General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cray Hill Pharmacy, 88 Cotmandene Crescent, StPauls Cray, ORPINGTON, Kent, BR5 2RG

Pharmacy reference: 1032865

Type of pharmacy: Community

Date of inspection: 24/10/2022

Pharmacy context

This is a community pharmacy in a parade of shops. The surrounding area is largely residential. The pharmacy mainly dispenses NHS prescriptions and offers other services such as Covid vaccinations and medication deliveries. It provides some medications in multi-compartment compliance packs to people who need help taking their medicines.

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. Its team members record and discuss mistakes that happen in the dispensing process, to help make the pharmacy's services safer. It generally keeps the records it needs to by law. And its team members know how to protect the welfare of a vulnerable person. The pharmacy mostly protects people's personal information well.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were accessible on the pharmacy's computer. The SOPs had previously been printed copies but were now held electronically. Staff had not yet signed to indicate that they had read and understood the electronic versions. But the trainee technician said that team members had read through the electronic SOPs relevant to their roles, and this was confirmed by several team members.

Near misses, where a dispensing mistake happened and was identified before the medicine was handed to a person, were recorded on the pharmacy's computer system. The computer was also used to record dispensing incidents, where a mistake happened and the medicine was handed to a person. The trainee technician explained how she reviewed the dispensing mistakes each month to try and identify any patterns or trends. Team members said that if a mistake happened, it was discussed with the wider team.

Staff were able to describe their roles and responsibilities. The medicines counter assistant (MCA) could explain what she could and could not do if the pharmacist had not turned up in the morning.

Prior to the pandemic, the pharmacy had undertaken an annual patient survey. This had not yet resumed. The pharmacy had a complaints procedure. And there was a sign in the public area explaining to people how they could make a complaint or provide feedback. The pharmacy had current indemnity insurance.

The right responsible pharmacist (RP) notice was displayed, and the RP records seen were well maintained. Private prescription records mostly complied with requirements, but the prescriber's details were not always recorded accurately. A small number of records about emergency supplies did not indicate the nature of the emergency. So, it could be harder for the pharmacy to find out these details if there was a future query. Controlled drug (CD) registers seen had largely been filled in correctly, but there was a small amount of crossing out. CD running balances were checked regularly. A random check of a CD medicine showed that the physical stock quantity matched the recorded balance. Records examined about unlicensed medicines supplied had the required details on them.

No confidential information was visible from the shop area. But there were some bags of dispensed medicines on the way to the consultation room. And a couple of the address labels could potentially be seen by people on the way to the room. Team members were made aware and said that the bags would be moved or the labels obscured. Staff had read the confidentiality and safeguarding SOPs. They were observed using their own smartcards to access the electronic NHS systems. Confidential waste was separated from general waste and placed into sacks for offsite disposal. The locum pharmacist had done the level 2 safeguarding course and could describe what he would do if he had a concern about a

vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They undertake some ongoing training to help keep their knowledge and skills up to date. And they feel comfortable about raising concerns or making suggestions. The pharmacy does not always check that agency staff have done the required training. So, it could be harder for the pharmacy to show that these staff have the skills and knowledge they need to do their roles effectively.

Inspector's evidence

During the inspection, there was a locum pharmacist, a regular pharmacist (who was providing vaccinations), a trainee technician (who worked as the admin manager), two trained dispensers, and a trained MCA. There was also an agency member of staff working as a locum dispenser. This person had completed a pharmacy degree and pre-registration training, but had not registered as a pharmacist and had not undertaken any accredited dispenser training. They had been working as a dispenser since around 2015. The team member had not worked in the pharmacy before and currently had no days scheduled to work at the pharmacy again.

Team members were observed communicating well with each other. The trainee technician explained how there had been some problems with recruiting and retaining staff. But although the pharmacy sometimes got busy, the team was up to date with the pharmacy's workload.

