General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Clerkenwell Pharmacy, 44 Exmouth Market, London, EC1R 4QE

Pharmacy reference: 9012004

Type of pharmacy: Community

Date of inspection: 28/11/2024

Pharmacy context

This pharmacy is located on a high street in Clerkenwell, London. It provides NHS services such as dispensing prescriptions, the New Medicine Service (NMS), flu vaccinations and the Pharmacy First service. The pharmacy supplies medicines in multi-compartment compliance packs to people who need this support to manage their medicines at home. And it provides a delivery service.

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 adequately manages the risks associated with its services. It uses written procedures to ensure that team members understand their responsibilities and how to carry out activities. People using the pharmacy's services can easily provide feedback. Team members protect people's information well and have the relevant training to safeguard the welfare of people using their services.

Inspector's evidence

Standard operating procedures (SOPs) were available in the dispensary for the team to refer to if required. They had been reviewed in 2023 and team members had signed a master sheet to show that they had read and understood them. When asked, team members were clear about their roles and knew when to refer to the responsible pharmacist (RP). They knew what activities could and could not be done in the absence of an RP.

The superintendent pharmacist (SI) was the RP on the day of the inspection, and the RP notice was correct and visible. The RP record was held electronically and was largely complete, with some sign out times missing. Documentation for unlicenced medicines supplied and private prescription records were generally well maintained, but for both of these prescriber details were not always recorded correctly. And this may mean that this information is harder to find out if there was a query. The SI said that they did not often give emergency supplies, due to the NHS 111 Emergency Prescriptions service.

A random physical check of two controlled drugs (CDs) showed the quantities matched the balance recorded in the register. Expired and patient returned CD medicines were separated from the stock medicines and the SI was aware of the need to contact the local Controlled Drugs Accountable Officer to obtain authorisation for destruction. The trainee pharmacy technician explained that they would complete the relevant checks, including confirming the identity of the person or representative, checking the relationship to the patient, and obtaining a signature for proof of collection when handing out CDs.

The pharmacy had logs available to record dispensing mistakes that were identified before reaching a person (near misses). Informal discussions with the pharmacist were had at the time the mistake was made to address any feedback and generate ideas to prevent future mistakes. The SI showed that a few medications with different strengths or those that looked alike, had been separated on the shelf, demonstrating some action taken to minimise mistakes. They explained that dispensing activities were separated where possible and where appropriate medicines were checked with people upon handout. The SI said that in the past they had experienced a dispensing mistake which had reached the person (dispensing error). They explained that staff were aware to escalate any errors to the SI and described the actions they would take, including speaking to the person who was impacted by the error, making corrections, reporting to the GP where necessary and discussing with the team members involved to establish learning and prevention. There was an SOP available for dealing with dispensing errors which included the Learn from patient safety events (LFPSE) service details to ensure any errors were reported to the national system.

The pharmacy had current indemnity insurance. Feedback or complaints from people using the pharmacy's services could be received verbally in person, by telephone, email or through the

pharmacy's website. If a complaint was received, team members could escalate issues to the SI. The SI explained that the pharmacy aimed to contact people within 48 hours following any concerns raised to allow time to investigate and action any changes that are required.

Confidential paper waste was shredded on-site. And checked medications that were awaiting collection were stored in the dispensary to ensure that people's information was not visible from the counter. Team members explained that they had completed data protection learning with their accredited courses. The pharmacy team members had also completed safeguarding training and understood safeguarding requirements. They were able to describe some of the signs to look for and the actions they would take to safeguard a vulnerable person. The dispensers explained that they would discuss any safeguarding concerns with the RP. Team members were reminded that they could refer to local safeguarding boards if required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff for the services it provides and manages its workload safely. The team has the appropriate skill mix to ensure safe practice, and team members can raise concerns if needed, in an open environment.

Inspector's evidence

The team present during the inspection consisted of the SI, an additional pharmacist, a trainee pharmacy technician, two qualified dispensers, one trainee dispenser and a trainee medicines counter assistant (MCA). All team members were qualified or enrolled on accredited courses. The SI explained that locum staff were employed for business continuity when required to cover any pharmacist absences.

There were some targets set for the services offered, but the SI felt comfortable in using their professional judgement when decision making. They said that they had regular meetings with the owners of the pharmacy to ensure no undue pressure was placed on the team. The team was up to date with dispensing prescriptions with no backlog of workload. The MCA and dispensers were able to demonstrate an awareness of medicines with the potential for misuse and could identify people making repeat purchases. They knew questions to ask when selling medicines or providing advice and knew when to refer to the pharmacist.

Team members did not have a formal appraisal, but the SI said informal discussions were had with individuals to discuss any feedback or concerns. When asked, team members felt able to raise concerns with the SI and described working openly as a team. Team meetings were held and team members felt able to share ideas, they explained that the most recent meeting was around the maintenance of the pharmacy, including date checking medicines and cleaning duties. They decided to create a rota and share the responsibility for fairness and continuity. The SI gave examples of other changes that had been made in response to the team's feedback. This included changing the location of certain medicines in the dispensary to make them easier to reach for staff and improve workflow. There was no structured process for ongoing development of the team. However, they were able to access pharmacy magazines and other training resources in work hours and discussed any new products together. And there was the opportunity to progress through different accredited courses.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy, with adequate space for providing its services safely. It keeps its premises safe and people visiting the pharmacy can have a conversation with a team member in private. The premises are secure from unauthorised access when closed.

