General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chana Chemist, 251 Walworth Road, Walworth, LONDON, SE17 1RL

Pharmacy reference: 1040891

Type of pharmacy: Community

Date of inspection: 10/06/2019

Pharmacy context

This is a community pharmacy situated on a busy highstreet and close to a GP surgery. It serves a mixed local population. The pharmacy sells a wide range of over-the-counter medicines and dispenses NHS prescriptions. It also supplies medicines in multi-compartment compliance aids and provides flu vaccinations, medicine delivery and the Minor Ailment Service.

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	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 generally manages risks well to make sure people are kept safe. It records mistakes that occur during the dispensing process and learns from them. The pharmacy generally keeps the records it needs to by law. So, it can show that supplies are made safely and legally. It protects people's personal information and team members are aware of how to protect vulnerable people.

Inspector's evidence

Members of the team covering the medicines counter checked if a person wanted to wait or call back for their medicines. Prescriptions were annotated with 'W' for waiting and 'CB' for calling back, as well as the number of prescription forms handed in by a person. This helped the team manage its workload and ensure all medicines were supplied to the person.

A clinical check was conducted by the pharmacist before the prescription was assembled. A double accuracy check was obtained to help reduce errors. The pharmacist rarely self-checked; he said he always picked and dispensed from prescriptions rather than labels and conducted an additional accuracy check if dispensing and checking a prescription.

Baskets were used throughout the dispensing process to prevent transfer of medicines between people's prescriptions. Workbenches were kept clear and tidy and there was ample clear space to work on.

Near misses were generally recorded; there had not been any documented since March 2019 and the pharmacist accepted that the team may not have been capturing all near misses. Group meetings were held as soon as any serious near misses were identified. Other near misses were reviewed with the team at the end of the month and action to be taken by the team was documented on the near miss log.

Staff had recently been reminded of the importance of recording near misses and dispensing from prescriptions rather than labels. Medicines had been spread out on the shelves to help reduce picking errors, for example those involving prednisolone and procyclidine, amitriptyline and amlodipine, and clarithromycin and ciprofloxacin. Methotrexate 2.5mg and 10mg were stored separately on the shelves.

Medicines expiring within the year were clearly marked with a coloured sticker. The pharmacist said that dispensing errors would be recorded on a form which could be found on the electronic patient medication record (PMR) system. There had not been any incidents since the pharmacy was taken over by the Chana pharmacy group last year.

Up-to-date standard operating procedures (SOPs) were in place to support the safe and effective provision of services. Members of the pharmacy team had signed the relevant SOPs to confirm they had read and understood them. In-date indemnity insurance was in place.

The responsible pharmacist (RP) sign was displayed in the dispensary, but it was not visible to people. It

was moved during the inspection. Samples of the RP record examined were in order.

Emergency supply records were either recorded electronically or at the back of the private prescription book; the nature of the emergency was not recorded for a number of entries checked. So it may not be possible to know why a supply was made, in case of a query. The private prescription record was in order. 'Specials' records for unlicensed medicines were filled out in line with MHRA requirements.

Controlled drugs (CDs) were stored in an organised manner; dispensed instalments were kept separate to stock. CD running balances were kept. A regular stock check of a CD agreed with the recorded balance. The pharmacist had contacted the CD Accountable Officer to arrange for the destruction of expired CDs. A returns and destruction register was available to record CDs which had been returned by people; these were destroyed promptly.

The complaints procedure was displayed in the retail area for people to see. Feedback from people was sought through an annual survey. Members of the team were currently in the process of completing customer service training following some feedback.

Computers were password protected and access to the PMR system was via individual Smart cards; these were seen to be kept on a staff member's person when not in use. Confidential waste was shredded at the pharmacy. Members of the team had read and signed confidentiality agreements and the NHS information governance training booklet. They had been briefed on the General Data Protection Regulation but had not completed formalised training on it. The pharmacist said he will obtain additional training material to ensure the team understood the changes.

The pharmacist had completed level 2 training about safeguarding vulnerable people from the Centre of Pharmacy Postgraduate Education. Other members of the team had not completed formalised training but had been briefed by the pharmacist. All members of the team could describe signs of abuse and neglect and said they would raise any safeguarding concerns with the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

Team members work in an open environment where they can make suggestions or raise concerns. They are provided with training resources, but they do not always have time set aside to complete them. This may reduce the opportunities they have to help keep their skills and knowledge up to date.

Inspector's evidence

There was a regular pharmacist, a trainee technician, a trainee dispenser and two trainee medicine counter assistants (MCAs) during the inspection. Two assistants covered the retail area; they were not involved in pharmacy tasks. The pharmacy also employed another two trainee MCAs.

Members of the team said that there was some pressure to complete tasks, but they were currently managing their workload. They explained that some tasks were time-consuming, such as the supervised consumption service, but they did not have any backlog. A second pharmacist was now working at the pharmacy for two days a week and a pre-registration student would also be starting in July 2019.

Set study time was not provided for members of the team. Trainee members of staff said they completed their course modules at home but reviewed their progress with the pharmacist every two to four weeks. They also read pharmacy magazines and leaflets from wholesalers though training records were not maintained to help keep track of training completed.

Both trainee MCAs described using the WWHAM questioning techniques when selling pharmacy only medicines (P medicines). They described referring to the pharmacist, for example, before selling medicines to under 12s and to pregnant women. They could name products which were open to abuse and said they would refuse to sell these to people frequently requesting them. One MCA said she could sell two packs of pseudoephedrine to a person at any one time. She was reminded of the legal restrictions on the sale of this medicine. Both MCAs said they would not sell P medicines in the absence of the RP; they were not involved in handing out dispensed medicines.

