General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sefgrove Ltd., 3-5 Westow Hill, Upper Norwood, LONDON, SE19 1TQ

Pharmacy reference: 1040916

Type of pharmacy: Community

Date of inspection: 21/11/2022

Pharmacy context

The pharmacy is located on a parade of shops in a largely residential area. It provides a range of services, including the New Medicine Service, flu vaccination service and COVID vaccination service. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and reviews its mistakes so that it can learn and make its services safer. The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. It protects people's personal information well. And people can provide feedback about the pharmacy's services. Team members understand their role in protecting vulnerable people. And the pharmacy largely keeps its records up to date and accurate.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. There were documented, up-to-date standard operating procedures (SOPs), and the pharmacy recorded and reviewed its dispensing mistakes. 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 once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded and reviewed regularly for any patterns. And items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that there had not been any recent dispensing errors.

Workspace in the dispensary was limited but there were clear spaces for dispensing and checking medicines. And there was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. Team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The trainee dispenser said that the shop would remain closed if the pharmacist had not turned up in the morning. And she would signpost people to another local pharmacy if needed. She knew which tasks should not be carried out if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly. And there were signed in-date patient group directions available for the relevant services offered. All necessary information was not recorded when a supply of an unlicensed medicine was made. The pharmacist said that she would ensure that this was done in future. The private prescription records were mostly completed correctly, but the prescriber details were not usually recorded. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to find these details if there was a future query. The pharmacist said that she would ensure that the necessary details were recorded in future. Controlled drug (CD) registers examined were largely filled in correctly but the address of the supplier was not routinely recorded.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The pharmacist said that there had been a recent complaint made about the pharmacy and this had been addressed. The trainee dispenser said that she would refer any complaints to the pharmacist.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And the pharmacist gave an example of action she had taken in response to a recent safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist (who was also the superintendent pharmacist), one trainee pharmacist, one trainee dispenser and one trainee medicines counter assistant (MCA) working during the inspection. The trainee dispenser and trainee MCA were undertaking accredited courses for their roles. The pharmacist said that the pharmacy was in the process of recruiting staff as some had recently left. The team communicated effectively and worked well together to ensure that tasks were prioritised and the workload well managed.

The trainee MCA appeared confident when speaking with people. She had been working at the pharmacy for around two months and said that she would refer to the pharmacist if a person asked to purchase more than one box of any over-the-counter medicine. And she said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She asked people questions to establish whether medicines were suitable for them.

The trainee pharmacist had been working at the pharmacy for around three weeks. The pharmacist was in the process of implementing a training plan for him. She said that he would be allowed set time each week to undertake training and he would receive ongoing feedback about his performance. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. She had recently undertaken some training about natural products to help with perimenopause symptoms so that she was better equipped to advise people about managing their symptoms. And she had completed a course about mentoring and leadership. She had completed declarations of competence and consultation skills for the services offered, as well as associated training. And she felt able to take professional decisions.

Team members had ongoing informal performance reviews. The pharmacist said that she was planning to undertake a formal appraisal and performance review for the trainee dispenser after she had completed the course she was undertaking. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. Targets were not set for team members. The pharmacist said that she provided the services for the benefit of the people using them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter but some were accessible to the side of the counter. The pharmacist said that she would address this promptly so that these medicines were no longer available on self-selection. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available and the room temperature was suitable for storing medicines. There were two chairs in the shop area for people to use while they waited.

Half of the shop area was cordoned off when there were not enough staff to cover that side. If a person wanted an item from that side of the pharmacy then they asked a team member to assist them. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was a small step up to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available.

Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that she spoke with people if they had recently been prescribed a higher-risk medicine. But this was not routinely done for people who had been taking these types of medicines for a longer time. And the pharmacy did not keep a record of any blood test results. The pharmacist said that she would highlight these prescriptions in future and review how these patients were managed. Prescriptions for Schedule 3 and 4 CDs were not highlighted. The pharmacist said that these would be highlighted in future to help minimise the chance of these medicines being supplied when the prescription was no longer valid. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacy did not have spare patient information leaflets, warning cards or warning stickers available for use with split packs. The pharmacist said that she would order these from the manufacturer. Team members were not aware that the warning cards attached to the medication packaging could be removed to allow space to attach the dispensing label. The pharmacist said that she would ensure that the dispensing labels were not covering any warnings on the packaging in future. She also said that she would make a note on the patient's medication record and refer them to their GP if they were not on a PPP and needed to be on one.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly and this activity was recorded. Short-dated items were marked and there were no date-expired items found in with dispensing stock. Part-dispensed prescriptions were checked frequently. Prescriptions for alternate medicines were requested from prescribers where needed. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacist said that uncollected prescriptions were checked regularly. If the items had not been collected after around four months the items would be returned to dispensing stock where possible. And the uncollected prescriptions were returned to the NHS electronic system or to the prescriber.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. The pharmacy requested prescriptions for people receiving their medicines in the packs in advance so that any issues could be addressed before people needed them. And a prescription progress tracker was used to ensure that the packs were ready

before people needed them. The pharmacist said that prescriptions for 'when required' medicines were not routinely requested and people ordered these if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. There was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. But the additional warnings required for some medicines were not printed on the backing sheets. The pharmacist said that she would ensure that these were printed in future. Team members wore gloves when handling medicines that were placed in the packs.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. But the pharmacy did not keep a record of any action taken which could make it harder for the pharmacy to show what it had done in response. The pharmacist said that she would keep a record in future.

Fridge temperatures were checked daily, with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Suitable equipment for measuring liquids was available. Separate liquid measures were marked for use with certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.