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: 25/07/2024

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 taking their medicines at the right time. Other available services include new medicines service (NMS), blood pressure monitoring, travel clinic medicines, prescribing, blood tests and seasonal flu vaccination vaccinations. The pharmacy offers some services via its website https://essentialslondon.com such as private GP and prescriber clinics. 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 not all met	1.1	Standard not met	The pharmacy does not routinely document risk assessments (RAs) for some services it provides. And it does not adequately set out its processes in writing to assess and manage the risks involved in providing the prescribing service. Such as consultation questionnaires which are specific to each condition which the prescriber treats and include reasons the supply was refused. And which ask for consent to share information with the person's regular GP to independently verify the person's medical information. So there is a risk the pharmacy could supply medicines inappropriately based on false information and the person's GP may be unaware of treatment they obtain elsewhere.
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 not all met	4.2	Standard not met	The pharmacy's consultation questionnaires are not specific to different conditions and people are not always asked for consent to share information with their regular GPs to independently verify their medical information.
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 routinely document risk assessments (RAs) for some services it provides. And it does not adequately set out its processes in writing to assess and manage the risks involved in providing the prescribing service. Such as consultation questionnaires which are specific to each condition which the prescriber treats and include reasons the supply was refused. And which ask for consent to share information with the person's regular GP to independently verify the person's medical information. So there is a risk the pharmacy could supply medicines inappropriately based on false information and the person's GP may be unaware of treatment they obtain elsewhere. Otherwise the pharmacy's working practices are safe and effective. It has adequate written instructions in place for its team members to follow to help manage risks and to make sure they work safely. The pharmacy team members do discuss their mistakes and take action to prevent them happening again although they do not always record their mistakes so they may be missing opportunities to spot patterns and learn from them. The pharmacy mostly keeps the records it needs to by law. So it can show the pharmacy generally supplies medicines 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 in place to review its dispensing errors and near misses. If the responsible pharmacist (RP) identified a mistake when checking a prescription, he asked the team member to correct it and learn from it to help avoid making the same mistake again. Team members did not always record mistakes, but they agreed actions to reduce the chances of them happening again. So, medicines which were involved in incidents, or were similar in some way, such as some inhalers or different preparations of hormone replacement therapy, were generally separated from each other in the dispensary drawers to minimise future selection errors. And if the RP were working alone, he tried to take a mental break between dispensing and checking prescriptions.

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. They used baskets to separate each person's medication and to help them manage workflow. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were clinically and accuracy checked by the RP.

Pharmacy team members showed the RP alerts for interactions between medicines prescribed for the same person. Sometimes they contacted the prescriber via phone or NHS email regarding availability of medicines and maintained an audit trail of significant interventions. Prescriptions with outstanding medicines were filed separately until stock was delivered and the remaining medicine was dispensed. And this included prescriptions for medicines in the fridge or for controlled drugs (CDs) which were not dispensed until the people came to collect them. Bagged prescriptions awaiting collection were stored on designated shelving and until someone collected 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 name, address and date of birth before they gave out prescriptions.

The pharmacy had standard operating procedures (SOPs) online for most of the services it provided. And the most recent SOP was for providing the NHS Pharmacy First service. 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 questions she would ask when recommending medicines over-the-counter (OTC) and when she would refer to the RP. She understood what she could and could not do if the RP was absent. She explained that she would not hand out prescriptions or sell medicines if a pharmacist was not present. And she 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 if people complained the RP replied within 48 hours. People had left positive feedback online and in person and sometimes left gifts for the team.

Regarding people taking a valproate, the RP was aware of the new rules for dispensing valproates so people would receive them in the original packaging. And the updated rules applied to dispensing topiramate. The RP risk assessed the pharmacy in preparation for providing the flu vaccination service annually. The RP was an independent prescriber and before agreeing aesthetic treatment, the RP completed a risk-assessment (RA) for providing the treatment to the person in a face-to-face consultation and maintained records on their file. After the visit, the RP supplied a blank consultation form for the aesthetics service which had sections about the person's current health and reasons for having the treatment. There was a section to record all the information about the products used and the form set out the possible risks to having the treatment. The form did not have a section to complete with details of the person's regular GP.

The RP explained that prescribing was mainly limited to treatment for skin conditions and before prescribing he would check for penicillin allergy, if the person was diabetic and that the person was aged 18 or over. The RP could check visually if somebody was seeking treatment for a skin condition such as a rash. The RP gained consent to view the person's National Care Record (NCR) if necessary. And he described prescribing audits for treatments of dry skin, dermatitis and skin rash. The RP did check people's identification and had refused to prescribe medicines for conditions which were outside his scope of practice such as asthma and diabetes although refusals were not documented. Written risk assessments (RAs) for prescribing and other services were not seen. Apart from aesthetic products, documented examples were not seen of prescribing audits, prescribing policies and SOPs and consultation forms for other medicines or conditions.

