General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Haggerston Pharmacy, 201 Haggerston Road, London, E8 4HU

Pharmacy reference: 9010985

Type of pharmacy: Community

Date of inspection: 20/10/2021

Pharmacy context

The pharmacy is situated in a retail unit at the bottom of a newly built residential building. It mainly dispenses NHS prescriptions. And supplies some medicines in multi-compartment compliance packs to people who need help managing their medicines. The pharmacy also provides a Covid vaccination service. The inspection was undertaken during the Covid-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 safe and effective. The pharmacy generally keeps the records it needs to by law so that medicines are supplied safely and legally. People who use the pharmacy can give feedback on its services. And the pharmacy team knows how to help protect the welfare of vulnerable people. Team members generally respond appropriately when mistakes happen during the dispensing process. But they don't consistently record near misses. So, this may mean that they are missing out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

Standard operating procedures (SOPs) were available and team members had read and signed SOPs which were relevant to their roles. The team had been routinely ensuring infection control measures were in place. Team members had been provided with personal protective equipment (PPE). The superintendent pharmacist (SI) explained that the necessary risk assessments to help manage Covid-19 had been completed and this included occupational ones for the staff. Information was displayed at the entrance asking people to wear a mask upon entering.

The pharmacy recorded dispensing mistakes where the medicine was handed to a person (dispensing errors). Dispensing mistakes which were identified before the medicine was handed out (near misses) were said to be recorded electronically, but no records had been made since 2017. The SI gave an assurance that the team would start recording these. When a near miss was identified it was discussed with the person who had made the mistake or on some occasions, they were asked to identify the error and rectify it. A discussion was held as to how and why the mistake had happened. The team had completed training on medicines which looked and sounded similar. These had been separated on the shelves along with other medicines that had similar packaging. Dispensing errors were investigated and a record was made. As a result of a past incident where someone else's medicines had been delivered to someone the pharmacy had changed the process and now deliveries were not carried out at the same time if two addresses were near each other or if people had similar sounding names. Similar sounding names were also highlighted on the delivery sheet.

A correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaint procedure. Prior to the pandemic the team had also carried out annual patient satisfaction surveys. The SI explained that the pharmacy was due to restart this. Feedback was also provided online. Due to a customer services complaint the SI had flagged the issues raised to the individual concerned and changes had been made.

Records for private prescriptions, unlicensed medicines dispensed, controlled drug (CD) registers and RP records were well maintained. However, there were four missing entries in the RP records. The SI checked the system and found that other records had been made on those days in the CD register and fridge temperature records. He explained that this could not be done without an RP signing in and thought there was a glitch in the system. The SI gave an assurance that he would speak to the systems provider. Emergency supply records were generally well maintained but the reason for supply was not always recorded. CDs that people had returned were recorded in a register as they were received. A random check of a CD medicine quantity complied with the balance recorded in the register. CD

registers were kept electronically and team members had individual log ins. CD balance checks were carried out regularly and the system prompted for balance checks to be completed if one had not been recorded.

Assembled prescriptions were stored behind the medicines counter and people's private information was not visible to others using the pharmacy. An information governance policy was available and team members had been briefed. Relevant team members who accessed NHS systems had smartcards and the SI was in the process of arranging smartcards for some team members. Pharmacists had access to Summary Care Records (SCR) and consent to access these was gained verbally.

The SI had completed the level 3 safeguarding training and all other team members including pharmacists had completed level two safeguarding training. The SI was aware of where to locate the contact details for safeguarding boards and had the NHS application downloaded on his phone.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services provided, and they do the right training for their roles. They work effectively together and are supportive of one another. The pharmacy supports its team members with ongoing training. This helps them keep their knowledge and skills up to date.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the SI, another two pharmacists, a trainee pharmacist, a trained dispenser, a trainee dispenser, and a medicines counter assistant (MCA). Other team members who were not present included three trainee MCAs who worked part-time and assisted with the vaccination service. Team members were all trained or undergoing training. Team members were able to manage their workload during the inspection. The SI felt that there were sufficient team members and he had overstaffed the pharmacy to ensure good customer service could be provided but to also help with the Covid vaccination service. When the service had first started one team member had been allocated to manage the telephone line as it had been very busy.

Individual performance and development were monitored by the SI who held ‘reasonably’ informal chats with each of the team members. Team members were also provided with ongoing feedback. There was also an opportunity for team members to progress in their roles. One of the team members had started off as an MCA and was working towards gaining her technician accreditation

Team members were provided with access to electronic resources to keep up-to-date. The pharmacists and trainee pharmacist also briefed team members with any new information. Team members were provided with training when new services were to be offered, the latest service team members had trained for was carrying out lateral flow tests. Team members also watched short training videos; the SI tried to do this in small groups so a discussion could also be held. Some training time was provided but training was also done in people’s own time.

The trainee pharmacist counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was aware of the maximum quantities of certain medicines which could be sold over the counter. The trainee pharmacist had scheduled reviews with the SI and had been enrolled on the Propharmace training programme. As part of this she attended monthly study days and also used online training resources.

Team meetings were held monthly and the team also discussed issues as they arose. The SI acknowledged that the team had worked very hard over the pandemic and was trying to reward them. Team members felt able to provide the SI with feedback and suggestions. There were no targets set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an appropriate environment to deliver its services from. And its premises are suitably clean and secure.

