General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Essential Pharmacy, 169 Drury Lane, Covent Garden, LONDON, WC2B 5QA

Pharmacy reference: 1041572

Type of pharmacy: Community

Date of inspection: 22/11/2023

Pharmacy context

The pharmacy is in a predominantly business area with low residential population. It provides health advice and dispenses private and NHS prescriptions. The pharmacy supplies medicines in multi-compartment compliance packs for people who have difficulty managing their medicines. Other available services include: new medicines service (NMS), blood pressure monitoring, smoking cessation, travel clinic medicines, prescribing, blood tests, COVID-19 and seasonal flu vaccination vaccinations. As the aesthetics service is taking place outside of the registered premises it is not included in the report.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	One team member has not been enrolled onto an accredited training course relevant to their role and in line with GPhC minimum training requirements
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

Overall, the pharmacy's working practices are safe and effective. It has adequate standard operating procedures in place to manage risks and make sure its team members work safely. The pharmacy team members do discuss their mistakes and take action to prevent them happening again although they do not always record them so they may be missing opportunities to spot patterns and learn from their mistakes. The pharmacy mostly keeps the records it needs to by law. So it can show the pharmacy is generally providing services safely. Members of the pharmacy team protect people's private information, and the pharmacist is appropriately trained in how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. If the responsible pharmacist (RP) identified a mistake when checking a prescription, he asked the team member to spot it too. And then they discussed the mistake to learn from it and reduce the chances of it happening again. But they did not always record mistakes so they could be missing opportunities to spot patterns or trends with the mistakes they made. The RP explained that medicines involved in incidents, or were similar in some way, such as one brand of amitriptyline and propranolol, were generally separated from each other in the dispensary. Members of the pharmacy team responsible for making 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. And assembled prescriptions were not handed out until they were clinically and accuracy checked by RP.

The pharmacy team members showed the RP alerts for interactions between medicines prescribed for the same person. They recorded significant interventions and dispensed outstanding medicines which were owed to people. Prescriptions awaiting collection were stored on designated shelving and the prescriptions were filed until someone came to collect them. Team members highlighted high-risk prescriptions about which the RP needed to talk to the person or their representative. And they checked the person's details before they gave out private information or medicines.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these had been reviewed since the last inspection visit. Members of the pharmacy team were required to read the SOPs relevant to their roles. The RP maintained digital training records to show they understood them and would follow them. A member of the team explained the procedure and questions to ask when recommending medicines via the over-the-counter (OTC) sales protocol. And they also knew what the team could and could not do if the RP was absent, what they were responsible for and when they might seek help. Their roles and responsibilities were described in the SOPs. A team member explained that 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 liable to misuse to a pharmacist. The pharmacy had a complaints procedure. And it had received positive feedback from people online. The RP followed up on negative feedback.

The RP had completed risk assessments in preparation for providing the flu and COVID-19 vaccination services. These were due to be reviewed. The RP had not completed all the current pharmacy quality

scheme (PQS) audits such as monitoring the safety of oral anticoagulants audits or optimising use of respiratory medicines at the time of the visit. But regarding people taking a valproate, the new rules for dispensing valproates were highlighted. The RP audited the pharmacy team members' dispensing error and near miss records to compile an annual patient safety review.

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 had a controlled drug (CD) register. Its team made sure the CD register was kept up to date and the stock levels recorded in the CD register were checked frequently. So, the pharmacy team would spot mistakes in the CD register quickly. A random check of the actual stock of a CD matched the recorded amount in the register. The pharmacy kept records for its supplies of unlicensed medicines, emergency supplies and private prescriptions. And these generally were in order but the prescriber's details were sometimes incorrectly recorded.

Records for administration of flu and COVID-19 vaccinations were maintained electronically via Sonar or PharmOutcomes. The pharmacy was registered with the Information Commissioner's Office. Members of the pharmacy team had signed confidentiality agreements. And they used their own NHS smartcards. The pharmacy computers were password protected. The notice that told people how the pharmacy and its team gathered, used and shared their personal information was due to be reprinted and displayed. The pharmacy team tried to make sure people's personal information could not be seen by other people and was disposed of securely.

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 not all met**

Summary findings

The pharmacy has not yet enrolled a member of the team onto a course relevant to their role in line with GPhC training requirements.
The pharmacy's team members work well together managing their workload. The pharmacy supports the trainee pharmacist's formal training and allocates protected learning time. Members of the team are able to raise concerns and provide feedback to improve the pharmacy's services.

Inspector's evidence

The pharmacy team consisted of the superintendent pharmacist (the RP), a full-time trainee pharmacist, a second full-time trainee pharmacist who had completed training and was awaiting the outcome of the pre-registration assessment, one part-time medicines counter assistant who was taking a university course which did not exempt them from accredited training and a part-time pharmacy student. Another team member had a part-time role which did not involve the pharmacy. The RP was supported at the time of the inspection by three team members.

