

# Registered pharmacy inspection report

**Pharmacy Name:** J Lord Chemist, 439 Lordship Lane, Wood Green,  
LONDON, N22 5DJ

**Pharmacy reference:** 1040528

**Type of pharmacy:** Community

**Date of inspection:** 26/07/2024

## Pharmacy context

This pharmacy is situated in a parade of shops on a busy main road. It is in close proximity to a health centre. As well as dispensing NHS prescriptions, the pharmacy provides a number of services including flu vaccinations, the Hypertension Case Finding Service, the Pharmacy First service, emergency hormonal contraception and the Community Pharmacist Consultation Service. The pharmacy supplies medicines for some people in multi-compartment packs and provides deliveries. And it offers travel vaccinations as a private service.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy's working practices are generally safe and effective. The pharmacy mainly keeps the records it needs to by law so that medicines are supplied safely and legally. And the pharmacy team knows how to help protect the welfare of vulnerable people. Team members respond appropriately when mistakes happen during the dispensing process. But the pharmacy does not regularly review mistakes for patterns or trends. So, team members may be missing out on opportunities to learn and make the pharmacy's services safer.

### Inspector's evidence

Standard operating procedures (SOPs) were available but were overdue for review. The pharmacist said they were in the process of reviewing them and converting them to digital platforms. Team members had signed the SOPs once they had read them. SOPs for the dispensary outlined roles and responsibilities of team members clearly. However, there were no SOPs outlining the roles of the medicines counter assistants. The importance of having SOPs that outlined the roles and responsibilities of all team members was discussed. At the time of the inspection, the pharmacy team had a good understanding of their roles and the services provided.

The pharmacy had processes to record dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were recorded and discussed with team members as they occurred. However, the discussions were not documented, and the near miss log was not reviewed. The importance of regularly reviewing the near misses was discussed. Team members gave an example of changes they had implemented to reduce the risk of errors. Medicines with similar names or appearances had been more clearly separated in the dispensary following near misses. These included amlodipine and amitriptyline. Dispensing errors were reported online and documented on the Patient Medication Record (PMR). Team members were able to describe the process they would follow if one happened. The pharmacist was aware that controlled drug (CD) related incidents should be reported to the CD accountable officer.

The correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The RP said the pharmacy had a complaints procedure but could not find this during the inspection. The superintendent (SI) pharmacist received complaints and the pharmacy also had a human resources (HR) department to help manage the complaints. A feedback stand was available on the shopfloor for people to use. As a result of previous complaints, the pharmacy team now requested people to write their personal details down rather than saying them out loud when collecting prescriptions.

Records about private prescriptions, unlicensed medicines supplied, and controlled drug (CD) registers were well maintained. A spot check of a random CD found that the quantity of physical stock matched the recorded balance. CDs that people had returned were recorded in an electronic register as they were received. Destruction of returned CDs was carried out with a witness. CD balance checks were completed at regular intervals. Records for emergency supplies and the RP log were generally well maintained. A few entries about emergency supplies did not have the reason for supply and there were a few instances where the RP had not signed out of the RP record. The importance of maintaining

accurate and complete records was discussed.

Patient confidentiality was protected using a range of measures. Prescriptions awaiting collection were generally stored in a way to ensure people's private information was out of sight of the public. However, on entering the pharmacy a bag containing meal-replacement drinks with a bag label was found on the shop floor. This was removed immediately and the importance of keeping people's private information out of sight was discussed. Team members all completed training about confidentiality. The pharmacy had an information governance policy that the team had read and signed. Team members who needed to access NHS systems had individual smartcards. The RP had access to Summary Care Records and consent to access these was gained from people verbally. Confidential waste was separated into designated bags and removed by a special contractor. Delivery sheets with people's information were returned to the pharmacy at the end of the day for disposal with the confidential waste. A privacy notice was displayed in the pharmacy.

The pharmacist had completed level three safeguarding training and the pharmacy technician had completed level two safeguarding training. All other team members had not completed safeguarding training. The RP gave an assurance that all team members would be enrolled on safeguarding training. Details for local safeguarding boards were displayed in the dispensary along with a sign explaining what to do if there are concerns about a child. Team members would refer any concerns to the RP.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy team works well together and feels well-supported at work. There are generally enough team members to manage the workload. And they do the right training for their roles.

### Inspector's evidence

At the time of the inspection the team comprised of the RP, a pharmacy technician, a trained dispenser, and a trained medicines counter assistant (MCA). The team were busy but felt they were able to keep up with the workload. The pharmacy was in the process of recruiting an additional team member to work in the pharmacy during the weekend and help manage the workload during the week. Locum pharmacists worked in the pharmacy when the regular pharmacist was absent. Individuals from other branches covered absences of the pharmacy team.

The RP was an independent prescriber, but limited their prescribing activity to issuing patient specific directions (PSDs) for the vaccination service. He had also completed the required training for the Pharmacy First service and completed the declaration of competence. Team members received regular training from an external training provider. And the RP held team meetings when there were significant updates or new services. The MCA was aware of the maximum quantities of some medicines that could be sold over the counter and referred queries to the pharmacist if required. Team members felt they were able to raise concerns or give feedback. They had direct access to the SI. Staff performance reviews were conducted annually by the SI. Team meetings were conducted quarterly by the SI and annual meetings were held with the owner. There were no targets set for services provided.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

### Inspector's evidence

The pharmacy comprised of a larger shopfloor and smaller dispensary. The dispensary had limited space, but workbenches had been allocated for specific tasks and there was a designated checking bench. The shopfloor was clean and tidy, with a seat for those waiting for prescriptions or services. The consultation room was easy to access and was lockable. It was not locked at the time of the inspection, and the importance of keeping the room locked when not in use was discussed. The room allowed a conversation at a normal level of volume to take place inside and not be overheard.

