

Registered pharmacy inspection report

Pharmacy Name: Blackheath Standard Pharmacy, 182 Westcombe Hill, Blackheath, LONDON, SE3 7DH

Pharmacy reference: 1040761

Type of pharmacy: Community

Date of inspection: 16/09/2020

Pharmacy context

This pharmacy is located on a busy main road. It is surrounded by residential premises and there are two doctor's surgeries nearby. The pharmacy serves people of all age ranges and receives most of its prescriptions electronically. It provides a range of services including Medicines Use Reviews, the New Medicine Service and the influenza vaccine (seasonal). It provides medication in multi-compartment compliance packs to people who live in their own homes and need help managing their medicines. This inspection was undertaken during the Covid-19 pandemic.

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. People who use the pharmacy can provide feedback and raise concerns and the pharmacy team have received some training to help protect the welfare of vulnerable people. Team members generally respond appropriately when mistakes happen during the dispensing process. But they don't always record these mistakes. So, they might be missing opportunities to learn and make the services safer. Although the pharmacy generally keeps the records it needs to by law it could do more to ensure that its responsible pharmacist records are filled in properly. So, that it is easier to identify who the pharmacist is if there was a future query.

Inspector's evidence

Standard operating procedures (SOPs) were available at the pharmacy but not all current members of the team had signed the relevant procedures. This may make it difficult for the pharmacy to show that members of the team have read and understood the procedures.

The pharmacy was restricting the number of people allowed into the pharmacy to help reduce the risk of cross-infection during the pandemic. Signage was displayed to help remind people of the restrictions. Personal protective equipment (PPE) and hand sanitizers were available for the team. The SI was aware of the requirement to report relevant Covid-19 infections in the workplace to the Health and Safety Executive. A staff risk assessment had been done and an SOP was in place covering use of PPE, staff risk assessments and dealing with people who may have Covid-19 symptoms.

Team members said that mistakes which had been identified before they reached people (near misses) were recorded in a book. Staff took some time to locate the book, but the last entry had been made in February 2019. The superintendent pharmacist (SI) said there had been some near misses since then, but they were not recorded. He said that medicines that sounded alike or looked alike were highlighted to the team. Some packs of medicines were stored untidily on the shelves, with various medicines mixed together. This could increase the chance of picking the wrong medicine. Following the inspection, the SI added "the regular pharmacist had been recording near misses on a separate sheet as the book had been miss-placed, these were recorded up to the month of March 2020".

The SI said that dispensing mistakes which reached people were recorded on a form. Previous records could not be found, and the SI said that there had not been any mistakes recently. He said that mistakes were discussed with the whole team to identify any learning needs and areas for improvement. There was limited workspace, but the pharmacy team used baskets to help reduce the chance of mixing peoples' prescriptions and medicines.

The pharmacy had current professional indemnity and public liability insurance. An incorrect responsible pharmacist (RP) sign was displayed; this was changed to the right one during the inspection. A spreadsheet was used to keep records about the RP, but this was filled in advance and amended if necessary. It was not fully clear who had made any amendments or when they had been made, which could make the records less reliable. The SI said that the pharmacy's main RP record was the spreadsheet. An additional record was also available on the pharmacy's electronic system, but this was incomplete as the RP did not always sign out when their responsibility ended. And this could make it harder for the pharmacy to show who had been the RP if there was a future query. The SI said that the pharmacy would start using the register on the pharmacy's electronic system instead of the

spreadsheet. Private prescription records did not always have the correct prescriber details recorded. Emergency supply records were generally in order but the nature of the emergency was not recorded for several entries checked. So, it may not be possible to know why a supply was made, if there was a query. Samples of controlled drug (CD) registers examined were in order. Random checks of CD medicines complied with the balance recorded in the register.

Feedback from people accessing services was sought via annual questionnaires. The pharmacy team said they had introduced additional services, such as the travel vaccine service, in response to feedback from people.

Confidential waste was shredded, computers were password protected and smartcards were used to access the pharmacy's electronic records. Confidential information was not visible to people visiting the pharmacy, including bagged items awaiting collection. Pharmacy team members had completed General Data Protection Regulation training.

The pharmacist had completed the safeguarding course from the Centre for Postgraduate Education (CPPE). The dispenser had attended a training session by the local Clinical Commissioning Group. He explained that he would raise any safeguarding concerns to the pharmacist and could search for the contact details of local safeguarding team online.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to provide its services. They work effectively together in a supportive environment and they can raise concerns. Team members are given ongoing training to keep their knowledge and skills up to date.

Inspector's evidence

During the inspection there was the SI, a dispenser and a trainee MCA. The pharmacy also employed a trainee dispenser who was currently enrolled onto the NPA course. Members of the team were observed completing tasks efficiently. They had good rapport with people.

The dispenser had just been registered onto the technician course but was still awaiting course material. He completed ongoing training regularly and showed a good understanding of services at the pharmacy. He attended training sessions whenever there was an opportunity and accessed a range of training tools online. For example, on mental health, stopping smoking, prescription-only to pharmacy-only medicine switches and minor ailments. He completed e-tests to receive certificates, which he retained to help keep track of his training.

The trainee MCA started her training course with the National Pharmaceutical Association in September 2019. She said she tried to complete some of the course material at work, but it had been difficult to do this during the pandemic. She felt supported by the SI and her colleagues and was able to ask for help when needed. She asked the relevant questions before selling Pharmacy-only medicines and was aware of sale restrictions on some products. When asked about tasks that she could or could not do in the absence of the RP, the trainee MCA said she would hand out dispensed medicines awaiting collection. She was advised to read the relevant SOP and retrain on the RP regulations.

