General Pharmaceutical Council

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: 27/11/2024

Pharmacy context

The pharmacy is located within a parade of shops on a local high street. It provides NHS dispensing services, the Pharmacy First service, and the New Medicine Service. The pharmacy supplies some medicines in multi-compartment compliance packs to people who live in their own homes and need this support.

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 met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy team does not keep all areas of the pharmacy clean and tidy. And it cannot provide assurances that its excess medicine is stored in appropriate conditions.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy cannot show that it always stores medicines which require refrigeration appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally identifies and manages the risks associated with the provision of its services. And it largely keeps its records up to date and accurate. It has some procedures to learn from its mistakes. And team members are provided with some training to help them protect people's confidential information.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which were easily accessible to the team. Current members of the team had signed a training record to show that they had read and understood the SOPs. Team members' roles and responsibilities were specified in the SOPs.

Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident and documented. However, it took the team some time to find the current record due to the dispensary being cluttered. This may make it harder to record all near misses in a timely manner. Learning points were discussed with the wider team but they were not routinely documented so the pharmacy may not be able to review any action points raised. A designated form was available to record dispensing errors, where a dispensing mistake had reached a person. No recent records were available and team members said that the pharmacy had not had any recent dispensing errors.

The correct responsible pharmacist (RP) sign was displayed. The RP record was kept electronically, and samples checked were generally in order but the time the RP ceased responsibility was not always recorded which meant the pharmacy may not always be able to demonstrate when the RP was present. The private prescription and emergency supply records were kept electronically. But the private prescription records did not always have the correct prescriber details which could cause delays retrieving the information in the event of any queries or concerns. The pharmacy did not always maintain clear audit trails when supplying unlicensed medicines so may not be able to demonstrate exactly what it had supplied. Controlled drug (CD) registers were maintained in accordance with requirements and the running balances were checked regularly. A random stock check of a CD agreed with the recorded balance. The pharmacy had current professional indemnity insurance cover.

A complaints procedure was available for the team to refer to. Complaints were referred to the pharmacist who would investigate them and provide a response to the person raising the complaint. They were also discussed during team meetings to help identify any learning needs.

Confidential waste was kept in separate waste bins. Both the general waste and confidential wase bins were clearly marked. Computers were password protected and computer screens faced away from people. Individual smartcards were used to access the NHS spine, but these were seen to be shared. Team members said they would ensure that they used their own smartcards when accessing patient medication records. Bagged items awaiting collection could not be viewed by people using the pharmacy. Team members said that they had completed training about the General Data Protection

Regulations (GDPR), but they could not specify what the training was. Guidance for community pharmacy on GDPR was available in the SOP folder.

Not all team members had completed training about protecting vulnerable people. Some could not describe signs of abuse but said that they would refer any concerns to the pharmacist. Other members of the team described handling a safeguarding concern and taking the appropriate action. The regular RP had completed a Level 2 CPPE module.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They are provided with some ongoing training to support their learning needs. And they have regular meetings where they can raise concerns or make suggestions.

Inspector's evidence

During the inspection there was the RP, a pharmacy technician, a trainee technician, a medicine counter assistant (MCA), and a trainee MCA. The pharmacy also employed another pharmacy technician who was not in at the time of inspection.

All members of the team were either suitably qualified for their role or enrolled onto the relevant course. There were contingency arrangements for staff cover if needed. The pharmacy was up to date with its workload, and team members were observed communicating effectively and working well together. Team members covering the medicines counter asked the appropriate questions before selling Pharmacy-only medicines (P-medicines). They were aware of medicines which were liable to misuse. And they knew that they should not hand out any dispensed items or sell any pharmacy-only medicines if a pharmacist was not present at the pharmacy.
Team members said they completed ongoing training to help keep their skills and knowledge up to date, but they generally did not keep records to keep track of training completed. They said that they were allocated protected time during work to complete ongoing training.

Team meetings were held regularly to discuss any complaints, issues, and changes. Staff performance was discussed informally. Team members said that they were comfortable to raise concerns or give feedback to the pharmacists and their colleagues. They said that the superintendent pharmacist (SI) took onboard any feedback and implemented changes, when necessary, for example, they had fitted two additional computer units following suggestions from the team. Targets were not set for the team.

