

Registered pharmacy inspection report

Pharmacy Name: The Chief Cornerstone, 4 Eastmead Avenue,
GREENFORD, Middlesex, UB6 9RA

Pharmacy reference: 1034910

Type of pharmacy: Community

Date of inspection: 06/04/2022

Pharmacy context

This is a community pharmacy in a residential area of Greenford. The pharmacy provides a range of services including dispensing prescriptions for people at home and for people living in residential and care homes. It has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a core range of other services, including a medicines delivery service. The pharmacy was inspected during the COVID-19 pandemic when restrictions had been lifted in England.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	Not all staff are adequately trained for the tasks they carry out.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not provide enough information with all of its medicines to help people take them properly. And it does not keep all of its medicines in appropriate packaging.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

In general, the pharmacy has adequate procedures to identify risk. It has written procedures in place to help ensure that its team members work safely. And it has insurance to cover its services. The pharmacy team has adapted its working practices suitably to minimise risks to people's safety during the COVID-19 pandemic. And it knows how to protect the safety of vulnerable people

Inspector's evidence

The pharmacy had put measures in place to keep people safe from infection during the COVID-19 pandemic. It had put screens up at its medicines counter. And it had hand sanitiser for people and the team to use. Team members had access to personal protective equipment in the form of gloves and masks and were observed wearing masks. The team had a cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. The responsible pharmacist (RP) explained that during the pandemic the pharmacy had felt the pressures of a heavier-than-usual workload. And it had also had staff shortages. And so it had found it difficult to complete all of its usual tasks. This had led to the pharmacy reducing its range of services including its flu vaccination service. While the team had a system for recording its mistakes it had not recorded any since October 2020. But the RP recalled that the team had not made many. She described how she highlighted and discussed 'near misses' and errors at the time with the team member involved. This enabled them to reflect and learn. The RP recognised that it was also important to monitor and review near misses and errors so that the team could learn as much as possible from them. She agreed that records should be kept. And that records should identify what could be done differently next time to prevent mistakes and promote continued improvement.

The pharmacy had a set of standard operating procedures (SOPs) to follow. But the SOPs had not had a full and thorough review for several years. This had been identified at the last inspection. But the impact of the pandemic had led to a further delay. The RP recognised the need for a full review of SOPs, particularly those that had remained unchanged since 2016. But team members had read the existing SOPs relevant to their roles. They appeared to understand their roles and responsibilities and were seen consulting the RP when they needed her advice and expertise. The RP had placed her RP notice on display showing her name and registration number as required by law. The inspector and RP discussed the RP notice and the importance of ensuring it was accurate. They also discussed the importance of displaying the certificate so that it was clearly visible to the public. People could give feedback on the quality of the pharmacy's services. Team members described having had a few complaints. Complaints had been related to people's expectations involving the time taken to get their medicines ready after they had requested their prescriptions from the surgery. And manufacturers' medicines shortages which the team did their best to resolve. The pharmacy had a complaints procedure in place. In general, the team sought feedback from conversations with people as well as staff at the homes it supplied medicines to. The pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints procedure online. But customer concerns were generally dealt with at the time by the regular pharmacists or by the superintendent (SP) if necessary. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers. It had professional indemnity and public liability insurance in place until July 2022. It is understood that when this date is reached the pharmacy will renew its insurance arrangements for the

following year.

The pharmacy generally kept its records in the way it was meant to, including its controlled drugs (CD) registers. It had a CD destruction register for patient-returned medicines which was up to date with team members having undertaken the necessary destructions. The pharmacy's RP record was generally in order, but it had some records missing at the end of a shift where the RP's responsibilities ended. In general the pharmacy's private prescription records were in order but they did not have the prescribers' details, as required by law. Historically the pharmacy maintained and audited its CD running balances. But this had not been done regularly over recent months. The RP recognised that the pharmacy should ensure that all of its essential records are accurate and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And had completed general training on confidentiality. Confidential paper waste was discarded into separate waste containers. And it was shredded daily. People's personal information, including their prescription details, were kept out of public view. The RP had completed appropriate safeguarding training. Other team members had been briefed although had not yet had any formal training. but they knew to report any concerns to the RP. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy still does not adequately train all its team members for the tasks they carry out. But, in general, the pharmacy team manages its workload safely and effectively. And team members support one another. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours and found one of the pharmacy's regular RPs on duty. On the day of the inspection the RP worked alongside a trainee technician who was also the manager. And a healthcare assistant. The healthcare assistant had not had any dispensing assistant training. But often helped out with selecting medicines for multi-compartment compliance packs when this dispensing activity required dispensing assistant training. This was also found to have been the case during the previous inspection. Overall, team members were seen to work effectively with one another. The pharmacy had a small, close-knit team who worked regularly together. The daily workload of prescriptions was in hand and customers were attended to promptly. RPs were generally able to make day-to-day professional decisions in the interest of patients. RPs generally felt that they could discuss their concerns with the owner who was also the SP. Team members did not have formal appraisals or reviews about their work performance, they felt that they were kept up to date and supported in their work by the RP. And they could raise concerns and discuss issues with her or the other pharmacists. Pharmacists could make their own professional decisions in the interest of people and were not under pressure to meet business or professional targets.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. And they are sufficiently clean and secure. The pharmacy has made some sensible adjustments to help keep people safe during the pandemic. But some areas of the pharmacy are cluttered. And its workspace does not fully benefit from the total space available.

