General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Westbury Chemist, 84-92 Streatham High Road, Streatham, LONDON, SW16 1BS

Pharmacy reference: 1041186

Type of pharmacy: Community

Date of inspection: 17/07/2023

Pharmacy context

The pharmacy is located on a busy high street in largely residential area. And it receives most of its prescriptions electronically. The pharmacy provides a range of NHS services, including the New Medicine Service, travel clinic, blood pressure checks and a range of Patient Group Directions. It also provides medicines as part of the Community Pharmacist Consultation Service. And it provides substance misuse medications to a large 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 records and regularly reviews any mistakes that happen during the dispensing process. And it protects people's personal information. It largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

Team members had signed to show that they had read, understood, and agreed to follow the pharmacy's standard operating procedures (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 once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded, reviewed regularly for any patterns, and discussed during team meetings. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The superintendent pharmacist (SI) said that he was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. He explained that dispensing errors would be recorded on a designated form and a root cause analysis would be undertaken.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Team members initialled the dispensing label when each item was dispensed and checked to show who had completed these tasks. The dispenser accuracy checker knew that she should only check prescriptions that had been clinically checked by the pharmacist and dispensed by another team member.

One of the dispensers explained the tasks that should not be undertaken if the pharmacist had not turned up. The medicines counter assistant (MCA) knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. Team members' roles and responsibilities were specified in the SOPs.

The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The pharmacy had current professional indemnity and public liability insurance. There were signed in-date patient group directions available for the relevant services offered. 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. The private prescription records were largely completed correctly, but the prescriber's details were not usually recorded. This could make it harder for the pharmacy to find these details if there was a future query. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were mostly checked at regular intervals. But some liquid overages had not been recorded in the register. The SI said that these balances would be checked more frequently, and the overages recorded in the register.

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. Bagged items awaiting collection could not be viewed by people using the

pharmacy.

The SI said that there had not been any recent complaints. The pharmacy's complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet.

Team members had completed training about protecting vulnerable people. One of the dispensers described potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The SI said that there had not been any safeguarding concerns at the pharmacy. 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 help maintain their knowledge and skills. Team members can make professional decisions to ensure people taking medicines are safe. And have regular meetings where they can discuss any concerns.

Inspector's evidence

There was one pharmacist (who was also the SI), two trained dispenser accuracy checkers, one trained dispenser, one trained MCA and one trainee MCA working during the inspection. And there were several team members who worked on the shop floor but did not work in the dispensary. The pharmacy was up to date with its dispensing. The team worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The SI said that he felt able to make professional decisions. And he was aware of the continuing professional development (CPD) requirement for professional revalidation. He had recently undertaken CPD about the COVID-19 vaccination booster for children. And he had completed declarations of competence and consultation skills for the services offered, as well as associated training. He said that other team members received some training on an ad hoc basis.

The team had weekly meetings to discuss any issues. Information was usually shared in a chat group so that all team members were informed promptly. They also had regular reviews of any dispensing mistakes and discussed these openly in the team. Team members felt comfortable about discussing any issues with the pharmacist. And they had yearly performance reviews. Targets were not set for team members. The SI said that the New Medicine Service was provided for the benefit of the people using the service.

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 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. The pharmacy was bright, clean, and tidy throughout and this presented a professional image. Air conditioning was available, and the room temperatures were suitable for storing medicines.

There were several chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. There were three consultation rooms in the main shop area. All were accessible to wheelchair users, suitably equipped and well-screened. 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

People with a range of needs can access the pharmacy's services. Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. 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

Services and opening times were clearly advertised and a variety of health information leaflets was available. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. And there was step-free access to the pharmacy through a wide entrance. The induction hearing loop appeared to be in good working order. And the pharmacy could produce large-print labels for people who needed them. There were two prescription self-check in screens at the dispensary counter. People could enter their prescription details onto the screen and this information was sent to the dispensary team so that they could locate the prescription promptly. This helped to minimise the chance of a team member searching for the wrong person's prescription. An alert sounded in the dispensary when a person had entered their details and the prescription, and a team member checked the details on the screen. This also helped to minimise the time a person waited for their prescription. Team members checked the details on the prescription with the person before handing over the items.

Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being handed out after the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. Team members said that they checked CDs and fridge items with people when handing them out. 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 SI said that he would refer people to their GP if they weren't on a PPP and needed to be on one. The pharmacy only dispensed whole packs of these medicines to ensure that people were provided with all the necessary information. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with people when collecting these medicines might be missed. A team member said that monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin were checked when available. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The SI explained the action the pharmacy took in response to any alerts or recalls. And any action taken was recorded and kept for future reference. The pharmacy had recently received a recall. The affected medicines had been removed from dispensing stock in preparation for them being returned.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next several months were

marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. The dispensing robot was checked daily for expired items, and these were removed for appropriate disposal. The fridges were suitable for storing medicines and were not overstocked. Fridge temperatures were checked daily and, maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range.

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. CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs.

One of the team explained that uncollected prescriptions were checked regularly. people were sent a text message when their prescription was ready to collect. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber after around three months. And the items were returned to dispensing stock where possible. Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. And prescriptions for alternative medicines were requested from prescribers where needed.

Deliveries were made by a delivery driver. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery. 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.

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

Equipment for measuring liquids was available but some were not suitable for pharmaceutical use. The SI said that he would ensure that these were not used in future. Separate liquid measures were used to measure certain medicines only. Triangle tablet counters were available and clean and 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. The machine used for measuring some liquids was calibrated daily and this activity was recorded.

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. The blood pressure monitor had been in use for around one year. The SI said that this would be replaced in line with the manufacture’s guidance.

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.