General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Eico Pharmacy, 97 Highgate Road, LONDON, NW5 1TR

Pharmacy reference: 1040601

Type of pharmacy: Community

Date of inspection: 18/11/2024

Pharmacy context

The pharmacy is in a parade of businesses in a residential area in northwest London. It dispenses NHS and private prescriptions, sells over-the-counter medicines and offers healthcare advice. It supplies medicines in multi-compartment compliance packs for people who have difficulty managing their medicines. Other services include blood pressure case-finding service, flu vaccination and NHS Pharmacy First.

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

The pharmacy generally identifies and manages the risks involved in providing its services. And it monitors the safety and quality of the services. The pharmacy team members follow appropriately written standard operating procedures. People who access pharmacy services can leave feedback to help it do things better. The pharmacy keeps the records it needs to by law to show how it supplies its services and medicines safely. Members of the team protect people's private information appropriately and they understand their role in safeguarding vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team discussed the mistakes they made to learn from them and agree actions to reduce the risk of them happening again. The RP explained that medicines involved in incidents, or were similar in some way, such as rivaroxaban and rosuvastatin were generally separated from each other in the dispensary. The pharmacy's medicines were arranged so the top 50 fast-moving medicines were together to improve workflow and this helped separate similar medicines and reduce the chance of picking errors. The superintendent pharmacist (SI) compiled regular patient safety reviews to share with the team and they were aware of reporting dispensing incidents to the NHS 'Learning from patient safety events' (LFPSE) service.

Members of the pharmacy team who made up people's prescriptions used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. Team members initialled dispensing labels to show who dispensed and checked assembled prescriptions. They alerted the responsible pharmacist (RP) to interactions between medicines prescribed for the same person. Sometimes the RP contacted the prescriber regarding interactions and maintained an audit trail of significant interventions which were recorded. Prescriptions were not handed out until they were clinically and accuracy checked by a pharmacist (RP). There was a process for dealing with outstanding medicines when stock was delivered and the remaining medicine was dispensed. The team highlighted high-risk prescriptions about which the RP needed to talk to the person collecting. And the team members checked the person's name, address, date of birth and if the prescription was exempt from charge before giving out a prescription.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these were reviewed regularly. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. There were training records to show members of the team had read, understood and would follow the SOPs in line with their roles and responsibilities. Members of the team followed a sales protocol when recommending medicines over-the- counter (OTC) and they knew when to refer to the RP. They understood what they would and could not do if the RP was absent. They would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar products, such as medicines people might abuse to a pharmacist. The pharmacy had a complaints procedure. And it displayed a practice leaflet. People who used the pharmacy submitted feedback online.

The RP discussed the factors taken into consideration when risk-assessing the pharmacy prior to

providing the flu vaccination services. Such as vaccine storage, clinical waste disposal and team training. The RP also risk-assessed the suitability of resources to offer NHS Pharmacy First Service such as record keeping on PharmOutcomes to inform the GP surgery and training to use the otoscope. The pharmacy liaised with the main local surgeries. The pharmacy team had completed pharmacy quality scheme (PQS) audits such as how people use their metered dose inhalers including their steroid inhaler with or without a spacer. The RP was aware of the clinical audit for people taking a valproate and updated guidance for dispensing valproates which had been extended to supplying topiramate too.

The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and it displayed a notice that told people who the RP was. The pharmacy maintained a CD register which was kept up to date and the stock levels recorded in the CD register were checked regularly. A random check of the actual stock of a CD matched the recorded amount in the CD register. Patient-returned CDs were listed and awaiting destruction. The RP maintained records of consent and interventions on the patient medication record (PMR). The private prescriptions records were generally in order and the specials records were complete. Records for treatments via the NHS Pharmacy First service were maintained electronically and shared with the person's GP. The pharmacy supplied treatments in line with the patient group direction (PGD) pathways and referred people seeking treatment but who did not comply with the pathway in some way.

The pharmacy was registered with the Information Commissioner's Office. The team members had read the information governance SOP and were aware of general data protection regulation (GDPR). They had signed confidentiality agreements. The pharmacy team members collected confidential waste to be disposed of securely. And they used their own NHS smartcards. The pharmacy had completed the NHS data security and protection toolkit. The pharmacy computers were password protected. The pharmacy privacy notice was displayed. The pharmacy had a safeguarding SOP. And the RP had completed a level 3 safeguarding training course. Members of the pharmacy team knew who they would make aware if they had concerns about the safety of a child or a vulnerable person. The RP was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

Members of the pharmacy team work well together and they manage their workload effectively. They are supported with training which helps to keep their skills and knowledge up to date. Team members are comfortable about providing feedback and suggestions which the pharmacy acts on to improve its services.

Inspector's evidence

At the time of the visit, the full-time RP was supported by a part-time pharmacist, a full-time registered pharmacy technician, and a full-time dispensing and medicines (combined) counter assistant and a full-time medicines counter assistant. Team members completed training modules via training providers such as eLearning for healthcare. And training had been undertaken in Pharmacy First, data security, infection control and supplying oral contraceptives.

