General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chemitex Ltd., 4a/b High Street, CATERHAM, Surrey, CR3 5UA

Pharmacy reference: 1036478

Type of pharmacy: Community

Date of inspection: 22/02/2024

Pharmacy context

This NHS community pharmacy is set on a shopping parade in Caterham-on-the-Hill. The pharmacy opens six days a week. It sells medicines over the counter. It dispenses people's prescriptions. It delivers medicines to people who have difficulty in leaving their homes. And it supplies multi-compartment compliance packs (compliance packs) to a few people who need help managing their medicines. The pharmacy can supply the morning-after pill to some people for free. It delivers the NHS Pharmacy First service to help people who have a minor illness or need an urgent supply of a medicine. And people can visit the pharmacy to get their flu jab or travel vaccination or have their blood pressure checked.

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	Good practice	2.2	Good practice	The pharmacy provides its team members with the training and support they need. And it actively encourages them to improve their skills.
		2.4	Good practice	Members of the pharmacy team work well together and have a work culture of openness, honesty and learning.
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 generally manages its risks appropriately. It has written instructions to help its team members work safely. It largely keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy keep a log of the mistakes they make and talk to each other about them to try to stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had a plastic screen on its counter to help reduce the spread of airborne infections such as coronavirus. And hand sanitising gel was also available for people to use. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed periodically by the superintendent (SI) pharmacist. Members of the pharmacy team had to read and sign the SOPs relevant to their roles to say they understood them and would follow them. They knew what they could and couldn't do, what they were responsible for and when they might seek help. Their responsibilities were described within the SOPs. And a notice in the pharmacy told people who the responsible pharmacist (RP) was at that time. The team members who were responsible for making up people's prescriptions tried to keep the dispensing workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by one of the pharmacists. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). Members of the pharmacy team kept a log of the mistakes they made and talked to one another about them to try to learn from them and help stop the same sort of things happening again. And, for example, they separated and highlighted the locations of a few medicines, which looked alike and whose names sounded alike, to help reduce the chances of them picking the wrong product. But they could do more to make sure they reviewed their near misses more frequently to help them spot patterns in the mistakes they made earlier so they could strengthen their dispensing process further.

Some people have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. And it had a notice that told people how they could provide feedback about the pharmacy or its team. People could share their views and make suggestions to the pharmacy team about how the pharmacy could do things better. And, for example, the pharmacy team tried to order a person's preferred make of a prescription medicine when it was asked to do so. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy had a CD register which was maintained as it should be. And its team checked the stock levels in the CD register as often as the SOPs asked them to be. The pharmacy kept records to show which pharmacist was the RP and when. But the pharmacist didn't always record the time they stopped being the RP. The pharmacy recorded the supplies of the unlicensed medicinal products it

made. But its team could do more to make sure it recorded when it received one of these products. The pharmacy required its team to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the details of the prescriber were incomplete in a few of the private prescription records seen. The pharmacy team gave an assurance that these records would be kept as they should be.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy displayed a notice that told people how it gathered, used and shared their personal information. It had arrangements to make sure confidential information was stored and disposed of securely. And its team needed to complete training on confidentiality and data security. But people's details weren't always crossed out or removed from the unwanted medicines returned to it before being disposed of. The pharmacy had a safeguarding procedure and a chaperone policy. And its team was asked to complete safeguarding training. Members of the pharmacy team knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough team members to provide its services safely and effectively. And it asks them to give feedback. Members of the pharmacy team work well together and have a work culture of openness, honesty and learning. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets. The pharmacy provides its team members with the training and support they need. It actively encourages them to improve their skills. And its team makes appropriate decisions about what is right for the people it cares for.

