General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: John Walker Chemist, 2/3 Medway Court, Leigh Street, LONDON, WC1H 9QX

Pharmacy reference: 1041553

Type of pharmacy: Community

Date of inspection: 23/09/2021

Pharmacy context

The pharmacy is in a street near Euston Station in north west London. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include prescription collection and delivery, and supervised consumption. The inspection took place during the COVID-19 pandemic. All aspects of the pharmacy were not inspected.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.8	Standard not met	The pharmacy does not have a procedure to raise safeguarding concerns and protect vulnerable people.
2. Staff	Standards not all met	2.1	Standard not met	There are not enough staff to manage the workload and complete routine tasks.
3. Premises	Standards not all met	3.1	Standard not met	There are areas of the pharmacy which are not clean and tidy and may represent a risk to the safe provision of some of its services.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	Some arrangements are not appropriate to the safe and effective management of the pharmacy's medicines such as storage of waste medicines, medicines not requiring safe custody and CDs, and CD record keeping.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not have satisfactory written procedures which cover all its services or for safeguarding vulnerable adults and children. The pharmacy mostly keeps satisfactory records of the things it needs to by law. So it can show the pharmacy is generally providing safe services. But it doesn't always complete those records in a timely way. The pharmacist has introduced new ways of working to help protect people against COVID-19 infection. And he keeps people's private information safe.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The responsible pharmacist (RP) worked alone and didn't routinely record them or the lessons that were learnt from them. So, he could be missing opportunities to spot patterns or trends with the mistakes that were made. The RP explained that medicines involved in incidents, or were similar in some way, were separated from each other in the dispensary. For instance, aripiprazole and olanzapine which were both used to treat the same condition. So the RP had an extra checking procedure when dispensing a prescription for either medicine. There was a standard operating procedure (SOP) and a complaints interview form for recording and reporting incidents, but no records were seen.

The RP used baskets when dispensing prescriptions to separate each person's medication and to help prioritise his workload. He placed items in a basket when labelling and picking products. Assembled prescriptions were not handed out until they were checked by the RP and the dispensing labels were initialled to show the medicines had been checked. The RP checked online or with the prescriber if there were interactions between two medicines for the same person. But the intervention was not always noted on the patient's medication record (PMR) which might make it harder for him to explain what happened later if needed. The RP took a mental break between dispensing and checking prescriptions. There was a procedure for dealing with outstanding medicines, so people received the complete course of treatment.

The dispensary bench was very untidy with miscellaneous paperwork and stacks of baskets, some of which contained prescriptions. There were several tote boxes containing prescriptions awaiting collection so there was little workspace. And an increased risk of things going wrong. The floor areas were used to store large items in boxes which may be a trip hazard in places.

To protect against infection, the RP had completed a risk assessment on the effects of COVID-19 on the premises and people visiting the pharmacy and he knew to report any COVID-19 infections contracted in the workplace to the relevant authorities. There was hand sanitiser at the medicines counter for people to apply. Personal protective equipment (PPE) was also available, and the RP wore a mask. As people entered the retail side of the pharmacy, they were generally standing at a distance from each other.

The pharmacy had SOPs which included controlled drug (CD) and complaints SOPs. They had been prepared and reviewed in Feb and Mar 2019 and there were training records to show the staff at that

time had read and understood the SOPs. The CD audit was not always carried out at the intervals stated in the CD SOP. The pharmacy did not have a safeguarding SOP explaining what to do or who to make aware if the RP had concerns about the safety of a child or a vulnerable person. Ensuring SOPs reflect actual practice and all the services provided by the pharmacy was discussed. The pharmacy displayed a notice inviting members of the public to provide their views and suggestions on how the pharmacy could do things better. The RP said there had been no patient feedback.

