General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** City Dock Pharmacy, Unit 2A, Building A, 142 Vaughan Way, London, E1W 2AF

**Pharmacy reference:** 9012156

**Type of pharmacy:** Community

**Date of inspection:** 04/11/2024

## Pharmacy context

This pharmacy is located within a parade of shops in a residential area of East London. The pharmacy mainly serves the local community. It dispenses NHS prescriptions received electronically and private prescriptions generated by external prescribers as well as its own pharmacist independent prescriber. It also provides a travel vaccine service. This is the pharmacy's first inspection since registering.

## 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 doesn't adequately manage the risks associated with its prescribing service. Some consultation notes for the prescribing service lack important information. The pharmacy does not have a robust prescribing policy in place and it does not complete any risk assessments for its prescribing service. |
| | | 1.2 | Standard not met | The pharmacy cannot demonstrate that it regularly audits its prescribing service adequately to ensure its processes are effective at keeping people safe. |
| **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 does not always make sure that it makes supplies of prescription-only medicines against current Patient Group Directions. And the prescriber cannot adequately demonstrate that people's regular prescribers are informed about prescribed medicines supplied through the pharmacy's private prescribing service. |
| **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 adequately manage the risks associated with its prescribing service. It does not have a risk assessment or a robust prescribing policy in place. So it may not be able to demonstrate that it assesses the risks associated with all the services it provides. And it does not carry out regular audits of its prescribing service. The pharmacy has written procedures to help manage risks associated with its other services. And team members discuss and record errors they make during the dispensing process. But they do not always record or report dispensing errors which have reached patients. This may make it harder to investigate the error and understand what may have gone wrong.

### Inspector's evidence

Current standard operating procedures (SOPs) were held electronically but individual SOPs were numbered rather than named. This made it difficult to find the relevant SOP. Current team members had signed an electronic log to confirm that they had read and understood the SOPs. The pharmacy had a prescribing policy, but it was missing some information, for example, it did not include any information on the health conditions that the PIP was prescribing for or a prescribing formulary. The policy stated to ‘specify the therapeutic areas in which the pharmacist independent prescriber (PIP) can prescribe', but this was not completed. This may make it harder for the pharmacy to show that it follows its procedures and policies to help make sure the service is provided in a safe manner. It also stated that evidence-based guidelines should be followed but there was no information as to which guidelines the prescriber was following. The pharmacy had not conducted a risk assessment for the prescribing service or any clinical audits. This may mean that it has not identified risks associated with its services and considered what action it would take to mitigate them.

The regular responsible pharmacist (RP), who was also a Pharmacist Independent Prescriber (PIP) said that risks associated with the dispensing service were reduced as medicine packs were scanned into the dispensing software. This helped reduce dispensing mistakes. Near misses, where a dispensing mistake was identified before the medicine was handed to a person, were seen to be recorded. The RP said that the record was reviewed and discussed with other team members. The RP had briefed the trainee pharmacist about the importance of confirming the brand when dispensing prescriptions for diltiazem. The RP described the procedure for dealing with dispensing mistakes which had reached a person, or dispensing errors. This included correcting and investigating the mistake, and documenting it. The most recent dispensing error, where the wrong strength of a medicine had been supplied, had not been documented. The RP said that they would ensure that dispensing errors were documented in a timely manner in the future.

The correct RP sign was displayed. The trainee pharmacist was not entirely sure of the tasks that they could or could not do in the absence of the RP. They said they asked several questions before referring to the pharmacist before selling pharmacy-only medicines (P-medicines). The RP provided assurances that they would provide refresher training for the trainee pharmacist. The RP record was kept electronically, and samples checked were in order. Samples of the private prescription and emergency supply records were generally in order. Controlled drug (CD) registers were not always maintained in accordance with requirements as headings were missing from several registers. This may increase the risk of making entries in the incorrect register. A random stock check of a CD did not agree with the recorded balance as an entry had not been made several days before the inspection. The RP corrected

the balance during the inspection. The pharmacy had current indemnity insurance cover.

