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:** 31/08/2022

## Pharmacy context

The pharmacy is in a street near Euston Station in northwest 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 delivery, and supervised consumption.

## 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's working practices are generally safe and effective. The pharmacy has satisfactory standard operating procedures (SOPs) which help members of the team to complete their tasks safely. The pharmacy team members mostly keep the records they need to up to date, so they can show the pharmacy is supplying its services safely. The pharmacy checks that the actual stock levels of some medicines match the records of what is in stock. The pharmacy protects people's private information, and members of the team are trained in how to safeguard vulnerable people.

### Inspector's evidence

The responsible pharmacist (RP) worked alone and did not routinely record near misses or the lessons that were learnt from them. But he did take a mental break during the dispensing process and when he spotted a mistake, he took action to reduce the chances of the same mistake happening again. The RP explained that medicines involved in incidents, or were similar in some way, were separated from each other in the dispensary. For instance, amitriptyline and amlodipine which had similar names and strengths. Tadalafil 10mg and 20mg tablets were on separate shelves and so were atenolol and allopurinol. The RP had previously described an extra checking procedure when dispensing prescriptions for aripiprazole and olanzapine which were both used to treat the same condition. There was a standard operating procedure (SOP) and a complaints interview form for recording and reporting incidents.

The RP used baskets to keep each person's medication and prescription together when dispensing prescriptions. He selected medicines from reading the prescription and then attached the dispensing labels. The RP initialled the labels to show the medicines had been checked against the prescription. And assembled prescriptions were not handed out until they were checked by the RP. The RP checked interactions between medicines prescribed for the same person either online or by contacting the prescriber. He demonstrated how interventions were noted on the patient's medication record (PMR) which might make it easier to explain what happened later if needed. There was a procedure for dealing with outstanding medicines, so people received the complete course of their treatment.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these had been reviewed since the last inspection. 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. The SOPs described what they could and could not do if the RP was not present, what they were responsible for and when they should seek advice from the RP. The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. There were fluid resistant face masks available to help reduce the risks associated with COVID-19. The pharmacy had wipeable seats set well apart for people who were waiting in the pharmacy.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy displayed a notice that told people who the RP was and it kept a

record to show which pharmacist was the RP and when. The pharmacy had controlled drug (CD) registers. And there was a record of when stock levels recorded in the CD registers were checked. So, the RP could spot mistakes quickly. A random check of the recorded amount of two CDs matched what was recorded in the CD register. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. And it kept a record of when one of these products was received, who it was supplied to and when. The pharmacy kept records of the private prescriptions it supplied electronically. And these generally were in order. But the name and address of the prescriber were sometimes incorrectly recorded.

The pharmacy was registered with the Information Commissioner's Office. And there was a folder of general data protection regulation (GDPR) information which was due for review. Following the visit, the RP confirmed the privacy notice template had been completed and was ready to display. The pharmacy made sure people's personal information could not be seen by other people and confidential wastepaper was collected for secure disposal. The pharmacy computer was password protected and backed up regularly. The pharmacy had a safeguarding SOP to follow to raise concerns about the safety of a vulnerable person. And it displayed safeguarding information in the retail area of the pharmacy. The RP was signposted to the NHS safeguarding app.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy team members work well together to manage the workload. They are comfortable about discussing suggestions to improve services to the people who visit the pharmacy.

### Inspector's evidence

The RP was working alone in the dispensary at the time of the visit. But he had recruited a new team member who was not present. The RP explained that the new team member was enrolled on accredited training although this was not seen during the visit. Following the visit, the RP emailed information about the nature of the training course the team member was studying. The inspector signposted the RP to GPhC training requirements for support staff (Oct 2020).

The pharmacy team consisted of the superintendent pharmacist (the RP) and the newly recruited full-time medicines counter assistant. The RP set aside study time when the new member of the team could study and discuss training topics. The RP explained that they both were comfortable about making suggestions on how to improve the pharmacy and its services such as where to locate the pharmacy's stock. Making sure the team members could raise concerns was discussed.