The pharmacy had appropriate 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. The pharmacy had controlled drug (CD) registers. But the RP had fallen behind with making sure the methadone registers were kept up to date so there was some recent outstanding information to record on receipt and supply of methadone. Following the visit, the RP confirmed that the methadone registers were up to date. So, the RP could have been missing opportunities to spot mistakes quickly. A check of the actual stock of two randomly selected strengths of CD matched the recorded amounts. There were patient returned (PR) CDs which required listing in the PR CD destruction register. The CD accountable officer (CDAO) details needed to be updated in case the RP had to report a problem with a CD. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. But it didn't always record information about the prescriber. The pharmacy recorded the private prescriptions it supplied electronically. And these generally were in order. But the name and address of the prescriber were sometimes not recorded.

The RP had completed the modules in a general data protection regulation (GDPR) folder following the last inspection visit although it may have required updating as the annual review dates were not signed off. But the pharmacy did not display a notice that told people how their personal information was gathered, used and shared by the pharmacy. The pharmacy had a shredder to make sure people's personal information couldn't be seen by other people and was disposed of securely. And the pharmacy computer was password protected and backed up regularly. The RP's own NHS card was in use and the computer screen could not be seen by an unauthorised person.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy is not adequately managing its current workload including its routine tasks. It does not have enough suitably trained staff to help the pharmacist.

Inspector's evidence

The RP was working alone in the dispensary at the time of the visit and explained that there were not enough staff to manage the workload. Another person who described himself as being a shop assistant was present in the retail area. He explained his duties as including cleaning shelves and taking out rubbish. He had not had any training yet. So, the inspector signposted the RP to check GPhC training requirements for support staff (Oct 2020). The RP was pursuing a new business opportunity for the pharmacy. There were three adult males on the pharmacy's premises. Two were in one area of the basement and the third had described himself as the shop assistant. Their role was not clear.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy does not keep its workbenches clear of clutter and tidy enough to work safely. This increases the risk of things going wrong. The pharmacy has introduced ways of helping to protect people from COVID-19 infection. And it prevents people accessing its premises when it is closed so that it keeps its medicines and people's information safe.

Inspector's evidence

The registered pharmacy premises were secure and consisted of a spacious retail area with a large consultation room near the entrance and a small dispensary at the far end of the public area. The medicines counter was situated in front of the dispensary. Fixtures and fittings were dated. There were two staircases leading down to areas in the basement. One area was used to store medicines stock and the other was used for general storage. The dispensary had limited workspace and storage available. So, larger items were stored on the floor behind the pharmacy counter. And worksurfaces in the dispensary were cluttered due to piles of paperwork and dispensing baskets. The dispensary had a clean sink although there were items stored on the drainer. The dispensary shelves were dusty and required cleaning in places. A half-gate at the medicines counter preventing people entering the dispensary. The pharmacy was satisfactorily lit and ventilated. The consultation room was not locked when not in use and contained a medical fridge which did not have any medicines in it. To help protect against infection, the chairs and tables were wipeable and a screen on casters could be moved to provide privacy. There were handwashing facilities and the lavatory included a shower cubicle. The lavatory and consultation room were generally clean. The floor covering was ‘anti-slip’. Hand sanitiser was available to apply.

The pharmacy’s website offered General Sales List (GSL) and Pharmacy (P) medicines for sale. This service was provided by a third-party pharmacy registered with the GPhC. The pharmacy did not advertise details of this third-party provider prominently on its website. But information was available upon check-out of baskets when people purchased medicines. The pharmacy’s website displayed some information about services which it provided such as flu and travel vaccination, but it was not up to date. The RP confirmed that the pharmacy did not provide these services so the information could be misleading to members of the public visiting the website.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not manage all its medicines adequately. It doesn't keep all of its medicines in the original manufacturer's containers. Some stock packs contain medicines from different batches with different expiry dates. This means it may miss them when checking stock in response to an alert or when date-checking stock. It also does not store some of its stock securely enough. The pharmacy does not provide enough written information with its compliance packs to help people identify each of the medicines inside. So, people may not have the information they need to use their medicines safely. The pharmacist acts apropriately if any medicines or devices need to be returned to the suppliers. Members of the public with a range of needs can easily access the pharmacy's services. The RP gives advice to people about where they can get other support.

