General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chana Pharmacy, 18 Harper Road, Rockingham Estate, LONDON, SE1 6AD

Pharmacy reference: 1040718

Type of pharmacy: Community

Date of inspection: 27/09/2023

Pharmacy context

This NHS community pharmacy is set on a small row of shops near a GP surgery within a residential area in the London borough of Southwark. The pharmacy opens six days a week. It sells medicines over the counter. It dispenses people's prescriptions. And it supplies multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. The pharmacy team can check a person's blood pressure. And people can get their flu jabs at the pharmacy too.

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 manages its risks appropriately. It has written instructions to help its team members work safely. It mostly 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 talk to each other about the mistakes they make 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 keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

Members of the pharmacy team knew what to do if the pharmacy needed to close. And they understood what they should do to make sure people could access the care they needed if the pharmacy was closed. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were put in place after the owner of the pharmacy recently changed. Members of the pharmacy team were required to read and follow the SOPs relevant to their roles. But the pharmacy could do more to make sure the SOPs described the roles and responsibilities of its team. And to make sure its team members signed the SOPs to show they understood them and agreed to follow them. Team members knew what they could and couldn't do, what they were responsible for and when they might seek help. And the pharmacy displayed a notice that told people who the responsible pharmacist (RP) was at that time. A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to the pharmacist. 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 the RP. 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). And its team recently put 'Select with Care' stickers in front of the different strengths of a painkiller to help reduce the risks of the wrong product being picked. Members of the pharmacy team discussed the mistakes they made to learn from them and help them stop the same sort of things happening again. But they didn't always record them.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. 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 appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had an electronic controlled drug (CD) register. But the stock levels recorded in this register weren't checked as often as they should be. The pharmacy kept records to show which pharmacist was the RP and when. But the time the pharmacist stopped being the RP wasn't always recorded. The pharmacy hadn't supplied any unlicensed medicinal products since it was taken over by its current owner. Its team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. And a sample of these were looked at during the inspection and were generally found to be in order. But the details of the prescriber were incomplete in a few of

the private prescription records. The RP gave an assurance that all the pharmacy records would be maintained 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 had a 'Record keeping and confidentiality' procedure. And it had arrangements to make sure confidential information was stored and disposed of securely. The pharmacy had a 'Safeguarding vulnerable adults and children' procedure. And the RP had completed 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 ✔ Standards met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. Members of the pharmacy team work well together and use their judgement to make decisions about what is right for the people they care for. They know how to raise a concern if they have one. And they can give feedback to help the pharmacy do things better.

Inspector's evidence

The pharmacy team consisted of an accuracy checking pharmacy technician (ACPT), two dispensing assistants and two trainee medicines counter assistants. The pharmacy depended upon its team, locum pharmacists and colleagues from nearby branches to cover absences. It didn't have a permanent pharmacist, but a pharmacist from another branch worked at the pharmacy at least one day a week to provide leadership and guidance to the pharmacy team. The people working at the pharmacy during the inspection included the RP, the ACPT and a dispensing assistant. They were up to date with their workload. They helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they didn't feel the incentives or the targets set for the pharmacy stopped them from making decisions that kept people safe. The RP supervised and oversaw the supply of medicines and advice given by the team. A team member described the questions they would ask when making over-the-counter recommendations. And 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. Members of the pharmacy team needed to complete accredited training relevant to their roles. They could ask the RP questions, discuss their development needs, read pharmacy-related literature and familiarise themselves with products when they had the time to do so. But the pharmacy could do more to make sure they had time to train when they were at work. Team members knew who they should raise a concern with if they had one. They were comfortable about making suggestions on how to improve the pharmacy and its services. And their feedback led to an additional patient medication record (PMR) terminal being installed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate environment to deliver it services from. And people can receive services in private when they need to. But its team members don’t always have the space they need to work in when it’s busy.

Inspector's evidence

The pharmacy was bright and secure. And its public-facing area was adequately lit and presented. But it wasn’t air-conditioned. So, steps were taken to make sure it didn’t get too hot or cold. The pharmacy had a retail area, a counter, a dispensary, a consulting room and a toilet. Its flooring was uneven in places. And some of its fixtures were dated too. The dispensary had limited workspace and storage available. And its worksurfaces could become cluttered when the pharmacy was busy. The consulting room was available for services that required one or if someone needed to speak to a team member in private. And people’s conversations in it couldn’t be overheard outside of it. But it couldn’t be locked. So, the pharmacy team needed to make sure its contents were kept secure when it wasn’t being used. The pharmacy had the sinks it needed for the services its team delivered. And the premises 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. And its team is friendly and helps people access the services they need. Members of the pharmacy team dispose of people's unwanted medicines properly. And they usually carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy gets its medicines from reputable sources. And it mostly stores them appropriately and securely.

Inspector's evidence

The pharmacy didn't have an automated door. But its entrance was level with the outside pavement. And members of the pharmacy team helped people who couldn't open the door easily, such as someone with a pushchair or a wheelchair, access the building. The pharmacy had a seating area people could use if they wanted to wait in the pharmacy. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. The pharmacy offered the Community Pharmacist Consultation Scheme (CPCS). People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on the nearby surgery to deal with people's urgent requests for medicines or treatments for minor illnesses. Members of the pharmacy team were friendly. They took the time to listen to people. So, they could help and advise them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And its team assessed whether a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. And patient information leaflets and a brief description of each medicine contained within the compliance pack were usually provided. But cautionary and advisory warnings about the medicines contained within the compliance packs weren't included on the backing sheets. So, people didn't always have the information they needed to take their medicines safely. The pharmacy team marked prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items, such as a CD or a refrigerated product, needed to be added. But it 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 ensure 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. And they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. But some de-blistered tablets and loose blister strips were quarantined ready for destruction as their manufacturer, batch number and expiry date were unknown. Members of the pharmacy team marked the containers of liquid medicines with the date they opened them. They generally marked products which were soon to expire. And they checked the expiry dates of medicines as they dispensed them and at regular intervals. But they could do more to make sure they recorded when they had done a date check. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. And it also stored its

CDs, which weren't exempt from safe custody requirements, securely. The pharmacy kept out-of-date CDs separate from in-date stock. It 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 the alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy team described the actions it took when an MHRA medicines recall was received. But it could do more to make sure it kept a record of the recalls it received and the actions it took.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's personal information is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of 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 two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team checked and recorded each refrigerator's maximum and minimum temperatures on the days the pharmacy was open. Members of the pharmacy team could check a person's blood pressure when asked. And the monitor they used was relatively new. The pharmacy restricted access to its computers and PMR 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.