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. A random check of the actual stock of two CDs matched the recorded amount in the register. The RP described the records required for supplying unlicensed medicines. The private prescriptions records were generally in order but the prescriber's details were sometimes incorrectly recorded. Records for treatments via the NHS Pharmacy First service were maintained electronically and shared with the person's GP. The pharmacy supplied treatments such as for female simple urinary tract infection via online patient group directions (PGDs) and records were maintained on Sonar.

The pharmacy was registered with the Information Commissioner's Office. Members of the pharmacy team 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. There was a privacy policy on the website. 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 and manage their workload. The pharmacy supports the trainee pharmacists' 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 (also the RP), two trainee pharmacists whose training courses had overlapped and one full-time medicines counter assistant (MCA). 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 the MCA.

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. The RP explained that the pharmacy team members undertook training through eLearning for Healthcare (elfh) and Centre for Pharmacy Postgraduate Education (CPPE).

The RP was the designated supervisor for the trainee pharmacists who were enrolled on the training course of an accredited provider. The trainee pharmacists were allocated regular protected learning time and time off before the assessment to help them achieve learning outcomes by the end of the foundation training year. They attended regular weekend training days and had an appraisal every 13 weeks with the RP. The other team members had six-monthly appraisals and occasional team meetings.

The pharmacy 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. The team member knew when to refer requests for medicines to a pharmacist such as a request for a medicine liable to misuse. Team members could make suggestions to the RP about how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. Team members could contact other team members through a WhatsApp group.

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. And the website generally sells cosmetic type skin preparations.

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 entrance with a ramp from the pavement outside and a spacious public retail area, a medicines counter, and dispensary. The pharmacy displayed service information in the window.

The pharmacy’s consultation room was signposted and protected people’s privacy so they 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. There was more space in the basement, but this part of the premises was not registered.

The pharmacy’s website generally offered skin preparations for sale. And it displayed information such as the address and GPhC registration number of the pharmacy and how to check registration status. The superintendent pharmacist (SI) details were not obvious. The pharmacy also provided private prescriptions upon face-to-face consultation with the RP who was an independent prescriber and specialised in dermatology. The RP gave an assurance that some out-of-date information on the website would be removed by the following day.

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

Summary findings

The pharmacy offers its prescribing service to people aged 18 and over. But in its consultation questionnaires it does not ask specific questions tailored to different conditions it treats. And it doesn't always ask people for consent to share information with their regular GPs to independently verify their medical information. 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 try to make sure people have all the information they need to take their medicines properly. They highlight prescriptions so the pharmacist knows which people he needs to counsel about their medicines. 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.

Inspector's evidence

The pharmacy had a wide entrance with a small ramp which made it easier for people who used a wheelchair, to enter the building. It had a sign 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, Bangladeshi, Turkish, Arabic and Spanish to help people whose first language was not English. And they signposted people to another provider if a service was not available at the pharmacy.

The pharmacy delivered prescriptions to a few people who could not attend its premises in person but the pharmacy did not offer delivery as a service. 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 and not within the compliance pack. It did not always provide patient information leaflets (PILs) but the RP gave assurances that moving forward the PILs would be supplied with each set of trays. So, people could refer to the manufacturer's information if they needed to. And labelling did not always include a brief description of each medicine to help identify different medicines in the compliance pack.

The pharmacy had mostly treated people through the NHS Pharmacy First service on a walk-in basis. And the pharmacy team's work pattern had not needed to be altered to accommodate the new service. It offered all available treatments and consultations were taking around 15 minutes. The RP was trained to use the otoscope for examining people's ears. Consultation records were maintained electronically and could be shared with the person's regular prescriber. The pharmacy team had liaised with the local surgeries to promote the service.

The RP was a PIP and conducted the aesthetics service in an area of the premises which was not registered as a pharmacy with the GPhC. The RP was initially trained in dermatology and limited the scope of practice to dry skin, dermatitis and skin rashes. The customer base was in the United Kingdom (UK) and aged 18 and over. The RP checked people's identification when they consulted him and he would refuse to provide treatment if the person had diabetes or asthma. People usually needed to complete a questionnaire when requesting aesthetics treatment. The pharmacy did not have consultation questionnaires specific to different conditions and people were not always asked for consent to share information with their regular GPs to independently verify their medical information.

The RP could check visually if somebody was seeking treatment for a skin condition such as a rash. The RP gained consent to view the person's National Care Record (NCR) if necessary.

Members of the pharmacy team mostly knew which of them prepared a prescription and they highlighted prescriptions to alert the pharmacist to speak to the person about the medication they were collecting. Prescriptions were filed separately if other items needed to be added when people visited the pharmacy to collect their medicines. The RP was aware of the valproate pregnancy prevention programme. And knew that people in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The new rules for dispensing medicines containing valproate in an original container were highlighted. And the guidance applied to topiramate too.

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 checking the date of dispensed medicines as part of the final check was discussed. 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 he took and what records they kept when the pharmacy received a concern about a product. The records were not seen.

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 glass measures for use with liquids. Members of the pharmacy team had access to up-to-date online 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 fridge. Team members 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.