Inspector's evidence

The pharmacy was on a small parade of shops and businesses in the midst of the local community. It had not been fully updated for many years and its fixtures and fittings were well used and dated looking. The pharmacy had limited retail space. But it had a seat for waiting customers. It had a medicines counter which supported a small transparent plastic screen to help reduce the spread of coronavirus. And it kept its pharmacy medicines behind the counter. The pharmacy had a small dispensary. The dispensary had a short run of dispensing bench which was used for most of the pharmacy's dispensing activities. Items were both dispensed and checked on this bench. Because of its limited space the dispensary also had several pinch points which meant that it could feel cramped when there were two or more team members working there. But in contrast to the size of the dispensary and retail space, the rest of the premises was spacious. It had five further rooms at ground floor level and three extra rooms upstairs. One of the rooms on the ground floor was used as a consultation room. The remaining ground floor rooms were used as stock rooms and an office. Because of the additional space it provided, the team used the consultation room for managing, dispensing and storing multi-compartment compliance packs. Dispensed items and prescriptions were stored so that people's information was generally kept out of view. But when the consultation room was being used for dispensing, the RP used one of the pharmacy's other rooms for private consultations.

Team members had placed a desk just outside the dispensary for additional dispensing activities. They also used this area for storing completed prescriptions for delivery. This area provided much needed additional space. And team members had taken steps to ensure that people's private information was not on view when taking someone past this area towards one of the rooms at the rear for a consultation. But the pharmacy did not carry out many private consultations. It had reduced the range of services it offered since the pandemic began, preferring to focus on the safe delivery of its core services. The team decided to reduce its range of services when staff shortages had put pressure on the team to complete its tasks. And so, the RP had not used the consultation room much during the pandemic. The rooms upstairs were not in general use. It was not possible to enter any of these rooms due to the clutter of boxes, equipment, old display stands and fixtures. And bags and boxes of paperwork and other items which it was not possible to access or identify. The team cleaned the ground floor area daily to ensure that contact surfaces were clean. Stock on shelves was tidy and organised. And floors and work surfaces were generally free from clutter. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines. The pharmacy had staff facilities to the rear.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy is not thorough enough in ensuring that it keeps all its medicines for dispensing in the appropriate packaging. And it does not do enough to ensure that all the medicines it supplies have the information that people need so they can take their medicines properly. In general, the pharmacy makes its services accessible for people. But it does not always ensure that it gives up-to-date information about its services. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacy had a short ramp at its entrance, providing step-free access. And its customer area was free of clutter and unnecessary obstacles. The pharmacy had a delivery service for people who found it difficult to visit the pharmacy. And it could also order people's repeat prescriptions for them. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. It provided medicines in multi-compartment compliance packs for people living at home who needed them. And for people living in care home and nursing home environments. The pharmacy labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. But its labelling directions did not give the required advisory information to help people take their medicines properly. And so, someone taking soluble aspirin may not realise that they needed to dissolve the tablet in water before taking it. Some labelling directions on compliance packs were unclear. Such as the direction to take 'daily' without stating how much of the medicine was to be taken. Another had directions to take '1 nocte'. Rather than clearly stating 'one to be taken at night'. The pharmacy generally supplied patient information leaflets (PILs) with new medicines, but not generally with regular repeat medicines. This too meant that people may not always have all the information they need about their medicines. The RP gave people advice on a range of matters. And she would give appropriate advice to anyone taking high-risk medicines. The RP had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP was aware of the precautions she would need to take, and counselling she would give, if it were to be prescribed for someone new. The owner had an internet pharmacy website. But he reported that it was not in use. The website indicated that internet services were associated with this pharmacy when they were instead associated with the owner's other branch. The owner agreed with the inspector that the website information should be updated.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines appropriately and in their original containers. But the inspector found a box of pregabalin capsules and a box of gliclazide tablets which both contained strips of medicines from different batches. Some of the strips of capsules and tablets had been part-dispensed with their expiry dates removed. So their outer packaging did not give enough essential information about the medicines they contained, and they did not accurately reflect what was inside. The inspector discussed this with the RP. It was agreed that team members should review their understanding of the correct procedures to follow when dispensing a split-pack of medicines. And when putting medicines back into stock after dispensing. Stock on the shelves was generally tidy and

organised. The pharmacy team date-checked the pharmacy's stocks regularly. And it kept records to help it manage the process effectively. A random sample of stock checked by the inspector was in date. In general, short-dated stock was identified and highlighted. And the team put its out-of-date and patient-returned medicines into dedicated waste containers. The team stored its CD and fridge items appropriately. But the fridge thermometer was not working so the team could not monitor the pharmacy's fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

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 the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies. The pharmacy had two computer terminals which had been placed in the consultation room and dispensary. Computers were password protected. And prescriptions were stored in the dispensary out of people's view.

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.