Inspector's evidence

Upon entry to the pharmacy there was a small counter separate from the dispensary where people could purchase any shop items such as toiletries and vitamins. And seating for people waiting for services was available. The dispensary was located at the rear of the premises, and allowed team members to clearly see people entering the pharmacy. The dispensary computer screens could not be seen from the shop area. There was a suitably sized consultation room for the provision of services, which was accessible from the retail area. The room allowed people to have a conversation inside at a normal level of volume and not be overheard. Pharmacy-only medicines were kept behind the counter which was joined to the dispensary and a screen was in place to help prevent the spread of infection. The dispensary had a barrier in place to prevent unauthorised access. The premises were clean, tidy, well-lit, and there was air conditioning available to maintain a suitable temperature for the storage of medicines. A cleaning rota was in place to ensure that the premises was well maintained. Handwashing facilities were available in the dispensary, and a staff toilet with separate handwashing facilities was available in the basement. There was a small kitchenette in the basement along with shelving for extra stock.

The pharmacy had a website which contained information about the pharmacy's services and contact information. Details of the SI and pharmacy registration details were not displayed, the SI gave assurances that this would be added to the website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, and is accessible to a range of people with varying needs. It obtains its medicines from reputable sources and stores them properly.

Inspector's evidence

The pharmacy's entryway had an automatic door large enough for people with wheelchairs and pushchairs. There was one step into the premises and the SI said that they were in the process of acquiring a ramp, currently staff helped people gain access where needed. Large-print labels were available on request and some team members were multi-lingual. The pharmacy offered the Pharmacy First service under patient group directions (PGDs) and these were printed in a folder for reference and signed by the SI.

Medicines were sourced from licensed suppliers. The SI said that expiry date checks were carried out periodically and a current record of the short-dated medicines that were on the shelves was seen during the inspection. A random spot check of stock revealed no expired medicines and stickers were used to highlight the short-dated items. The short-dated items were removed monthly as per the records made. Dates of opening for liquid medicines were seen to be written on the bottles for staff to know if they were still suitable to use. Temperature records for the pharmaceutical fridges were completed daily and showed no deviations in temperature outside of the required range of between 2 and 8 degrees Celsius.

The pharmacy received safety alerts and drug recalls, or information about other problems with medicines or medical devices, through the pharmacy's email. The SI said that the emails were checked by team members daily. The pharmacy did not have an audit trail of the actioned alerts, however the trainee pharmacy technician gave assurances that one would be created for future alerts. The trainee technician showed a recent example of when they had used the yellow card scheme to report adverse side effects to the Medicines and Healthcare products Regulatory Agency (MHRA) about a new medication for a patient.

Team members were observed following the SOP for dispensing prescriptions and baskets were used to keep items for different people separate. Dispensing labels included 'dispensed by' and 'checked by' boxes to indicate who had carried out those tasks. The pharmacy dispensed some medicines in multi-compartment compliance packs for people who needed help to manage their medicines. Packs were assembled in a designated room next to the dispensary to avoid distractions. The pharmacy used information sheets to keep track of regular medications and any changes. The dispenser used the information sheets to order repeat prescriptions for these people to help ensure they were ordered in a timely manner for dispensing. The SI said that they contacted the surgery if there were any items missed or any changes made to a person's regular prescription. Documented examples for this were seen during the inspection. Required warnings needed for certain medicines were printed on some of the labels inside of the packs, but not all. The SI gave assurances that the system would be checked to ensure warnings were printed where necessary. Descriptions of each of the medicines was not seen. The SI explained that they routinely provided patient information leaflets with every supply, as brands of medicines often changed, and it was difficult to ensure the correct description. This could make it more difficult for people to quickly identify the medications inside of the packs.

The pharmacy offered a delivery service and had two designated delivery drivers for this. All deliveries were made within the pharmacy opening hours and an audit trail of what deliveries had been made was kept. Medicines were returned to the pharmacy if people were not home, and the pharmacy had cards to post through people's doors and contact numbers to reschedule where necessary.

People were given an owing slip for medicines that were not in stock, and a label was attached to the prescription for the pharmacy to order the items. For uncollected medications, the prescriptions were removed from the shelf every four months. Those prescriptions that people did not come in to collect were returned to the prescriber or marked as not dispensed on the system. Stock for these prescriptions was returned to the shelf where appropriate.

When asked, the trainee pharmacy technician was aware of the risks involved when supplying valproate products to people who could become pregnant. They also knew about the guidance to supply these products in complete original manufacturer's packs, and to ensure they didn't cover any of the warnings with dispensing labels. The importance of undertaking individual risk assessments if valproate was not dispensed in the original manufacturer's pack was discussed with the SI who gave assurances that this would be completed where appropriate. Prescriptions for other higher-risk medicines were highlighted by the PMR system when dispensing. However, there was no system in place to remind the team to refer to the pharmacist when handing out these medicines. This may mean that opportunities to provide counselling to people about these medicines could be missed.

Valid and signed PGDs were seen for the Pharmacy First services offered. The SI explained that they had established a working relationship with the closest GP practice to ensure that they were aware they can signpost people to the pharmacy and to make sure referrals were appropriate. They also worked with them when making repeat requests for people to make sure prescriptions were received in a timely manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use.

Inspector's evidence

The pharmacy used suitable standardised conical measures for measuring liquids and clean triangle tablet counters were available for dispensing loose medication. Separate conical measures and triangle counter were available for certain substances that were marked to avoid cross-contamination. A new digital otoscope with disposable specula covers was available for providing the Pharmacy First services. There was a blood pressure monitor in the consultation room, the SI said that this was new and would usually be replaced annually. An adrenaline auto-injector and sharps bin were stored in the consultation room for when flu vaccinations were being administered. A portable telephone enabled the team to ensure conversations were kept private were necessary. All computers were password protected to safeguard information.

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.