The trainee pharmacist described ways in which the pharmacy protected people's confidential information, including shredding confidential waste and signposting people to the consultation room for more privacy. Team members had read the SOP about information governance. Computers were password protected and smartcards were used to access the pharmacy's electronic records. Confidential information was not visible to members of the public.

People were able to provide feedback online, verbally, or by email. The RP said they would signpost people to other organisations, such as the General Pharmaceutical Council, if necessary. The pharmacy had received several positive reviews online.

The trainee pharmacist had read the pharmacy's SOP about safeguarding. The RP had completed Level 3 training with an external provider. The trainee pharmacist was unsure about what they would do if they had a concern about a vulnerable person and the contact details of local safeguarding team were not readily accessible. This could cause delays in dealing with a concern. The RP said that they would ensure that the policy was updated with the relevant contact details.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff to manage its workload. Team members have access to some ongoing training. But they may benefit from additional structured training to ensure that services are provided safely. Team members do not always know how to provide feedback to help improve the pharmacy's services or raise concerns if needed.

### Inspector's evidence

During the inspection there was a regular RP and a trainee pharmacist. The pharmacy was relatively quiet during the inspection and team members were observed managing the workload well.

The trainee dispenser said they were responsible for dispensing, sorting deliveries, managing CDs including carrying out CD balance audits, serving customers, and dealing with queries. The trainee pharmacist attended a study session once a month with an external training provider. They completed pre-work and coursework for each module. They completed independent training by researching about commonly prescribed medicines and medicines they were not sure about. They were provided with one hour study every week. The trainee pharmacist discussed her performance with the RP but had not had a formalised review since starting her placement. The trainee pharmacist did not know how they could raise concerns. Targets were not set for the team.

The RP explained that their prescribing area of expertise was hypertension. They discussed this with their peers and referred to the BNF, NICE guidance, and Patient Group Directions (PGDs) when prescribing. The RP mainly prescribed antibiotics. Following the inspection, the RP sent certificates to confirm that they had completed an eLearning for Health module about infection control, a Health Education England module about antimicrobial stewardship in community pharmacy, and a CPPE module about weight management in adults. They had also completed additional training to provide services via PGDs, including weight loss medicines.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is clean, tidy, and provides a safe and appropriate environment for people to access its services. It has several consultation rooms for people to have private conversations. And the pharmacy is kept secure from unauthorised access.

### Inspector's evidence

The pharmacy was clean, bright, and fitted to a high standard. It comprised of a spacious shopfloor and a dispensary at the back of the shop. The dispensary had ample storage and workspace. Workbenches were kept clean and tidy. The shopfloor was well maintained and had several seats for those waiting for prescriptions or services.

There were four clearly signposted consultation rooms, some were fitted with sinks and therapy beds. P-medicines were kept behind the medicines counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. There were two large TV screens fitted at the window which were used to promote services.

A disabled access toilet was available for staff and members of the public. The premises were secure from unauthorised access when closed.

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

### Summary findings

The pharmacy does not always ensure that it makes supplies of prescription-only medicines against current Patient Group Directions. This may mean that supplies of prescription-only medicines are made against out-dated PGDs that may not contain all the updated information. And it does not always keep appropriate consultation notes for its prescribing service. The pharmacy orders its medicines from appropriate sources and largely stores them properly. It. And its services are accessible.

### Inspector's evidence

Entry into the pharmacy was via two entrances, one was step-free. Services and opening hours were clearly displayed, and screens were used to promote services. The shopfloor was spacious and open, and this assisted people with restricted mobility or using wheelchairs.

Dispensing audit trails were maintained to help identify who was involved in dispensing and checking a prescription. Baskets were used throughout the dispensing process to help prevent different people's prescriptions geting mixed up. Medicine packs were scanned onto the dispensing software, which would alert the team member if the incorrect pack was scanned. The system did not allow for prescriptions to be dispensed unless they had been clinically screened and signed off by a pharmacist. Stock was picked by the trainee pharmacist and checked by the RP.