Inspector's evidence

The pharmacy had a wide automated door. And its entrance was level with the outside pavement. This made it easier for people who used a wheelchair or had a small child in a pram to enter the pharmacy. The pharmacy had seats for people who were waiting for their prescription to be dispensed or to speak to the RP. The seats were away from the counter which helped to keep people at a social distance. The RP signposted people to another provider if a service wasn’t available at the pharmacy.

The pharmacy provided a delivery service to people who couldn’t attend its premises. They called the RP to arrange the delivery details. The RP knew the people he made deliveries to but he did not keep an audit trail for the deliveries which would show that the right medicine was delivered to the right person. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The RP cleared a section of the dispensary bench to prepare compliance packs. The patient called the pharmacy and asked the RP to re-order their prescription when they needed the next compliance pack. The new prescription was checked for changes in medication. Labelling did not provide a description which made it difficult for people to identify each of the medicines contained within the compliance packs. And the pharmacy didn’t always provide patient information leaflets. So, people may not have had the information they needed to use their medicines safely. The RP initialled the dispensing labels to show who prepared the prescription. And there was a process for dealing with outstanding medication to make sure the person was not left without their medicine.

The RP was aware of the valproate pregnancy prevention programme and there was a poster about it displayed in the dispensary. He knew that people needed to be counselled if they were in the at-risk group and being prescribed a valproate. Ensuring people in the at-risk group were counselled and recording the intervention on the PMR was discussed. Valproates must be dispensed with a patient information leaflet (PIL) and for valproates which were re-packaged, there should be a warning on the container. The patient should be reminded to have an annual specialist review. The RP explained counselling for people taking warfarin such as the dose, asking for the INR and advice about the effects of over-the-counter medicines and certain foods on the INR.

The pharmacy obtained medicines and medical devices from reputable suppliers. Medicines were generally stored in manufacturer's original packaging. But were not all stored in an orderly fashion. So there were some lose strips of tablets and capsules on the dispensary shelves and original containers which contained strips of mixed batches and manufacturer. Liquid medicines were marked with a date of opening. In a random check a small quantity of date-expired stock was found on the dispensary shelves. There were prescriptions awaiting collection in tote boxes in the dispensary dated February or March 2021 which patients should have been contacted about to see if the medicines were still needed. Obtaining authorisation to clear obsolete CDs from the CDAO would free up much needed storage space in line with requirements. Cold chain items were stored in the medical fridge between two and eight Celsius. The pharmacy stored its waste medicines in pharmaceutical waste bins but these were not kept in a secure location. The waste medicines were stored in yellow pharmaceutical waste bins which were not sealed and situated just inside the open door of the consultation room. The consultation room was opposite the open entrance door to the pharmacy. The RP described the actions taken when drug alerts were received by email and stock was checked for affected batches which may have to be quarantined so it is not supplied to people. But a record was not kept to show the actions taken by the pharmacist in response to an alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy mostly has appopriate equipment and facilities it needs for the services it offers. The pharmacy uses its equipment in a way to keep people's private information safe.

Inspector's evidence

The pharmacy had hand sanitiser for people to use if they wanted to. There was PPE available and the RP wore a mask. The pharmacy had glass measures for use with liquids, and one marked for use with certain liquids. The RP had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had a fridge to store pharmaceutical stock requiring refrigeration. And the RP demonstrated how to monitor maximum and minimum temperatures of the refrigerator. The RP had a blood pressure monitor to check people's blood pressure if they asked. But there was no evidence that it was maintained or re-calibrated in line with the manufacturer's guidance to ensure it gave accurate readings. The pharmacy had a shredder to dispose of confidential waste appropriately. The pharmacy restricted access to its computer and PMR and positioned the computer screens so it was not visible to an unauthorised person.

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.