General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Baba Chemist, 5-7 Tulse Hill, LONDON, SW2 2TH

Pharmacy reference: 1041018

Type of pharmacy: Community

Date of inspection: 17/07/2023

Pharmacy context

The pharmacy is on a parade of in a largely residential area. The pharmacy receives most of its prescriptions electronically. The pharmacy provides NHS dispensing services and additional services including the New Medicine Service, travel vaccination service, anti-malarial and erectile dysfunction medicines. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people.

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 protects people's personal information. And people using the pharmacy can feedback about its services. It largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people. But the pharmacy doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

Team members had signed to show that they had read, understood, and agreed to follow the standard operating procedures (SOPs). A team member explained how near misses (where a dispensing mistake was identified before the medicine had reached a person) were dealt with. It would be 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 it. Near misses had not been recorded recently even though team members said there had been some. This was discussed with one of the dispensers and he said that he would ensure that team members recorded their own mistakes in future. And he said that the near miss records would then be reviewed regularly to help identify any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. One of the dispensers said that there had not been any recent dispensing errors, where a dispensing mistake had reached a person. A previous error had been recorded on the pharmacy's computer and a root cause analysis had been undertaken.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. Workspace in the dispensary was free from clutter and baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed 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 pharmacist had not arrived at the pharmacy by the time the inspection had started. Team members knew that they should not hand out any dispensed items or sell any medicines if there was no responsible pharmacist (RP) signed in. But they were not sure about some of the other tasks that should not be undertaken without an RP signed in. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up. The pharmacist turned up shortly after the start of the inspection.

The pharmacy had current professional indemnity and public liability insurance. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Liquid overage was recorded in the register. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The private prescription records were largely completed correctly, but the prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The pharmacist displayed her RP notice when she signed in and the RP record was largely completed correctly. But there were a few occasions recently where the RP had not signed out when they had finished their shift and a different pharmacist was working the following day. This was

discussed with the team during the inspection.

Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items awaiting collection could not be viewed by people in the shop area. 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.

The complaints procedure was available for team members to follow if needed. Team members said that there had not been any recent complaints. One of the dispensers said that they would refer any complaints to the pharmacist, and she said that she would refer them to the pharmacy's superintendent pharmacist if she was not able to deal with it.

Team members had completed training about protecting vulnerable people. One of the dispensers was aware of the potential signs that might indicate a safeguarding concern and they would refer any concerns to the pharmacist. There said that there had not been any safeguarding concerns at the pharmacy. And the pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

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 discuss any concerns as they arise. And team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist, two trained dispensers and one trainee medicines counter assistant (MCA) working in the main dispensary during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was up to date with its dispensing. There were two other team members working downstairs and their roles were to de-blister medicines and load them in the dispensing robot that assembled the multi-compartment compliance packs. They had received training specific to their roles and did not work in the main dispensary.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine-containing products. She would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. And she referred queries to dispensary staff during the inspection. She asked relevant questions to establish whether over-the-counter medicines were suitable for the person they were intended for.

The pharmacist was aware of the continuing professional development requirement for revalidation. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. Team members said that they were not provided with regular training, but they did receive some on an ad hoc basis. They had to mostly complete the training modules at home but could sometimes do it in the pharmacy during quieter periods. They explained that they had recently completed some training as part of the Pharmacy Quality Scheme.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. They said that they had yearly appraisals. And information was usually passed on to all team members informally during the day. The pharmacist felt able to make professional decisions. Targets were not set for team members. The pharmacist said that services such as the New Medicine Service were provided for the benefit of people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was bright, clean, and tidy throughout and this presented a professional image. It was secured from unauthorised access and pharmacy-only medicines were kept behind the counter. 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 temperatures were suitable for storing medicines.

There was one chair in the shop area for people to use while they waited. It was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. Toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available.

The consultation room was in the shop area, and it was accessible to wheelchair users. It was suitably equipped, well-screened and conversations at a normal level of volume in the consultation room could not be heard from the shop area. The room was not kept locked and there were some in-use sharps bins in the room and an unlocked fridge which was used to store some medicines. The fridge could be locked and there were lockable cabinets in the consultation room. One of the dispensers said that he would ensure that these items were kept secured in future.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. Overall, the pharmacy provides its services safely and manages them well. It responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use. And people who get their medicines in multi-compartment compliance packs receive all the information they need to take their medicines safely. The pharmacy gets its medicines from reputable suppliers and largely stores them properly.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with an automatic door. Services and opening times were clearly advertised and a variety of health information leaflets was available. The induction hearing loop appeared to be in good working order and the pharmacy printed large-print labels for people who needed them. There was a counter in the shop area which was at a suitable height for people in wheelchairs to use.

Dispensed fridge items were kept in clear plastic bags to aid identification. Team members said they checked CDs and fridge items with people when handing them out. One of the dispensers said that the pharmacy supplied valproate medicines to a few people. The pharmacy had recently carried out an audit and 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 the warning stickers and additional warning cards for use with split packs. One of the team said that the pharmacy only dispensed whole packs of these medicines so that people were provided with all the relevant information. And people would be referred to their GP if they were not on a PPP and needed to be on one. The pharmacist said that she sometimes spoke with people about their medicines to ensure that they were taking them correctly and having the relevant tests if needed. But prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 and 4 CDs were not highlighted. Team members said that they would highlight these in future to help minimise the chance of these medicines being supplied when the prescription was no longer valid.

The dispenser said that uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their items after around two months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. Part-dispensed prescriptions were checked regularly. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS, MHRA and suppliers. One of the dispensers explained the action the pharmacy took in response to any alerts or recalls. He said that the pharmacy had kept a record of the action taken, but this information had been lost during a recent computer update. He said that the pharmacy would keep a record of this information in future.

Stock was stored in an organised manner in the dispensary. Expiry dates were usually checked every two months and this activity was recorded. And items with a short expiry were largely marked. There were several loose foils and mixed batches found with dispensing stock. Most of the loose foils did not have the batch number or expiry date on. One of the dispensers said that he would ensure that these were disposed of appropriately and that medicines were kept in their original packaging in future. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately.

Fridge temperatures were checked daily and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked. 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 kept separated from dispensing stock. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

The pharmacist said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. One of the dispensers said that the pharmacy contacted people to ask 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. Packs were suitably labelled and there was an audit trail to show who had assembled 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. The robot dispensed medicines into the packs and these were then checked by the pharmacist. The dispensing robot computer could be accessed remotely so that any issues could usually be dealt with promptly. A team member said that an engineer would be on hand to fix any issues usually with a couple of days if needed.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible, and these were recorded in a way so that another person's information was protected. When the person was not at home a card was left at the address asking the person to contact the pharmacy to rearrange delivery. And the items were returned to the pharmacy before the end of the working day.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. And tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Suitable equipment for measuring liquids was available but not for volumes less than ten millilitres. The pharmacist said that she would order a suitable measure. Separate liquid measures were marked for use with certain medicines only.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for around six months. Team members said that this would be replaced in line with the manufacturer's guidance. 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.