop area and available for people to use. But it was not clear when it had last been calibrated, and team members were unsure if this had ever been done.

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.