General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Osbon Pharmacy, 179-181 Lewisham Way, LONDON, SE4 1UY

Pharmacy reference: 1085737

Type of pharmacy: Community

Date of inspection: 27/09/2024

Pharmacy context

This is a community pharmacy on a busy road in Southeast London. It provides NHS services such as dispensing, the New Medicine Service, the Pharmacy First service, and a locally commissioned vitamin D service. It supplies medicines in multi-compartment compliance packs to some people who need this additional support. And it delivers medicines to some people in their own homes. The pharmacy provides a travel vaccination service using patient group directions (PGDs). Since the last inspection, in February 2024 the pharmacy installed a small post office on the premises.

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 adequately manages the risks associated with its services. People using the pharmacy can provide feedback and raise concerns, and team members know how to protect the welfare of a vulnerable person. The pharmacy largely keeps the records it needs to by law. And on the whole, it protects people's personal information well. Team members do not always record any dispensing mistakes, so they may be missing out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

The responsible pharmacist (RP) explained that the standard operating procedures (SOPs) were available online, and although he was familiar with them, he was unable to access them. There was a paper set of SOPs, but these were not current and some were from 2014. Following the inspection, the responsible pharmacist (RP) confirmed that he had gained access to the online SOPs and saved a copy on the pharmacy computers so that staff could access them. With a little prompting, a team member could explain what they could and could not do if the RP had not signed in at the pharmacy. They could explain what they would do if someone attempted to make repeated purchases of medicines liable to misuse. Another team member could clearly explain what activities could be done if the RP was not signed in.

There were records about near misses, where a dispensing mistake happened and was identified as part of the dispensing process. But the last recorded near miss was from May 2022, and the RP felt it was likely there had been near misses since then. The value of recording and learning from near misses was discussed with the RP. Team members explained that the RP would discuss any near misses with them at the time. The RP was not aware of any recent dispensing errors, where a mistake happened and the medicine was handed out. He could demonstrate how he would record one if one occurred.

People could provide feedback or raise concerns through several routes including online or in person. There was a sign with a QR code in the shop area which took people to the Google review website. The RP thought there was a complaint procedure, but he was unfamiliar with it and said he would look into it. He was not aware of any recent complaints.

The pharmacy had current indemnity insurance, and the right RP notice was displayed. The RP record largely complied with requirements, but on occasion the RP had not signed out. Several private prescription records did not detail the prescriber, and some records about emergency supplies did not include the nature of the emergency. The importance of maintaining complete and accurate records was discussed with the RP. Controlled drug (CD) registers seen contained the required information. A physical check of the stock of a CD found that there was a discrepancy with the recorded balance and the RP confirmed after the inspection that the discrepancy had been resolved. Two other random stock checks found that the recorded balances matched the physical stock present. Records about unlicensed medicines supplied by the pharmacy had the required information recorded.

No confidential information was readable from the public area. Confidential waste was separated and destroyed with a shredder. One piece of paper containing a person's confidential information was found in general waste. This was highlighted to the RP and the paper was immediately removed. Team

members had individual smartcards for accessing the electronic NHS systems.

The RP confirmed he had done level 2 safeguarding training, and he could explain what he would do if he had a concern about the welfare of a person. Contact details for local safeguarding agencies were available in the dispensary. The dispenser had also completed safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services safely. Team members feel comfortable about raising any concerns, and they get some ongoing training to help them keep their knowledge and skills up to date. They generally do the right training for their roles, but the pharmacy does not always enrol its staff on the relevant courses in a timely way.

Inspector's evidence

At the time of the inspection there was the RP, and a trained dispenser. And another member of staff who was working on the counter and had worked at the pharmacy for six months. The team member showed that they were reading through the course materials for an accredited counter assistant course but not yet been registered on a course themselves. Following the inspection and on the same day, the RP provided evidence that this person had now been registered on a medicines counter assistant (MCA) course. The team members were up to date with their workload and were observed communicating effectively with each other. There was also a trained MCA who was currently working in the post office.

Team members felt comfortable about raising any concerns. Ongoing training for team members was not structured, but they did receive some, and had access to pharmacy magazines and training about new services such as the Pharmacy First service. Some numerical targets were set for team members, including for the Pharmacy First and blood pressure services, but the RP did not feel under any undue pressure to meet them. He felt able to take professional decisions.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a suitable and secure environment for the pharmacy to provide its services. People can have a conversation in a private area. The pharmacy is generally clean and tidy, but there is some clutter in the corridor leading to the consultation room.