The RP was a pharmacist independent prescriber (PIP) and his initial scope of practice as a PIP was in dermatology. He had also trained through Derma Medical to provide an aesthetics service. Another team member had undertaken training to help provide the flu and COVID-19 vaccination services and phlebotomy service. The RP explained that the pharmacy team members undertook training through eLearning for Healthcare (elfh), Centre for Pharmacy Postgraduate Education (CPPE). And sometimes industry representatives provided training sessions for the team on new products.

The RP was designated supervisor for the trainee pharmacist following training materials of an accredited provider to achieve learning outcomes by the end of the foundation training year. The trainee pharmacist described areas of study such as sections of the British National Formulary (BNF), mock tests and assessments at designated intervals. The RP allocated regular protected learning time and time off before the assessments.

The pharmacy team members 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 ask the RP questions about medicines when they had the time to do so. They could make suggestions when they had one-to-one meetings with the RP about how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. There was a team WhatsApp group to contact and communicate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are bright, secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe, and people's private information is protected.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. And steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a wide level entrance from the pavement outside and a spacious public retail area, a medicines counter, and dispensary. The pharmacy had signposted its consultation room where people could have a private conversation with a team member. The worksurfaces in the dispensary were tidy and floor areas were generally clear. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy. The team members had comfortable kitchen facilities and there were more consultation rooms, but this part of the pharmacy premises was not registered.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. It tries to make sure people with different needs can easily access the pharmacy's services. Members of the pharmacy team mark prescriptions so the pharmacist knows which people require more information and support to use their medicines properly. The pharmacy obtains its medicines from reputable sources so they are fit for purpose and safe to use. It stores medicines securely, at the correct temperature. The pharmacy team members can show what actions they take when they receive a drug alert or recall.

Inspector's evidence

The pharmacy had a wide level entrance which made it easier for people who used a wheelchair, to enter the building. It had a notice that told people when it was open. And a monitor in its window displayed information about some of the services the pharmacy offered. Members of the pharmacy team could understand or speak Farsi, Turkish, Arabic and Spanish to help people whose first language was not English. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy delivered prescriptions to a few people who could not attend its premises in person. It supplied medicines in multi-compartment compliance packs to people who found it difficult to manage their medicines. The pharmacy team generally supplied high-risk medicines separately but checking whether a medicine was suitable to be re-packaged if necessary was discussed. It provided patient information leaflets (PILs) So, people could refer to the manufacturer's information if they needed to. It did not always provide a brief description of each medicine to help identify different medicines in the compliance pack.

The pharmacy received a low number of community pharmacist consultation service referrals via Sonar. The RP had liaised with local doctor's surgeries regarding referrals for minor illness. The pharmacy provided the flu and COVID-19 services via the National Protocol for each vaccine. For COVID-19 vaccinations, people could book an appointment through the national booking service or attend as a 'walk-in'. The pharmacy maintained vaccination records including consent and clinical assessment via Outcomes4Health on PharmOutcomes. It stored and monitored vaccines between two and eight Celsius. And it disposed of vaccination sharps in sharps bins. Pharmacy team members cleaned the consultation room surfaces between vaccinations. The service risk assessment was due for review. The team members who provided the service had completed required training such as safeguarding, administration of vaccines, resuscitation and treating anaphylaxis. The pharmacy also provided NHS and private flu vaccination services which were mostly 'walk-in'. NHS flu vaccination records were entered onto Sonar and team members had completed appropriate training. The pharmacy provided a phlebotomy service and people could have a blood test to obtain their profile such as vitamins or allergy. The pharmacy recorded the person's details on the medical laboratory's portal and the sample was sent via courier to the laboratory for analysis. The results were sent direct to the person.

Members of the pharmacy team mostly knew which of them prepared a prescription and they highlighted prescriptions to show 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 was aware of the

valproate pregnancy prevention programme. And knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The new rules for dispensing medicines containing valproate were highlighted. The RP was an independent prescriber and he explained his prescribing was limited to prescribing for the services he provided. And if there were concerns about a person's mental or physical health, he referred them to a doctor.

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. The pharmacy team checked the expiry dates of medicines. And it generally recorded when it had done a date-check. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs securely in line with safe custody requirements. The pharmacy had procedures for handling obsolete medicines and these were kept separate from stock. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took and what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had a few glass measures for use with liquids. Members of the pharmacy team had access to up-to-date reference sources. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the refrigerator. Its team 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 with their own password. The pharmacy team members used their own NHS smartcards.

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.