Inspector's evidence

The pharmacy team consisted of the SI, three regular locum pharmacists, an accuracy checking pharmacy technician (ACPT), a dispensing assistant, a medicines counter assistants (MCA), a trainee MCA and a delivery driver. The people working at the pharmacy during the inspection included the SI, a locum pharmacist (the RP), the ACPT, the dispensing assistant and the MCA. The pharmacy depended upon its team and locum pharmacists to cover absences. And two pharmacists worked alongside each other four days a week. Members of the pharmacy team were mostly up to date with their workload. They worked well together and helped each other so people were served quickly, and prescriptions could be dispensed safely. The SI managed the pharmacy and its team. They led by example. And the supply of medicines and advice given by the pharmacy team was supervised and overseen by the SI and the RP. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist. The pharmacy had an induction training programme for its team. Members of the pharmacy team needed to complete mandatory training during their employment. They were required to undertake accredited training relevant to their roles after completing a probationary period. They regularly discussed how they were doing and their development needs with the SI. And, for example, the dispensing assistant felt supported and had been encouraged to complete an accuracy checking course to help them improve their skills further. Team members could ask questions and familiarise themselves with new products. They kept their knowledge up to date by completing online training. They were encouraged to train while they were at work. But they could choose to train in their own time if they preferred. The pharmacy had a culture that encouraged its team members to be open and honest about the mistakes they made and share what they learnt with each other at team meetings. This meant it could improve the safety of the services it offered. People who worked at the pharmacy didn’t feel the targets set for the pharmacy stopped them from making decisions that kept people safe. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. They were asked to make suggestions on how to improve the pharmacy and its services. They felt comfortable in providing feedback to the pharmacy owner. And, for example, changes to the pharmacy’s layout had recently started following their feedback.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy had some new exterior signs fitted and its exterior was repainted recently. It was air-conditioned, bright and secure. And its public-facing area was professionally presented. The pharmacy had a consulting room, a counter, a dispensary, a kitchenette, a retail area, a stockroom and a toilet. The pharmacy had seen an increase in its dispensing volume and the number of services it provided since the last inspection. And it had just enough storage and workspace for its current workload. But its layout was due to be changed over the coming weeks to provide two new consulting rooms and more storage and workspace. The carpet in the dispensary and stockroom was dusty in places and a small section was missing. The SI gave an assurance the carpet would be repaired and deep cleaned once the refurbishment was complete. The current consulting room was available for services that needed one or if someone needed to speak to a team member in private. It could be locked when it wasn’t being used to make sure its contents were kept secure. And people’s conversations in it couldn’t be overheard outside of it. The pharmacy had the sinks it needed for the services it provided. It had a supply of hot and cold water. And its team was responsible for keeping its premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are generally safe and effective. Its team is friendly and helps people access the services they need. And it keeps adequate records for its vaccination service to show that it has given the right vaccine to the right person. But it doesn't always give people who use compliance packs all the information they need to take their medicines safely. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team usually dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy didn't have an automated door. But its entrance was almost level with the outside pavement. And its team helped people who had difficulty in opening the door enter the premises and use its services. The pharmacy had some notices that told people when it was open and what services it offered. And it had a seating area for people to use if they wanted to wait in the pharmacy. The pharmacy team asked people who were prescribed a new medicine if they wanted to speak to the pharmacist about it. And it dealt with Pharmacy First referrals. People benefited from this service as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for some minor illnesses. Members of the pharmacy team were friendly and helpful. And they took the time to listen to people. So, they could help and advise them, and signpost them to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a local delivery service to people who couldn't attend its premises in person. And it kept a record to show the right medicine was delivered to the right person. The pharmacy had, until recently, provided NHS coronavirus boosters. And its team could administer these boosters and NHS flu jabs under the relevant national protocol. And a specified registered healthcare professional completed the stages of the national protocol they needed to. The national protocol afforded the pharmacy some flexibility in arranging vaccinators to be on-site to deliver the service if needed. But the patient group direction (PGD) could also be used to administer the coronavirus booster or flu jab if a pharmacist preferred. And private flu jabs and travel vaccines were administered under the appropriate PGD. The pharmacy had the anaphylaxis resources it needed for its vaccination service. And the vaccinators were appropriately trained to vaccinate people. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And an assessment was done to determine if a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. But a patient information leaflet and a brief description for each medicine contained within the compliance pack weren't always given. So, sometimes people didn't have all the information they needed to take their medicines safely. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. The pharmacy used reminder stickers to alert its team when these items needed to be added or if extra counselling was needed. But its team could do more to make sure assembled CD prescriptions awaiting collection were marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully. Members of the

pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. They were aware of the new rules on dispensing valproate-containing medicines in the manufacturer's original full pack. And they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept most of its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team usually marked the containers of liquid medicines with the date they opened them. They kept a list of the products that were expiring soon. And they checked the expiry dates of medicines as they dispensed them and at regular intervals. But they didn't always record when they had done these checks. The pharmacy stored its stock, which needed to be refrigerated, at the right temperature. It stored its CDs, which weren't exempt from safe custody requirements, securely. And its team recorded the destruction of the CDs that people returned to it. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And a team member described the actions they took and the records they made when the pharmacy received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And its team makes sure the equipment it uses is clean and suitable for what it's being used for.

Inspector's evidence

The pharmacy had some glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out or count medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had three medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team checked each refrigerator's maximum and minimum temperatures on the days the pharmacy was open. The pharmacy had suitable equipment for the Pharmacy First service as well as for other diagnostic tests such as measuring a person's blood pressure. And this equipment appeared to be well maintained. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were stored securely when they weren't working.

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.