Performance was discussed informally. The pharmacists informed the team of any areas for improvement and how they could improve services. The trainee MCA discussed her performance every few months with her tutor. She had been told that she would be signed onto the dispensing course as soon as she finished her MCA course, which she was hoping to complete in mid-October 2020.

Members of the team said they could openly speak to colleagues and raise any concerns to the regular pharmacist or the SI. Targets were not set for the team.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are mostly clean. People can have a conversation with a team member in a private area. But the pharmacy could do more to make sure that it keeps its dispensary and storage rooms clean and tidy.

Inspector's evidence

The pharmacy was relatively small, and the dispensary was narrow. Fittings had not been updated for some time and there was limited workspace. The carpet in the dispensary was stained in some areas and the rug at the front door was not very clean. There was a small medicines counter and pharmacy-only medicines were stored behind it. Some pharmacy-only medicines were kept inside lockable plastic units. Some retail products were stored untidily on the shelves behind the counter.

A small storage room was located behind the dispensary. The room had a door which opened out to a small courtyard, which was shared with residential premises. The basement was also used for storage purposes, but it was cluttered and filled with spider webs. There were several historical bottles found which contained liquids, and this was discussed with the SI during the inspection. A small consultation room was available for services and private conversations. The room was clean and generally tidy.

The room temperature was suitable for storing medicines. Lighting was sufficient. The pharmacy had a floor-to-ceiling partition fitted between the medicines counter and the front door. This created a small waiting area for people. There was a hatch in the partition which people could talk through, hand in their prescription or collect their medication. People were allowed into the pharmacy to use the consultation room or browse products.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy generally provides its services safely and people with some additional needs can access the pharmacy's services. The pharmacy orders its medicines from reputable sources. But it does not always store its medicines in properly labelled containers. This could increase the chance of supplying date-expired medicines and make it harder for the pharmacy to respond appropriately to safety alerts.

Inspector's evidence

There was step-free access into the pharmacy. Services were clearly advertised on the front window so that people knew what they could access at the pharmacy. There were several leaflets displayed in the consultation room. The consultation room was big enough for wheelchair users but not for larger mobility scooters. A delivery service was available for housebound people.

Team members signed the dispensing label when they dispensed and checked a medicine to show who had completed these tasks. A note was left for the pharmacist if there were any interactions or changes.

The SI said he checked if people taking higher-risk medicines were attending their annual reviews with their GP. He added that prescriptions for these medicines were normally highlighted using a 'pharmacist required' sticker. But one prescription found for warfarin was not highlighted in any way. People taking warfarin were asked for their yellow book, but the SI said most did not carry their book on them. The dispenser was aware of labelling requirements for sodium valproate and said he would print out additional leaflets to hand to people in the at-risk group who were taking this medicine.

The pharmacy team said that CD prescriptions were highlighted with coloured stickers. One prescription for tramadol capsules was not marked in any way, although the prescription was in date. Not highlighting CD prescriptions could increase the chance of handing these medicines out past the validity date of the prescription.

The pharmacy provided multi-compartment compliance packs to help some people take their medicines. It reviewed peoples' needs for the trays annually. Some people had reverted to original packs, for example, one person who was now taking fewer medicines and could manage without the multi-compartment compliance packs. The SI described changing another person to weekly pick-ups rather than monthly ones after noticing that the person was coming too often to collect their medication. He had discussed the change with the person's carer before implementing it. The packs were labelled with a backing sheet, but these did not always include the recommended warnings. This may mean that people do not have all the information they need to take their medicines safely. Patient information leaflets were only provided at the start of the service or if a new medicine was prescribed. And this could mean that people do not always have all the up to date information about their medicines. Prescriptions were not attached to the assembled packs. So this could make it harder for staff to check what a person had been prescribed if there was a query. Assembled trays were stored in clear plastic bags so that the contents could be clearly seen. The SI described visiting an assisted living home to help a resident book a blood test after their GP refused to issue a prescription without one.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacist said that there had been delays in conducting expiry date checks as one dispenser had been off. Staff said

that the last date check was conducted in July 2020, but this was not documented. Medicines with short expiry dates were not always marked to help reduce the chance of them being handed out past their use-by date. Varying batches of some medicines were seen to be mixed together and several loose blisters were found on the shelves. Betahistine tablets which had been removed from their blister and stored in an amber medicine bottle were not labelled with batch number or expiry date. Other tablets stored in an amber medicines bottle were not labelled with medicine name, strength, batch number or expiry date. This could increase the likelihood of dispensing errors and make it difficult for the pharmacy to date-check the stock properly or respond to drug safety alerts. Not all medicines requiring special storage were stored in accordance with requirements. This was mostly resolved during the inspection and following the inspection the SI provided evidence to the inspector that this had been fully resolved. The SI said that drug alerts and recalls were received via email, printed out and stored in a folder. The folder could not be located at the time of inspection.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy generally has the equipment and facilities it needs to provide the services safely. But it could do more to ensure that its fridge is appropriately maintained.

Inspector's evidence

A small fridge was used to stored medicines requiring cold storage, but the freezer box had completely frosted over. Fridge temperatures were generally checked and recorded daily. Records indicated that the temperatures were maintained within the recommended range. But the maximum temperature was seen to be 12 degrees Celsius at the time of inspection. The pharmacist said that he would defrost the freezer compartment and purchase a new thermometer.

Plastic measures were used to measure out liquid. One was marked for use with certain liquids. The pharmacy team ordered glass measures during the inspection. Tablet counting equipment was available. Equipment was clean and ready for use. A separate tablet counting triangle was used for cytotoxic medicines. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Members of the team had access to the internet and several up-to-date reference sources. Confidential information was stored securely and was not visible to people visiting the pharmacy. The shredder was in good working order.

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.