The trainee pharmacist had read the guidance about valproate but was not aware of the need to dispense this medicine in its original container. They described the relevant checks they would make when supplying the medicine to people in the ‘at-risk’ group. However, the RP was aware of the updated guidance. Warning cards were available at the pharmacy.

The pharmacy provided a range of treatments via PGDs, including travel vaccines, hair loss, acid reflux, acne, erectile dysfunction, oral contraception, ear infection, Chlamydia, malaria prophylaxis, period pain relief, urinary tract infections, weight management, and nausea. However, all PGDs had expired in August 2024. There was evidence that the pharmacy had administered travel vaccines and made supplies of prescription-only medicines, such as finasteride and naproxen, since then. This may mean that supplies were made against out-dated PGDs and may not contain all of the updated information to help make sure supplies of medicines are completed safely. People were asked to complete a questionnaire when accessing the service. The RP then reviewed the inclusion and exclusion criteria before deciding to supply a medicine.

The RP was prescribing a small number of antibiotics and weight loss medicines. A sample of notes for the prescribing service were checked. They included information about the presenting complaint, medical history, symptoms, assessment, medication supplied, and advice provided. Some clinical notes were missing important information, for example, for the weight loss service some records did not include the person’s weight or BMI. Notes for a malaria prophylaxis consultation did not include area of travel and duration of stay. A record for the supply of antibiotics for a urinary tract infection (UTI) indicated that it was a recurrent UTI. There was no evidence of referring the person for a urine culture as per NICE Clinical Knowledge Summaries (CKS) for recurrent UTI. There was no indication if the person was pregnant, or breastfeeding and it was unclear if the RP had confirmed if the person did not have a fever. The rationale behind prescribing an antibiotic was not documented. The RP had also prescribed

melatonin 3mg tablets for jet lag. The medicine was licensed for use up to five days, but it had been prescribed for up to 30 days use and was therefore off label usage. There was no record of any discussions with the person around prescribing the medicine outside the national guidelines or that it was an unlicensed medicine.

The pharmacy did not routinely request consent to share information with the person's regular prescriber and the RP said that they encouraged people to share information with their doctor. The pharmacy only carried out face to face consultations. Some prescriptions were found where a copy of the dispensing label was attached in place of written details of the medicine prescribed. As the labels could be removed, this could allow for amendments to prescriptions.

There were audit trails available for the multi-compartment compliance pack service. Prescriptions were clinically checked by the RP once they were received before medicine stock was picked by the trainee pharmacist. Packs were assembled by the trainee pharmacist and checked by the pharmacist. Prepared packs observed were not always labelled with product descriptions. This may make it harder for people to identify their medicines. Patient information leaflets were not routinely supplied. This may mean that people do not have up-to-date information about their medicines. The RP said that they would ensure that PILs and medicine descriptions were provided in the future.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. Medicines were stored in an organised manner on the shelves. The pharmacy team said that they checked the expiry dates of medicines at regular intervals but did not keep clear records of this. No expired medicines were found on the shelves in a random check in the dispensary. The fridge temperature was monitored daily. Records indicated that the temperatures were maintained within the recommended range. But the maximum temperature of the fridge was seen to be 10 degrees during the inspection. The RP did not know how to reset the thermometer and said they would follow the pharmacy's procedure covering fridge temperature deviations. Following the inspection, they confirmed that they had ordered a new thermometer. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier. Drug alerts and recalls were received and filed electronically. The pharmacy had actioned the latest MHRA alert.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy generally has the equipment it needs to provide its services safely. And it uses the equipment in a way to protect people's private information.

### Inspector's evidence

The pharmacy had several plastic measures for measuring liquid. Following the inspection, the RP confirmed that they had ordered calibrated glass measures. The blood pressure meter was relatively new. The phone was cordless and could be moved to a more private area to help protect people's personal information. Computers were password protected and people using the pharmacy could not see the information on the screens.

## 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. |