

Registered pharmacy inspection report

Pharmacy Name: Carters Chemist, 47 Roman Way, LONDON, N7 8XF

Pharmacy reference: 1040361

Type of pharmacy: Community

Date of inspection: 12/09/2024

Pharmacy context

This pharmacy is located in a parade of shops in a residential area of Islington. The pharmacy provides NHS services such as dispensing prescriptions, the New Medicine Service (NMS), Emergency Hormonal Contraception (EHC), COVID and flu vaccinations and the Pharmacy First service. The pharmacy supplies medicines in multi-compartment compliance packs to people who need this support to manage their medicines at home, and it offers a delivery service. The pharmacy also offers private services using patient group directions (PGDs), this includes a travel clinic, ear microsuction and vitamin B12 injections.

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	3.1	Good practice	The pharmacy has a high standard of fixtures and the dispensary is designed to help manage workload efficiently.
		3.3	Good practice	The pharmacy is well maintained with cleaning logs in place and has suitable hygiene arrangements for the provision of services.
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 keeps the records it needs to by law, and it uses written procedures to ensure that team members understand their responsibilities and how to carry out activities. Team members respond appropriately when a mistake happens during the dispensing process, and they make records to identify learnings. People using the pharmacy's services can easily provide feedback. Team members protect people's information well and have the relevant training to safeguard the welfare of people using their services.

Inspector's evidence

Standard operating procedures (SOPs) were available for the team to refer to if required. One team member had not signed the SOPs relevant to their role but said that they had read them and gave assurances they would be signed to show that they understood them. When asked, team members were clear about their role and knew when to refer to the responsible pharmacist (RP). They knew what activities could and could not be done in the absence of an RP and to contact the SI if a pharmacist is not available upon opening of the pharmacy. Team members had a good understanding of the dispensing processes that they followed and were able to clearly demonstrate their understanding of the pharmacy robot systems.

The RP notice was correct and visible at the time of inspection. The RP record was held electronically and was generally complete. Records for unlicensed medicines were well kept. And the RP said that they did not often give emergency supplies, due to the NHS 111 Emergency Prescriptions service. Private prescription records did not always have the correct prescriber recorded and this may mean that information is harder to find out if there was a query.

A random physical check of two controlled drugs (CDs) showed the quantities matched the balance recorded in the register. And regular balance checks were recorded with the shortest expiry date documented to ensure these were separated from stock medicines when appropriate. Expired and patient returned CD medicines were separated from the stock medicines. The RP explained that prescriptions for CDs that require safe storage were usually dispensed when a person came to collect from the pharmacy. The RP said they would complete the relevant checks, including confirming the identity of the person or representative, checking the relationship to the patient, and obtaining a signature for proof of collection upon handout of a CD. The registers of medicines which sounded similar or came in different formulations were colour coded to minimise mistakes being made when recording entries.

The pharmacy had a system available to record dispensing mistakes that were identified before reaching a person (near misses). And near misses were usually recorded by the person who made the mistake, to encourage ownership and learning. Each team member had their own login on the system and entries were checked by the pharmacist alongside an informal discussion to address any feedback and generate ideas to prevent future mistakes. The pharmacy technician explained that the pharmacy's near misses were low due to automation (dispensing robot equipment) in the dispensing process and if a mistake was made it was usually to do with quantity.

The RP and technicians explained how they reported any dispensing errors (where a dispensing mistake

had reached a person) to the SI and these were discussed in a team meeting. The team described the steps that they would take in the event that a dispensing error occurred. These included speaking to the person who had received the error and reporting to the person's GP if necessary. And completing a root cause analysis with the team members involved to identify the cause, learnings, any specific outcomes and establish corrections. There was a reporting tool on the pharmacy system which allowed entries to be reported to the Learn from patient safety events (LFPSE) service.

The pharmacy had current indemnity insurance. Feedback or complaints from people using the pharmacy's services could be received verbally in person, by telephone or via the pharmacy's website. The RP said that people sometimes gave feedback via online platforms. If a complaint was received, team members had an SOP to refer to and they could escalate issues to the SI. The trainee pharmacy technician explained that the SI used the consultation room to discuss people's concerns with them in private, and the team meeting to drive improvements.

Confidential paper waste was collected by an external contractor for appropriate destruction. And checked medications that were awaiting collection were stored in the dispensary to ensure that people's information was not visible from the counter. Patient-returned medicines that were to be sent for destruction had patient details still attached, the RP gave assurances that these would be removed or redacted appropriately in the future. Team members had completed General Data Protection Regulation (GDPR) and information governance training through e-learning for healthcare (e-LfH). All pharmacy team members had completed safeguarding training and understood safeguarding requirements. Team members were able to describe some of the signs to look for and the actions they would take to safeguard a vulnerable person. The pharmacy technician explained that they would discuss any safeguarding concerns with the RP. And there was an SOP for the team to refer to where necessary. The MCA was able to give an example of when they had raised a safeguarding concern.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff for the services it provides and manages its workload safely. The team has the appropriate skill mix to ensure safe practice, and team members can raise concerns if needed, in an open environment. Learning resources are available for ongoing training and there are opportunities for team members to complete further qualifications.