Inspector's evidence

The pharmacy had a professional appearance and was clean and lighting was good throughout. The dispensary was generally clean and tidy, with enough clear workspace for staff to work on. And there was air conditioning. There was some clutter in the wide corridor leading to the consultation room, which the RP said was from the post office, but there was enough space for people to walk to the room safely. The consultation room was set away from the shop floor and allowed people to have a conversation in private. The room was used for vaccinations, but it was relatively small and likely would not allow space for someone to lie down if they had an adverse reaction to a vaccination. This was discussed with the RP, and there was enough space just outside the room which would offer a degree of privacy if someone needed it. There was a large storeroom behind the room which the RP said may be suitable to turn into a consultation room.

The premises were secure from unauthorised access. The post office was open the same times as the pharmacy and was staffed by pharmacy team members.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and they are accessible to people with different needs. It gets its medicines from reputable sources and largely stores them properly. Team members respond appropriately to safety alerts to help ensure that people get medicines and medical devices that are safe to use.

Inspector's evidence

There was a small step into the pharmacy from the street via the manual door. There was enough space in the shop area to allow people with pushchairs or wheelchairs to manoeuvre. The pharmacy could generate large-print labels if required. It delivered medicines to some people in their own homes and kept audit trails to show when deliveries had been made.

Baskets were used through the dispensing process to keep different people's medicines separate, and there was one area of the dispensary used for checking prescriptions. Prescriptions for CDs were not routinely highlighted, which could make it harder for staff handing them out to know if the prescriptions were still valid. Prescriptions for higher-risk medicines were not highlighted, but the RP said that these were dispensed when people came in and he personally handed them out. The importance of providing any required counselling information to people collecting these medicines was discussed with the RP.

Most multi-compartment compliance packs were prepared by the pharmacy's hub dispensary, but the pharmacy prepared some packs onsite for a small number of people. The packs from the hub were not supplied with patient information leaflets (PILs), but there was a link to an online resource where people could download a leaflet. However, the link was in printed in small text, which could make it harder to read for people with visual issues. And some people unable to access the internet may find it harder to get up to date information about their medicines. The packs prepared in the pharmacy were not labelled with any mandatory warnings which were required for certain medicines. The importance of having any relevant warnings on the packs was discussed with the RP. The local medicines optimisation service assessed if people needed their medicines in the packs and liaised with the person's GP and the pharmacy. If people's medicines were changed or stopped, a record was kept on the patient medication record. Example records seen were clear and contained sufficient information.

The pharmacy had in-date patient group directions (PGDs), and the majority of supplies under them were vaccinations. The RP showed how he had completed a declaration of competency for the PGDs. This included one for weight loss medicines, but these were not provided often.

The pharmacy obtained its medicines from licensed wholesale dealers and specials suppliers and stored them tidily in the dispensary. Team members explained how they date-checked the stock, but this activity was not recorded. One date-expired medicine was found during a random check of the stock and brought to the attention of the RP. Several packs of medicines were found which contained mixed batches, which could make date checks and dealing with product recalls less effective.

The temperature of the medical fridge was monitored daily. Although the records seen were within the appropriate range, the RP did not know how to reset the thermometer or that it needed to be done.

The maximum temperature during the inspection was slightly over the appropriate range. The thermometer was reset and remained within the range during the inspection. The RP gave assurances that the thermometer would be reset each day and the minimum and maximum temperatures recorded. CDs were stored in a suitable cabinet. Waste medicines were kept separate from stock until they could be collected by a designated carrier.

Drug alerts and recalls were received via email, and the RP described the steps that were taken in response. A record of the action taken was not kept, which could make it harder for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services and maintains it appropriately.

Inspector's evidence

There was a range of calibrated clean glass measures, with some marked for use with certain liquids only. The blood pressure meter was less than a year old and there was an otoscope for ear examinations. The RP explained he took an anaphylaxis kit into the consultation room when he did vaccinations, and showed the pharmacy had in-date injections available for this. Computer terminals were password protected and screens were turned away from people using the pharmacy. The phone was cordless and could be moved somewhere more private to help protect people's personal information.

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.