## Principle 3 - Premises ✔ Standards met

### Summary findings

Overall, the pharmacy's premises are secure and suitable for the provision of its services. The pharmacy has a spacious consultation room where people can talk privately to the pharmacist but it doesn't keep it very tidy. The pharmacy prevents people accessing its premises when it is closed so that it keeps its medicines safe.

### Inspector's evidence

The registered pharmacy premises were bright and 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 some medicines and general stock. Access to the second staircase was restricted by tote boxes. The retail public area of the pharmacy was clean with items neatly displayed for sale.

The dispensary had limited workspace and storage available. Floor areas were generally clear and worksurfaces in the dispensary were mostly tidy. The dispensary sink was clean. A half-gate at the medicines counter prevented people entering the dispensary. The pharmacy was satisfactorily lit and ventilated. The consultation room was not locked when not in use. It was not tidy and it contained a medical fridge which did not have any medicines in it. To help protect against infection, the chairs and tables were wipeable. There were handwashing facilities, and the lavatory included a shower cubicle. 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 met

### Summary findings

The pharmacy's working practices are generally safe and effective, and it gets its medicines from reputable sources. It stores its medicines securely at the correct temperature so that medicines it supplies are fit for purpose. The pharmacy provides people with the printed information they need regarding the medicines in their compliance aids. The pharmacy does not keep adequate records of the prescription deliveries which may make it difficult to show the right medicines were delivered to the right person. The pharmacist knows what to do if any medicines need to be returned to the suppliers. Members of the public with different needs can easily access the pharmacy's services. The pharmacist 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 with mobility issues 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 was not available at the pharmacy.

The pharmacy provided a delivery service to a small number of people who could not attend its premises. The RP knew the people he made deliveries to but he did not keep an audit trail for the deliveries to show that the right medicine was delivered to the right person. The pharmacy used a disposable pack for people who received their medicines in multi-compartment compliance aids. The pharmacy checked new prescriptions for changes in medication and it generally supplied high-risk medicines separately to the compliance aids. The RP explained that labelling did not always include a description identifying the tablets or capsules if people did not want it. But the pharmacy provided patient information leaflets so people 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 any 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 in the at-risk group needed to be counselled if they were being prescribed a valproate. Ensuring the intervention was recorded on the PMR was discussed. The patient should be reminded to have an annual specialist review. The pharmacy prepared instalments of medication for people accessing the substance misuse service. A random check of a supply of medication made on an FP10MDA prescription corresponded to the entry in the appropriate CD register.

The pharmacy obtained medicines and medical devices from reputable suppliers. Medicines were mostly stored in manufacturer's original packaging in an orderly fashion. Liquid medicines were marked with a date of opening. The RP checked the expiry dates of medicines regularly. And generally recorded

when he had done a date-check. But some expired medicines were found on the shelves amongst in-date stock. These were quickly removed during the inspection. There were prescriptions awaiting collection in tote boxes at the far end of the dispensary. CDs which were not exempt from safe custody requirements were stored securely. The pharmacy stock which needed to be refrigerated was stored in a fridge in the dispensary at temperatures between two and eight Celsius. It stored its waste medicines in pharmaceutical waste bins separate from other stock. The RP described the actions taken when drug alerts and recalls were received by email. The RP had a folder to file alerts annotated after stock was checked for affected batches which may have to be quarantined so it was not supplied to people. Filing alerts where no action had been necessary, after checking stock, was discussed.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy mostly has appropriate equipment and facilities it needs for the services it offers. The pharmacy uses its equipment so that it keeps people's private information safe.

### Inspector's evidence

The pharmacy had anti-bacterial wipes to clean surfaces and fluid resistant face masks if needed to protect against infection. The pharmacy had clean 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 could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had a fridge in the dispensary to store pharmaceutical stock requiring refrigeration. And the maximum and minimum temperatures were shown to be within range of two to eight Celsius. CDs were stored in line with requirements in the new CD cabinet. The pharmacy had a shredder to dispose of confidential waste appropriately. The pharmacy restricted access to its computer and PMR and positioned the computer screen 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. |