Inspector's evidence

The team present during the inspection consisted of the RP, a trainee pharmacy technician, a qualified pharmacy technician, a newly qualified accuracy checking pharmacy technician (ACPT) and two medicines counter assistants (MCAs). All team members were qualified or enrolled on accredited courses. The pharmacy technician explained that locum staff were employed for business continuity when required to cover any pharmacist absences.

The trainee pharmacy technician explained that they were set an objective to encourage the take-up of blood pressure services. However, currently no numerical targets were set for the services offered and the team was up to date with dispensing prescriptions with no backlog of workload. When asked, the MCAs were able to demonstrate an awareness of medicines with the potential for misuse and could identify people making repeat purchases. They knew questions to ask when selling medicines or providing advice and knew when to refer to the pharmacist.

The ACPT said that team members had an annual appraisal with the SI, where they were given an opportunity to discuss any feedback or concerns. When asked, the pharmacy technicians felt able to raise concerns with the SI and RP, and described working openly as a team. The trainee pharmacy technician explained that the SI held a monthly informal meeting to discuss any trends and patterns with the near misses. They said that they were also able to put forward ideas for change in this meeting. The RP gave an example of this for dispensing CD medications, they described that they ensure that more than one team member is involved in the dispensing process for CDs to reduce the likelihood of mistakes. The RP said that they felt comfortable using their professional judgement.

Team members were able to access pharmacy magazines and leaflets, and online training resources. Any new products or processes were discussed in the monthly team meeting, and the trainee technician said that occasionally they will have lunch hour sessions where they discuss relevant topics. However, when asked, team members said that there was only designated training time in work hours for completing their qualifications rather than ongoing training. This may mean that it is harder for them to stay up to date with current information.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and tidy, with adequate space for providing its services safely. And a high standard of fixtures and fittings. It keeps its premises safe and people visiting the pharmacy can have a conversation with a team member in private. The premises are secure from unauthorised access when closed.

Inspector's evidence

The pharmacy was modern and well fitted and projected a professional appearance. The dispensary was located at the rear of the retail area, which allowed team members to see people entering the pharmacy. And there were clear designated workspaces for different dispensing activities and space for the RP to check prescriptions safely and effectively. The dispensary computer screens could not be seen from the shop area. There were two suitably sized consultation rooms to the right of the pharmacy for the provision of services. One was currently used for storing medicines, but the MCA explained that this would soon be made available for offering services again. The rooms were locked at the time of inspection and allowed people to have a conversation inside at a normal level of volume and not be overheard. Suitable hygiene and infection control arrangements were in place for the provision of services, such as a sharps bin for correct disposal of vaccinations, disposable specula covers for ear check services and sanitising wipes.

Pharmacy-only medicines were kept behind the counter. The premises were well-lit, and there was air conditioning available to maintain a suitable temperature for the storage of medicines. Handwashing facilities were available in the dispensary and kitchenette. And a staff toilet was available with separate handwashing facilities. The team had a daily cleaning rota to ensure that the premises was well maintained, and overall the premises was seen to be visibly clean and kept to a high standard.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides its services in a safe way, and it is accessible to a range of people with varying needs. It obtains its medicines from reputable sources and generally stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

The pharmacy had step-free access available with an automatic door large enough for people with wheelchairs and pushchairs. Large-print labels were available on request and healthcare leaflets were available on the medicines counter. Some team members were multi-lingual.

Medicines were sourced from licensed suppliers. The trainee pharmacy technician said that expiry-date checks had been carried out recently for the stock on the shelves. The dispensing robot held the majority of the pharmacy's stock, and batch numbers and expiry dates were checked as it restocked. For boxes that had been split, the remaining quantity, batch number and expiry date was entered in the system manually before being put back into the robot. Items that were due to expire within a month were quarantined by the machine. A random spot check of shelf stock revealed some expired medicines that were not routinely used, these were disposed of immediately by the RP. Dates of opening for liquid medicines were not written on the bottles and two bottles of medicine that were required to be used within three months of opening, as per manufacturers guidance, were found. This may make it harder for staff to know if they were still suitable to use. Medicinal waste bins were available and were collected periodically by a waste contractor. Temperature records for the pharmaceutical fridges were completed daily and showed no deviations in temperature outside of the required range of between 2 and 8 degrees Celsius.

Team members were observed following the SOP for dispensing prescriptions and baskets were used to keep items for different people separate. The prescriptions were signed at each step in the dispensing process including when they were dispensed, clinically checked, and accuracy checked. Dispensing labels included 'dispensed by' and 'checked by' boxes to indicate who had carried out those tasks.