Principle 3 - Premises **Standards not all met**

Summary findings

The team does not keep all areas in the pharmacy clean and tidy, which means it may not always be able to work effectively. Otherwise, the pharmacy is generally suitable for the services it provides. And there is a room where people can have private conversations with a team member.

Inspector's evidence

The pharmacy took up one shop unit. Fittings were aged and the carpet inside the dispensary was stained and marked. A barrier of wood and Perspex had been fitted during the Covid-19 pandemic which prevented people from entering the pharmacy's retail area but allowed them to wait inside, near the front door.

The dispensary was relatively small and there was limited workspace. Workbenches were cluttered which may increase the risk of errors. Stock was stored in a disorganised manner on the shelves which may increase the likelihood of picking the incorrect medicine.

Excess medicine stock was stored in the basement, which was accessed via a trapdoor in the dispensary floor and steep, narrow stairs. The basement smelt of damp and its walls were covered in spider webs, indicating the lack of cleaning routines. Team members said that builders had recently attended the premises and checked that the humidity levels in the basement were 50-60% but there was no documentation provided to confirm this.

There was a door at the back of the dispensary which led to a courtyard. The door was kept unlocked during the inspection and the courtyard was shared with another property, which meant there could be a risk of unauthorised access.

A small consultation room was available or private conversations and services. It was generally clean and tidy. A sink, with hot and cold water, was fitted in the dispensary but it was not clean. A staff toilet was available and accessed via the courtyard. The pharmacy had adequate lighting. And it was secured from unauthorised access.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy cannot show that it keeps medicines requiring cold storage at the right temperature. This means that it is not able to demonstrate that the medicines are safe to use. The pharmacy generally manages its other services adequately. And people can access the pharmacy's services.

Inspector's evidence

There was a small step into the pharmacy. Team members said they would meet people with restricted mobility outside or help them in. Opening hours were clearly displayed and there was a small range of health information leaflets in the consultation room.

Most prescriptions were received electronically. Baskets were used to separate prescriptions to prevent transfer between patients. The dispensed by and checked by boxes on the labels were seen to be routinely used, and this helped identify who was involved in these processes. Team members were observed confirming the person's details before handing out dispensed medicines.

The pharmacy was providing the Pharmacy First service, but patient group directions (PGDs) for the service were not available at the time of inspection. So the pharmacy was not able to show that they were in order or that it was properly following them. The pharmacists had completed all the relevant training for the service and records of supplies were maintained via the electronic system.

Team members said that they highlighted prescriptions for higher-risk medicines, where additional checks may be required. But any checks made were not routinely documented, which meant the team was not able to show what had been checked. Team members confirmed that they had read the MHRA guidance on sodium valproate and were aware of the need to dispense this medicine in its original packaging.

There were clear audit trails for the multi-compartment compliance pack service, and this helped the team keep track of when packs were due. The pharmacy kept a record for each person which included any changes to their medication. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were provided to help people and their carers identify the medicines, but patient information leaflets were not always supplied. Team members said they would provide PILs with every supply in the future.

A designated driver delivered medicines to people in their own homes. The pharmacy maintained a list of deliveries due on the day so that team members could deal with queries. The delivery driver also had their own list and ticked the person's name once they successfully delivered the medicines. Undelivered medicines were returned to the pharmacy for the team rearrange the delivery. The RP said that the driver had been provided with training about data protection and safeguarding vulnerable people, but they had not signed the relevant SOPs to confirm this.

The pharmacy used licensed wholesalers to obtain its pharmaceutical stock. Medicines were stored in a disorganised manner on the shelves. Team members said they would review the storage of medicines. Expiry date checks of medicines were seen to be done at regular intervals and documented. The fridge temperatures were monitored daily for one fridge only, although two fridges were used to store

medicines. The pharmacy team could not provide assurances that medicines were stored within the recommended range in the second fridge. Records for the one fridge indicated that the temperatures were maintained within the recommended range. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier. Drug alerts and recalls were received electronically, but the pharmacy did not maintain audit trails so it could not show the action taken in response to them. The RP said that they would maintain clear records in the future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Computers were password protected and screens faced away from public view to protect people's confidentiality. The pharmacy had two glass measures and a plastic measure. The plastic measure was disposed of during the inspection There were several tablet counting triangles. The RP said that the blood pressure monitor was relatively new. The pharmacy had two fridges, and both contained some food inside. Team members said they would use one fridge for medicine and another for food. 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.

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.