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: 21/09/2023

Pharmacy context

The pharmacy is on a parade of shops on a busy main road in a largely residential area. It provides NHS dispensing services and offers the New Medicine Service. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people. The pharmacy receives most of its prescriptions electronically.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And people can provide feedback about the pharmacy's services. The pharmacy largely keeps its records up to date. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. The pharmacist said that the SI was in the process of updating the SOPs and these would then be available electronically. Team members recorded and reviewed their own near misses, where a dispensing mistake was identified before the medicine had reached a person. Once they had been made aware that they had made a mistake, they were then responsible for identifying and rectifying them. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Team members were not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. The pharmacist said that she would record them, undertake a root cause analysis and report to the pharmacy's head office.

Workspace in the dispensary was largely free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. The team members largely signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. But this was not always done when the multi-compartment compliance packs were checked. The pharmacist said that she would do it in future.

The dispenser explained that the pharmacy would open if the pharmacist had not turned up in the morning. He knew which tasks he should not undertake if there was no responsible pharmacist (RP) signed in. And he knew that he should not sell any pharmacy-only medicines or hand out dispensed medicines if the RP was not in the pharmacy. Team members' roles and responsibilities were specified in the SOPs.

The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The pharmacy had current professional indemnity insurance. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. And any liquid overage was recorded in the register. Most of the records where a prescription-only medicine had been supplied in an emergency without a prescription, had not been recorded correctly. The nature of emergency had not been recorded and they had been recorded as having been requested by the prescriber. The private prescription records were largely completed correctly, but the correct prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The pharmacist said that she would ensure that both records were completed correctly in future.

Computers were password protected and people using the pharmacy could not see information on the computer screens. And the pharmacy shredded its confidential waste. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection.

The dispenser said that he was not aware of any recent complaints. The complaints procedure was available for team members to follow if needed. And details about how people could contact the pharmacy's head office were on the pharmacy's website.

Team members had undertaken training about protecting vulnerable people. The dispenser described potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. And he said that there had not been any safeguarding concerns at the pharmacy. The team members could give examples of action they had taken in response to safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They can raise any concerns and can make professional decisions. But the pharmacy could do more to ensure that its team members are enrolled on an accredited course within the required time frame.

Inspector's evidence

There was one pharmacist, one trained dispenser and one trained MCA. And there was another person who had worked at the pharmacy for some time but had previously been unsure about whether they were still going to continue working for the pharmacy. They had not yet been registered on an accredited course, but immediately following the inspection the pharmacist provided evidence that they had now been registered on an appropriate course.

Team members appeared confident when speaking with people. The dispenser was aware of the restrictions on sales of pseudoephedrine containing products. And he said that he would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. The MCA was observed selling two over-the-counter medicines which were liable to misuse without asking any questions to establish whether the medicines were suitable for the person they were intended for. The pharmacist said that she would remind team member which questions to ask.

The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. She explained that she was in the process of setting up user profiles for team members so that they could access online training modules. The pharmacist was aware of the continuing professional development requirement for professional revalidation. And she felt able to make professional decisions. The pharmacist said that she was due to complete the training for the flu vaccination service.

The pharmacy used a messaging group so share information with other pharmacies in the group. The pharmacist said that team members had ongoing informal reviews of their performance. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. Targets were not set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. The lighting was suitable for the provision of the services and the pharmacy was kept clean and tidy throughout. Pharmacy-only medicines were kept behind the counter. Air conditioning was available, and the room temperature was suitable for storing medicines.

Some people’s personal information on some bagged items waiting collection could potentially be read by people using the pharmacy. The pharmacist said that she would ensure that the information was not visible in future.

There were two chairs available in the shop area for people to use while waiting. The consultation room was accessible to wheelchair users. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. An in use pharmaceutical waste bin was in the consultation room and the contents were potentially accessible to people using the room. The pharmacist gave assurances that this would be moved to a more suitable place. Toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy frontage was still showing the details of the previous pharmacy name. This was discussed with the pharmacist during the inspection and she said that she would raise this with the pharmacy's head office.

Prescriptions for higher-risk medicines were not routinely highlighted. The pharmacist explained that bagged items were checked by a member of the dispensary team before being handed out so that higher-risk medicines were identified. These medicines were handed out by the pharmacist if needed which mean that there was the opportunity to speak with these people about their medicines. The pharmacist said that prescriptions for Schedule 3 and 4 CDs were highlighted. And this helped minimise the chance of the prescriptions being no longer valid when the medicines were handed out. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacy had the relevant patient information leaflets, warning cards and stickers available for use with split packs. The pharmacist said that she would refer people to their GP if they needed to be on the PPP and weren't on one.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next few months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. The pharmacy received its medicines and medical devices from licensed wholesalers. Drug alerts and recalls were received from the pharmacy's head office and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. But the pharmacy did not keep a record of any action taken. This could make it harder for the pharmacy to show what it had done in response.

Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the acceptable ranges. The fridge was suitable for storing medicines and it was not overstocked. CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and kept separate from dispensing stock. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Uncollected prescriptions were checked regularly. Items uncollected after around three months were

returned to dispensing stock and the prescription were returned to the prescriber or to the NHS electronic system. Part-dispensed prescriptions were checked frequently. ‘Owings’ notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

People had assessments to show that they needed their medicines in multi-compartment compliance packs to show that they needed them. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. The pharmacist said that the prescriptions were ordered in advance so that any issues could be addressed before the person needed their medicines. And she usually checked the medicine against the prescriptions before it was put into the pack. But this was sometimes carried out by one of the dispensers. The dispensing labels were attached to the trays before the final check was undertaken. But the medicine packaging was not available during the final check. This may make it harder for the pharmacist to know that the correct medicines were in the packs. The pharmacist said that she would ensure that the packaging was available at the final check in future. Patient information leaflets were routinely supplied with the packs.

Deliveries were made by a delivery driver or team members to people who were not able to get to the pharmacy themselves. The pharmacy did not currently obtain people’s signatures to help minimise the spread of infection. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

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

Suitable equipment for measuring liquids was available and separate ones were used to measure certain medicines only. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Triangle tablet counters were available and clean. And a separate counter was marked for cytotoxic use only which helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor had been in use for less than one year. And it would be replaced in line with the manufacturer’s guidance. The weighing scales and the shredder were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

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.