The pharmacy dispensed some medicines in multi-compartment compliance packs for people who needed help to manage their medicines. Packs were assembled using an automated machine in a designated area of the dispensary to avoid distractions. The pharmacy used information sheets to keep track of ordering regular medications in a timely manner and any changes were clearly documented on these once confirmed using the NHS Summary Care Records. The ACPT said that they were often contacted by the surgery if there were any changes made to a person's regular prescription. Any discrepancies were followed up with the GP surgery and notes were made on the patient's medication record (PMR). The ACPT demonstrated how the compliance packs were processed. Medicine warnings were printed on the sheets inside of the packs, alongside pictures of each of the medicines. Patient information leaflets were not routinely provided, and this may mean that people do not have up-to-date information about their medicines. The SI gave assurances that people would be offered these in the future.

The pharmacy deblistered medicines that were to be dispensed in the automated machine. The

pharmacy team was aware that not all medicines could be deblistered. Such as those that were in special containers or those that could be damaged if removed from the original pack. There was a process for putting the medicines into the containers in the pharmacy robot. This included documenting which medications had been deblistered on a sheet and giving this to the pharmacist alongside the empty medicine packaging for them to check the medicine before it was put in the machine. The batch number and expiry date were entered into the machine and the ACPT explained that this helped in checking the medicines when there was a safety alert or medicine recall. One bottle of medicines that had been deblistered and put in a bottle was found on the shelf, however no batch number or expiry date was written on the label. This was put with the medicinal waste when highlighted to the RP.

The pharmacy received safety alerts and drug recalls, or information about other problems with medicines or medical devices, through the pharmacy's computer system and email. There was an option on the pharmacy system to record action taken against these alerts, however during the inspection, team members were not aware of this. The SI has since provided evidence that this system is in place and all alerts had been actioned. Alerts were also received through the wholesale deliveries and the MCA said that they always handed these to the RP for actioning.

The pharmacy offered a delivery service and had a designated delivery driver, all deliveries were made within the pharmacy opening hours. A diary was used as an audit trail for the deliveries that were made and the driver obtained signatures when CDs were delivered to people. Medicines were returned to the pharmacy if people were not home, and the pharmacy had contact numbers for people receiving deliveries and would reschedule where necessary.

For uncollected medications, the prescriptions were removed from the shelf every three months. Those prescriptions that people did not come in to collect were returned to the prescriber or marked as not dispensed on the system. Stock for these prescriptions was returned to the shelf where appropriate.

When asked, the RP and ACPT were aware of the risks involved when supplying valproate products to people who could become pregnant. They also knew about the guidance to supply these products in complete original manufacturer's packs, and to ensure they didn't cover any of the warnings with dispensing labels. They explained that they had some people that received valproate medications in compliance packs. Individual risk assessments had not been undertaken for these people, but none of them fell within the at-risk group. The SI has since provided an example of a risk assessment that had been completed and gave assurances that they would be completed for other people receiving valproate products in compliance packs. Prescriptions for other high-risk medicines were highlighted by the PMR system. The pharmacy kept copies of monitoring documents for higher risk medicines to ensure care was taken when dispensing these medications to people. CDs that did not required safe storage were not always highlighted to make team members aware to check the validity of the prescription. This may mean that prescriptions with a 28-day validity are not identified prior to handing out.

The RP said that PGDs for the Pharmacy First service were saved on the computers for reference alongside the clinical pathway information. They explained that people requiring the Pharmacy First service were mostly referred from local surgeries, but they received some self-referrals. The RP confirmed they had completed the training to provide the service and the SI had communicated key points to the rest of the team to ensure they understood when to refer to the pharmacist.

The PGDs for the private services offered were stored electronically. These were not available during the inspection. Copies of PGDs were provided following the inspection and had been signed and dated by the SI who provided the services. Examples of certificates of competency were also provided,

alongside examples of consultation notes and a travel risk assessment form. The pharmacy administered vitamin B12 injections to people who had received a private prescription through a third-party service. The protocol for administering this medicine was in place and there was a declaration of competency for the SI who was delivering the service. Basic risk assessment checklists had also been completed for the travel clinic and B12 injection service.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use.

Inspector's evidence

The pharmacy used suitable standardised conical measures for measuring liquids. Separate conical measures were available for certain liquids that were marked to avoid cross-contamination. A digital otoscope was available for providing private and Pharmacy First services. There was a blood pressure monitor in the consultation room, the SI said that this was replaced every two years, with the most recent machine purchased in February 2024. The 24-hour ambulatory blood pressure monitors were due for calibration in October 2024. An anaphylaxis kit was available in the consultation room for providing the vaccination service. A portable telephone enabled the team to ensure conversations were kept private where necessary. All computers were not visible from the shop area, and they were password protected to safeguard information. And team members had their own smartcards to access NHS information and electronic prescriptions. Fire extinguishers were available in the dispensary.

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.