A sink was available for preparing medicines with hot and cold running water. Toilets were available for team members and were kept clean. The room temperature was adequate for providing pharmacy services and storing medicines. The premises were secure from unauthorised access.

## Principle 4 - Services ✓ Standards met

### Summary findings

Overall, the pharmacy provides its services safely. It takes steps to help ensure that people with a range of needs can access the pharmacy's services. It orders its medicines from reputable sources and stores them securely. However, the pharmacy does not routinely highlight prescriptions for higher-risk medicines, so may miss out on opportunities to speak with people collecting them.

### Inspector's evidence

The pharmacy had a small step at the entrance and team members would help people requiring assistance. The RP was observed helping a person with a pushchair enter the pharmacy. The shopfloor was wide and clear with easy access to the pharmacy counter. The pharmacy had the ability to produce large-print labels. Some team members were multilingual, and people were signposted to other services where appropriate. The MCA was observed signposting a person to another shop for products they did not stock. Pharmacy only medicines were kept behind the medicines counter.

Most prescriptions were received electronically by the pharmacy. The pharmacy also dispensed a large portion of private prescriptions from a nearby private clinic. Baskets were used to separate prescriptions to prevent transfer between patients. The dispensed and checked by boxes on the labels were not always used, which could make it difficult to identify who was involved. The importance of maintaining clear dispensing audit trails was discussed. Prescriptions were dispensed by the dispenser or technician and checked by the pharmacist. Dispensed medicines awaiting collection were kept on shelves in a tidy manner with bag labels attached, but the prescriptions themselves were filed away. This meant the team could not easily identify what the prescription was for without opening the medicines bag. Prescriptions for fridge items and CDs were kept with the medicine bag so the team could check the date and ensure they do not hand out expired prescriptions. The team removed prescriptions from the shelf every four weeks to review if the medication was still needed and ensure they did not hand out expired prescriptions. The RP explained that they provided counselling to people who were newly started on medicines that required regular monitoring such as warfarin and methotrexate. However, prescriptions for these medicines were not routinely highlighted, which means the pharmacy could miss opportunities to provide additional checks. Team members were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). At the point of dispensing the technician checked if the person fell into the at-risk group and alerted the pharmacist. Team members were aware of where to place the label on the pack.

The pharmacy supplied medicines in multi-compartment compliance packs to people who required them. The ordering of prescriptions and preparation of the packs were managed electronically using a spreadsheet. The team attached backing sheets to the packs, which indicated when each medicine should be taken. However, the sheets did not include the required warnings or descriptions of the medicines. The pharmacy technician said he would ensure the packs included the required warnings. Not having a description of the medicines inside the packs could make it harder for people or their carers to identify the medicines. The team kept electronic copies of the backing sheets, where they documented any changes to people's medicines. They also recorded changes and if people were in hospital on the patient medication record (PMR). The pharmacy provided people with patient information leaflets about their medicines every three months. The importance of supplying the leaflets

with each pack was discussed. An audit trail was maintained of who had dispensed and checked the packs. The pharmacy provided a delivery service. If nobody was available to receive the delivery, the medicine was returned to the pharmacy.

In date patient group directions (PGDs) were available for the services provided. The Pharmacy First service was the only service available under a PGD at the time of the inspection. The RP had completed all the accreditation for the service and signed the PGD. The RP provided travel vaccinations against PSD. These were completed and administered by the RP. Relevant records were maintained for the service.

Medicines were obtained from licensed wholesalers and stored appropriately. These included medicines requiring special consideration such as CDs. Fridge temperatures were monitored daily and recorded; records seen were within the required range for storing temperature-sensitive medicines. Date checking was done every six months by the team and every three months by external stock takers. No date-expired medicines were seen on the shelves checked. However, the pharmacy held two anaphylaxis kits for the services it provided. One kit was found to be expired; this was removed straight away. A date-checking matrix was available. Short-dated stock was labelled. Out-of-date and other waste medicines were separated and then collected by licensed waste collectors.

Drug recalls were received electronically on the computer system. The team could explain how they would action alerts straight away if they were relevant. However, the team did not keep a record of their actions. This could make it harder for the pharmacy to show how they had protected people's health and wellbeing in the event of a product safety alert. The importance of maintaining a log of their actions and indication they had reviewed the alerts was discussed.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the necessary equipment and facilities to provide its services safely and to protect people's confidentiality.

### Inspector's evidence

The pharmacy had glass, crown-stamped measures, and tablet counting equipment. Separate labelled measures were available for measuring liquid CD preparations to avoid cross-contamination. A separate labelled tablet counter was available for cytotoxic medicines. The pharmacy had a tablet counting machine, but this was not in use. It had a medical grade fridge and a CD cabinet. A blood pressure machine was available to deliver the pharmacy's services, and this was calibrated annually.

The team used up-to-date reference sources such as the BNF and NICE guidelines, and they had access to the internet. Computers were all password protected and screens faced away from people using the pharmacy. The pharmacy had a cordless phone so team members could move to somewhere private for confidential conversations.

### 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.