

Registered pharmacy inspection report

Pharmacy Name: Grafton Pharmacy, 132-132a Tottenham Court Rd,
LONDON, W1T 5AZ

Pharmacy reference: 1041338

Type of pharmacy: Community

Date of inspection: 17/09/2024

Pharmacy context

This is an independently owned pharmacy near Warren Street underground station on Tottenham Court Road, central 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, travel and seasonal flu vaccinations, hormonal contraception and NHS Pharmacy First.

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
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. It has suitable written instructions to help its team members to work safely and effectively. And it monitors the quality of its services. People who use the pharmacy 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 protecting vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The responsible pharmacist (RP) checked prescriptions and if he found an error he asked the team member to identify their own mistake and correct it. Members of the pharmacy team discussed the mistakes they made to learn from them and agreed actions to reduce the chances of them happening again. The RP explained that medicines involved in incidents, or were similar in some way, such as amitriptyline and amlodipine, were generally separated from each other in the dispensary to minimise the risk of a picking error. The RP compiled regular patient safety reviews to share with the team and he was aware of reporting dispensing incidents to the NHS 'Learning from patient safety events' (LFPSE) service.

The RP described factors taken into consideration when risk-assessing the pharmacy prior to providing the vaccination services. Such as vaccine storage, clinical waste disposal and team training. He also risk-assessed the suitability of resources to offer NHS Pharmacy First Service such as linking record keeping on the patient medication record (PMR) to inform the GP surgery and training to use the otoscope. The RP had undertaken pharmacy quality scheme (PQS) audits in anti-coagulants, asthma and antibiotics although the data set was not enough in some cases to draw an effective conclusion. He 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.

When members of the pharmacy team took in prescriptions at the medicines counter, they completed the legal check to make sure all the required sections of the prescription were completed. The RP used baskets to separate each person's medication and to prioritise workflow. Team members referred to prescriptions when picking or labelling products. And initialled dispensing labels to show who dispensed and checked assembled prescriptions including interactions between medicines prescribed for the same person. Prescriptions were not handed out until they were clinically and accuracy checked by the RP. Sometimes the RP contacted the prescriber via phone or NHS email regarding interactions or availability of medicines and maintained an audit trail of significant interventions which were recorded. There was a process for dealing with outstanding medicines when stock was delivered and the remaining medicine was dispensed. Bagged prescriptions awaiting collection were stored on designated place until someone collected them. The team highlighted high-risk prescriptions about which the RP needed to talk to the person. And the team members checked the person's name, address and date of birth before giving out prescriptions.

The pharmacy had a set of standard operating procedures (SOPs) online with a copy on flash drive as a backup. These covered most of the services provided, were reviewed regularly and included RP SOPs.

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. The most recent SOP concerned a COVID update. 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. People could leave feedback online via a patient survey on the website or in person.

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 when. 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 frequently. The pharmacy demonstrated records of interventions on the PMR and records of consent for services. The private prescriptions records were generally in order. The specials records were complete. Records for treatments via the NHS Pharmacy First service were seen to be 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 and they were aware of general data protection regulation (GDPR). The pharmacy team members tried to make sure people's personal information could not be seen by other people and was disposed of securely. And they used their own NHS smartcards. The RP had completed the NHS data security and protection toolkit. The pharmacy computers were password protected. The pharmacy privacy notice required reprinting. 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

The pharmacy's team members work well together to manage their workload safely and effectively. The pharmacy supports its team members with ongoing training to help keep their skills and knowledge up to date. Team members are comfortable about providing feedback and suggestions which the pharmacy has acted on to improve its services.

Inspector's evidence

The pharmacy team consisted of two full-time pharmacists, a part-time dispensing assistant and three full-time medicines counter assistants. The pharmacy relied upon its team to cover absences. The pharmacy maintained training records which included induction and reading SOPs. The team members were provided with service updates. And the RP had completed Centre for Pharmacy Post-graduate Education (CPPE) Pharmacy First training course. Members of the pharmacy team had completed or were enrolled on accredited training relevant to their roles. They could request protected learning time. The RP described skincare training the team members had undertaken via online seminars and it covered treating conditions such as eczema under the eyes.

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 which its team needed to follow. This described the questions the team member needed to ask people when making OTC recommendations. And when they should refer requests to a pharmacist. Members of the pharmacy team could make decisions to help keep people safe. And they had annual appraisals to monitor training needs. They received updates via a WhatsApp group. They were comfortable about making suggestions on how to improve the pharmacy and its services and had suggested highlighting short-dated stock on the dispensary shelves to alert team members to check the expiry date would cover the treatment period if it was dispensed. 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 provides a suitable environment to deliver healthcare services. 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 had been refitted since the last inspection and the pharmacy was bright and secure. And steps were taken to make sure the pharmacy and its team did not get too warm. The pharmacy had a large retail area, a medicines counter, and a dispensary. There was seating for people who wanted to wait. The pharmacy had a consultation room. So, people could have a private conversation. Worksurfaces in the dispensary could become cluttered when the pharmacy was busy. The pharmacy had handwashing facilities. Members of the pharmacy team were responsible for keeping the pharmacy's premises clean and tidy in line with a matrix.

The pharmacy website did not sell any products. Referring to the GPhC distance selling guidance, it did not prominently display all the required information described in the guidance. But it did have useful information about the pharmacy and its services. People could re-order their repeat prescriptions.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy and its services are easily accessible to people with a variety of needs. Its working practices are safe and effective. The pharmacy obtains its medicines from reputable sources and stores them securely at the correct temperature to help ensure 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 so people who found steps difficult, such as someone who used a wheelchair could access the pharmacy's services. To make sure people could use the pharmacy's services, members of the pharmacy team could speak or understand languages such as Urdu, Hindi, Gujarati and Punjabi to help people whose first language was not English. The pharmacy displayed information about its opening hours and services. And it updated Pharmacy Choices regularly. 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. For instance, University College London Hospital, Mortimer Market and Marie Stopes.

The pharmacy provided flu and COVID-19 vaccination services on a walk-in or appointment basis via PGD or national protocol. It had completed risk assessments prior to commencing these services. 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 vials and syringes to administer adrenaline in the event of anaphylaxis. Arrangements were in place to dispose of clinical waste. The business continuity plan included extra staff members to manage the retail side and free up the pharmacy team's time. The team members who vaccinated had completed face-to-face training including level 3 safeguarding and informed the insurance providers about the service.

Members of the pharmacy team could identify which of them prepared a prescription and they marked some prescriptions to highlight 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. The pharmacy delivered some medicines locally to people in their homes. Making sure there was a robust audit trail was discussed.

The pharmacy prepared, checked and sealed the compliance packs at the same time. The pharmacy used a disposable multi-compartment compliance pack to supply medicines to people who had difficulty managing their medicines. The RP re-ordered prescriptions for people and audited them for changes before dispensing. And interventions were recorded on the backing sheet. The RP went

through how best to use the compliance packs with people when they were first being supplied medicines in a pack. And they were advised about taking medicines such as lansoprazole and levothyroxine before other medicines. High-risk medicines were mostly supplied separately. Prescriptions for CDs were dispensed and supplied within the period that the prescription was valid. The RP 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. Members of the pharmacy team could identify which of them prepared a prescription and they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added.

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 requirements. Waste medicines were kept separate from stock in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described receiving the alert email, printing, stamping and dating. Stock was checked and people 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 the maximum and minimum temperatures. 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.