Staff felt comfortable about raising any concerns or making suggestions. They did ongoing training provided by the pharmacy's head office, and were usually able to complete it during work at quieter times. Recent training had included the Ask For 'ANI' initiative. The MCA was clear about the steps she would take when people requested medicines which would be abused. She said that the pharmacy had had several requests for codeine linctus, but this was not stocked by the pharmacy. The regular pharmacist was able to describe the training he had undertaken for the Covid vaccination service. Staff had occasional team meetings, and team members described how they included any current issues and any dispensing mistakes which had happened. No formal targets were set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy’s services, and they are kept secure. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was generally clean and tidy, with good lighting throughout. Fixtures and fittings were fit for purpose and the sink was clean. Staff had access to toilet and handwashing facilities.

There was a large amount of workspace available for dispensing and other tasks. The pharmacy had two consultation rooms, one of which was set a distance away from the public area and was being used for vaccinations. Both rooms allowed a conversation to take place inside at a normal level of volume and not be overheard. The premises were secure from unauthorised access when closed.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and makes sure that they are accessible to people with a range of needs. It gets its medicines from reputable sources and stores them properly. It takes the right action in response to safety alerts, so that people get medicines and medical devices that are safe to use. The pharmacy does not always highlight prescriptions for higher-risk medicines. So, staff may miss out on opportunities to give people taking these medicines the information they need to help them take their medicines safely.

Inspector's evidence

The pharmacy had step-free access from the street. The public area of the pharmacy was large, with ample space to help people with pushchairs or wheelchairs manoeuvre. There was a waiting area with several seats, set away from the counter to help protect people's privacy. Details of the services provided were on the pharmacy's website.

Baskets were used during the dispensing process to help prevent people's medicines becoming mixed up. There was a clear workflow through the dispensary, with a designated area used for checking. Staff initialled labels when dispensing and checking, to help provide an audit trail. The trainee technician explained that part of the pharmacy's dispensing activity was due to transfer to the company's dispensing hub in the future.

The regular pharmacist showed the signed patient group directions for the Covid vaccination service. The vaccinations were done in a rear consultation room, and there was an area used for vaccine preparation.

Dispensed multi-compartment compliance packs were labelled with a description of the medicines inside, to help people and their carers identify them. People's hospital discharge letters were retained. Staff initialled the labels on the packs to show who had dispensed and checked them. People were assessed for their need for the packs by the local medicines' optimisation service. Patient information leaflets were usually supplied with the packs each month.

The pharmacy did some medicine deliveries to people's homes. The driver showed how she obtained signatures from recipients to indicate safe delivery. The signatures were obtained on the other side of the address labels, to help protect people's personal information. A copy of the delivery sheet was left with the pharmacy when the driver went out, to assist them if anyone had queries about their delivery.

Prescriptions for higher-risk medicines such as methotrexate and lithium were not always highlighted, and the trainee technician said that this would be reviewed. CDs were highlighted with the date of the prescription expiry, to help team members handing the medicines out to know if the prescriptions were still valid.

Team members were aware of the additional guidance about pregnancy prevention for medicines containing valproate, and had additional warning cards. The pharmacy did not have any spare warning stickers, and the trainee technician said that some would be ordered in. Warning cards were present on

the original packs of medicines containing valproate. A dispensed prescription for valproate was awaiting collection, and there was a note on the person's record that the pharmacist had previously checked that they were taking contraception.

Medicines were obtained from licensed suppliers and were stored in an orderly way in the dispensary. Stock was regularly date check and electronic records were kept for this activity. No date-expired medicines were found on the shelves sampled. Bulk liquids were marked with the date of opening, so that staff knew if they were still suitable to use. The pharmacy had two fridges, and the temperatures were checked regularly. Temperature records seen showed that the medicines inside had been kept within the appropriate temperature range. CDs were kept secure. Medicines people had returned for destruction were separated from regular stock and put in designated bins and sacks.

A team member explained how the pharmacy received drug alerts and recalls, and how the stock was checked. A printed copy of the alert or recall was kept, and a note made of the action that had been taken as a result.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protected people's personal information.

Inspector's evidence

There were clean glass calibrated measures for dispensing liquids. One measure was marked for use with certain liquids only to help avoid cross-contamination. Tablet and capsule counting equipment was generally clean. There was an in-date anaphylaxis kit in the room being used to provide vaccinations, and the kit was easily accessible in an emergency. The phone was cordless and could be moved to a more private area to help protect people's personal 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.