Members of the pharmacy team had completed or were enrolled on accredited training relevant to their roles. They generally studied when it was quiet in the pharmacy. The RP shared information about new OTC products and drug alerts and recalls. The RP explained training completed to deliver the flu vaccination service. The RP was signposted to the GPhC Knowledge Hub. The pharmacy relied upon its team to cover Saturday shifts and absences.

Members of the team worked well together. So, people were served quickly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an OTC sales and self-care SOP for its team to follow. This described the questions the team member needed to ask people when making OTC recommendations. Team members knew when to refer requests to a pharmacist. The RP described giving ream members feedback ‘in the moment’ rather than an appraisal. They were comfortable about making suggestions to the superintendent pharmacist on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, bright and secure and it is a suitable environment in which to deliver healthcare. The premises are suitably equipped to protect the pharmacy's medicines stock and people’s private information when the business is closed.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. The premises had been refitted since the previous inspection visit. And steps were taken to make sure the pharmacy and its team did not get too warm. The pharmacy had a large retail area, and a medicines counter with a moveable section which could be locked in different positions. The dispensary was towards the back of the pharmacy. There was seating for people who wanted to wait. The pharmacy had a consultation room which was signposted. So, people could have a private conversation with a team member. Worksurfaces in the dispensary were kept clean and tidy. The pharmacy had handwashing facilities. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. Its services are easily accessible to people with a variety of needs. The pharmacy obtains its medicines from reputable suppliers and stores them securely at the correct temperature so they are fit for purpose when they are supplied to people. The pharmacy team members carry out appropriate checks for affected stock when they receive medicine alerts and recalls. This helps make sure people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy entrance was level with the outside pavement and the opening hours were displayed. There was information about pharmacy services displayed on a screen in the front window. To make sure people could use the pharmacy's services, members of the pharmacy team could speak or understand languages such as Gujarati, Hindi, Nepali and Urdu to help people whose first language was not English. The pharmacy had seating for people to use if they wanted to wait. Members of the pharmacy team signposted people to another provider if a service was not available at the pharmacy.

The pharmacy provided a flu vaccination service mainly on a walk-in basis via national protocol. It had completed a risk assessment prior to commencing the service. The pharmacy recorded consent, clinical assessment including vaccines type electronically and the information was passed to people's GP surgeries. Vaccines were stored in a fridge and the maximum and minimum temperatures were monitored and recorded daily. The RP had adrenaline injections to administer in the event of anaphylaxis. Arrangements were in place to dispose of clinical waste. The pharmacy team would contact the SI regarding implementing the business continuity plan to continue providing services following a systems failure. The team members who vaccinated had completed face-to-face training including safeguarding and informed the insurance providers about the service.

The pharmacy provided Pharmacy First service and treatment for each condition via PGD. People were generally referred and consultations took around 15-20 minutes. Records were maintained electronically and the most common conditions treated were for urinary tract infections and sore throat. People who did not meet the inclusion criteria on the PGD would be signposted to their GP or A&E. Members of the pharmacy team could identify which of them prepared a prescription and they highlighted some prescriptions to indicate when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added. The RP counselled people taking a valproate and explained the pregnancy prevention programme making sure they had educational information such as a patient card and patient information leaflet (PIL). He was aware of updated guidance for dispensing valproates which had been extended to supplying topiramate too.

The RP gave examples of counselling and therapeutic monitoring for other medicines. For instance, checking the person's yellow book for the most recent INR and blood test dates for people who took warfarin. And providing counselling on foods which may affect INR. He explained therapeutic monitoring for people who were supplied isotretinoin. The pharmacy prepared, checked and sealed the compliance packs according to a matrix. The pharmacy used a disposable multi-compartment compliance pack to supply medicines to people who had difficulty managing their medicines. The

pharmacy re-ordered prescriptions for people and checked them for changes before dispensing. Changes of medication were reflected in the backing sheet which was replaced and the previous backing sheet was retained. And interventions were recorded. And they were advised about taking medicines such as lansoprazole and levothyroxine before other medicines. High-risk medicines were supplied separately or highlighted to the person if they were included in the compliance pack. Prescriptions for CDs were dispensed and supplied within the period that the prescription was valid. The pharmacy team generally provided a brief description of each medicine contained in the compliance packs and always provided patient information leaflets. So, people had the information they needed to make sure they took their medicines safely.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices in their original manufacturer's packaging. And team members recorded when they had completed a date-check. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. CDs were stored in line with safe custody requirements. Waste medicines were kept separate from stock in one of its pharmaceutical waste bins which were collected by a contractor. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described checking stock for affected batches and people who had been supplied an affected medicine were contacted if necessary. The RP described yellow card reporting too when medicines or devices were faulty.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And its team makes sure the equipment protects private information.

Inspector's evidence

The pharmacy team had access to up-to-date reference sources online. The pharmacy had measures for use with liquids. The pharmacy had a fridge to store pharmaceutical stock requiring refrigeration. Team members regularly checked and recorded the maximum and minimum temperatures. The CD cabinet was fixed with bolts. The pharmacy had adrenaline injections to deal with anaphylactic shock. And the team knew the location of the nearest defibrillator. They disposed of confidential waste appropriately. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. They used their own NHS smartcards. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team.

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.