The trainee MCAs said they regularly received feedback about their performance from the pharmacist as well as other colleagues, such as the trainee dispenser. Group meetings were also held to discuss customer service, changes, suggestions and any issues. Members of the team said they were happy to raise concerns with the pharmacist, one of the owners or the superintendent pharmacist. Targets were not set for the team, but they were encouraged to sign people onto services which may be of benefit to them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, and the pharmacy provides a safe and secure environment for people to receive services.

Inspector's evidence

This was a large, spacious pharmacy. The dispensary was located on a raised platform at the back of the shop and it was clean and organised. P medicines were stored securely behind a medicines counter. There was ample space in the retail area and it was well-maintained. A clearly signposted consultation room was available for services and was suitable for private conversations. The room was generally clean and tidy.

A small storage room was located behind the dispensary. This was also used as a staff room. Staff facilities included a small kitchenette and WC. Another storage room was located on the first floor, and this was accessed via the consultation room.

The cleaning was currently shared by the team. A cleaner was booked in to clean the premises twice a week from the following week. A clean sink, with hot and cold running water, was available for the preparation of medicines. The room temperature and lighting were suitable for the provision of pharmacy services. The premises were secure.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy generally provides its services safely. But team members are not all aware of what advice to give people taking some higher-risk medicines. This could mean that people might not get all the information they need to take their medicines safely. It largely manages medicines well to make sure that they are safe for people to use.

Inspector's evidence

Access into the pharmacy was step-free and via wide doors. There were several chairs in the waiting area for people wanting to wait for a service. Aisles were wide and there was ample space for people with wheelchairs or pushchairs. Some members of the team were multilingual and helped translate for people who did not speak English well, when possible.

Services were advertised in the window and on the NHS website. Members of the team described signposting people to other service providers, such as sexual health clinics and walk-in centres.

Members of the team previously checked people's full address when handing out dispensed medicines. They had reviewed the hand-out process and were now only asking for door number and postcode, to help reduce the sharing of people's personal information.

Dispensing audit trails were generally maintained to help identify which members of the team were involved in dispensing and checking prescriptions.

The trainee technician and trainee dispenser had read the valproate guidance but could not remember what checks they would make or what information to provide. Additional warning stickers had been ordered but the team could not find these. One patient in the 'at-risk' group had received valproate from the pharmacy but staff accepted that they had not provided the information card or made the necessary checks.

The pharmacist said he checked INR levels of people taking warfarin if they had their yellow book on them. But these levels were not recorded at the pharmacy for reference.

CD instalments were dispensed in advance for the day, but dispensing audit trails were not always maintained to help identify staff involved in assembling and checking these. The medicine labels for final instalments were annotated with 'last' to help ensure people were reminded that it was their last instalment and that they would need a new prescription for further supplies.

There was currently no system in place to highlight prescriptions for schedule 3 and 4 CDs once they were dispensed and bagged up. This could increase the chances of these items being supplied when the prescription is no longer valid.

People receiving their medicines in multi-compartment compliance aids were normally signposted to the service by their GP. The pharmacy did not have a review process to check if people would benefit from the service or if it was suitable for them. The pharmacist said he checked how people were getting

on with their trays when conducting Medicines Use Reviews, though this was normally done annually. People were not normally offered to return their compliance aids to the pharmacy for disposal; this could mean that the pharmacy missed any compliance issues. A list was maintained to keep track of when repeat prescriptions were due to be requested, assembled and delivered. A record of repeat requests sent to the GP was also maintained to help keep track. The team followed up any requests which had not been received back after two to three days. Once prescriptions were received, they were cross-checked with a master backing sheet and any changes were documented on the PMR system. Team members involved in assembling the compliance aids checked against the backing sheet and prescription to help reduce errors. Medicine descriptions were provided on the backing sheets and patient information leaflets (PILs) were routinely supplied.

Audit trails for the delivery service were not maintained. This could make it harder for the pharmacy to show that the medicines had been delivered safely. Medicine was returned to the pharmacy if the person was not at home and was not posted through the letterbox.

Stock was obtained from reputable wholesalers and was stored in an organised manner. The pharmacist said that expiry date checks were conducted every six months, but according to the records, the last checks were conducted in March 2019 (though not on all sections of the dispensary) and June 2018. Two packs of expired medicines were found still on the shelves.

Members of the dispensary team did not know much about the Falsified Medicines Directive and did not know if they had the equipment or the system to meet it. The pharmacist had not received any updates from the pharmacy's head office.

The fridge temperatures were checked daily and kept within the required range of 2 to 8 degrees Celsius. The room temperature was also checked and recorded daily.

The pharmacist said he checked the MHRA's website for drug alerts and recalls. These were printed out and annotated with action taken but he was not aware of some of the recent alerts. He signed onto the MHRA's email subscription service at the time of inspection, in order to receive the alerts and recalls in a timely manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And it maintains them appropriately to ensure they are safe to use.

Inspector's evidence

There were several glass measures, each marked for their intended use. The CD measuring equipment was cleaned daily and looked well-maintained. It was calibrated every morning to help ensure it was accurate. Clean counting triangles were available, including a separate one for cytotoxic medicine.

The fridges were clean and suitable for the storage of medicines. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Amber medicine bottles were capped while stored. Members of the team had access to the internet and several 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.