Inspector's evidence

The pharmacy was modern, bright, clean, and organised. The pharmacy had relocated to a new premises a few years prior to the inspection. There was ample workspace which was clear of clutter and organised. Cleaning was carried out by team members. A clean sink was available for the preparation of medicines. Team members were observed to use face masks. Screens had also been fitted at the counter. Hand sanitiser was available for team members to use. The pharmacy had a large clean consultation room which was easily accessible. The room allowed a conversation at a normal level of volume to take place inside and not be overheard. The room was being used for the Covid vaccination service. The pharmacy also had access to another vaccinating pod on the shop floor but this was not being used as the service was not as busy as it had been at the start. The consultation room was used between vaccinations when needed. For some services such as emergency contraception the consultation was carried out over the telephone.

For the Covid vaccination service, people accessed the pharmacy from a second door. Vaccines were stored and administered in the consultation room and prepared in the dispensary. The room was clean. A post-observation area had been created under a canopy outside. The RP gave an assurance that he would consider moving the observation area to inside the premises as the service was less busy.

The room temperature was adequate for the provision of pharmacy services and the safe storage of medicines. Air conditioning was available to help regulate the temperature. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. The pharmacy makes its services adequately accessible for people. And it gets its medicines and medical devices from appropriate sources. Team members generally make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy generally stores its medicines properly and provides its services safely.

Inspector's evidence

The pharmacy was easily accessible, it was situated at street level and had a wide automatic door. The door was left open to allow ventilation. There was easy access to the medicines counter. Services were appropriately advertised to patients. Team members knew what services were available and described signposting people to other providers where needed. Team members were multilingual and spoke languages spoken locally.

Most prescriptions, approximately 95% were received electronically. Once prescriptions were received, they were printed out and labelled. These were dispensed by the dispensers and left for the pharmacists to check. It was very rare that the pharmacists had to self-check. Dispensed and checked-by boxes were available on labels which were observed to be used. Baskets were used to separate prescriptions, preventing transfer of items between people. People were sent a text message to notify them when their prescription was ready for collection if they had consented to the service.

The SI was aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. In most cases sodium valproate was dispensed in its original pack. The SI was informed of the need to use the warning labels when sodium valproate was not dispensed in its original pack by the inspector. Additional checks were carried out when people collected medicines which required ongoing monitoring. INR records were sent to the surgery when repeat requests were sent. These were checked by the pharmacy team but records were not kept. The SI gave an assurance that the team would start doing this. For other medicines such as methotrexate, people were counselled on the dosage. Local GPs did not issue repeat prescriptions until people had their monitoring blood tests done.

Some people's medicines were supplied in multi-compartment compliance packs. A poster detailing how the service was to be managed was stuck on the dispensary wall for reference. The pharmacy ordered prescriptions on behalf of people for this service. Prescriptions were checked for any changes. Any queries were queried with the prescriber and team members then notified one of the pharmacists. The pharmacy was also notified of hospital admissions via email. Individual record sheets were available for each person. Any changes were amended on these. Packs were prepared by the dispensers and checked by the pharmacists. Medicines were checked before being placed into the packs. Assembled packs were labelled with product descriptions and mandatory warning. Patient information leaflets (PILs) were not routinely supplied. The SI assured that leaflets would be given monthly.

The pharmacy was a part of a group of pharmacies in Hackney which provided an out-of-hours palliative care service. Pharmacies provided the service on a rota basis. The pharmacy which was on rota were asked to ensure their phone was on and to keep a list of medicines in stock. The pharmacist would then

receive a call usually from a GP asking for medicines to be delivered. The prescription was left with the person requiring the medicines.

The pharmacy provided the Covid vaccination service. Team members had completed paediatric life support training and the SI had completed the Level three safeguarding training. There were four chairs in the waiting area and a number of chairs under a canopy outside which was being used as an observation area. The majority of the people using the service booked appointments prior to coming in. People were checked-in by a team member at a designated desk. A printed list was kept and the counter and another was with the vaccinator. The pharmacy used the consultation room for vaccinations and the preparation area was in the dispensary. Vaccinations were provided by one of the three pharmacists. The observation area was situated outside the pharmacy. Now that the service was less busy the SI discussed bringing this inside and moving the waiting area outside. The pharmacy had dealt with one or two people who had fainted after having their vaccination. An air bed was available and used when needed. In summer fans had been used and biscuits and water were also available.

The pharmacy provided a delivery service. Deliveries were carried out by a volunteer or team members. Signatures were no longer obtained when medicines were delivered and this was to help infection control. Records of deliveries were kept in the pharmacy. In the event that someone was not available medicines were returned to the pharmacy. Contact details were printed on the bag label allowing the person delivering to call and check if anyone was available. Volunteers were DBS checked.

Medicines were obtained from licensed wholesalers. The SI reported that deliveries had been erratic, occasionally the pharmacy received phone calls from the supplier informing of cancelled deliveries. Fridge temperatures were monitored and recorded. Records seen showed that the temperature were within the required range for the storage of medicines. CDs were generally held securely. Date checking was completed at least every three months. Short-dated stock was marked. A date checking matrix was available but this had not been updated recently. No date-expired medicines were found on the shelves checked. Out-of-date and other waste medicines were kept separate from stock, stored securely and then collected by licensed waste collectors. Drug recalls were received via the ‘Pharmdata’ system. Records were updated on Pharmdata once the alert had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment. Equipment was clean and ready for use. Separate measures were used for liquid CDs and separate tablet counting triangles were used for cytotoxic medicines to avoid contamination. Two medical fridges of adequate size were available. A blood pressure monitor was used for services provided. The monitor was replaced annually. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. Confidential paperwork and dispensing labels were segregated and shredded.

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.