General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cheltenham Chemist, 20-22 Turnham Road, LONDON, SE4 2LA

Pharmacy reference: 1087665

Type of pharmacy: Community

Date of inspection: 19/02/2020

Pharmacy context

This is a community pharmacy next to a medical centre, in a largely residential area. It mainly dispenses NHS prescriptions, and provides a small number of Medicines Use Reviews and New Medicine Service checks. It supplies medications in multi-compartment compliance packs to some people who need help managing their medicines. And it provides a delivery service for dispensed medicines to a few people living in their own homes.

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 identifies and manages the risks associated with its services. When a mistake is made, team members respond well. They generally protect people's personal information well. And they know how to safeguard vulnerable people. People who use the pharmacy can provide feedback. The pharmacy largely keeps the records it needs to by law, to show that its medicines are supplied safely and legally. But the pharmacy has several versions of its standard operating procedures. And this could make it harder for staff to know which version they should use.

Inspector's evidence

The pharmacist did the dispensing and checking of medicines, and she described taking a mental break between the two activities. She showed how the pharmacy recorded near misses, where a dispensing mistake had been identified at the checking stage. But the near miss that had been recorded was from 2019. The pharmacist was not aware of any more recent near misses that had occurred and said that they were rare. She said that she reviewed the near misses annually for any patterns but did not document this. A near miss had occurred between Eucerin cream and lotion and the two forms had since been separated on the shelves. Dispensing errors, when a dispensing mistake had reached a person, were recorded on a designated form. The form did not include the person's name, which could make it harder for the pharmacy to find these details if there was a query. A previous error had occurred where the wrong quantity had been supplied. This was found to be due to the medicine coming in two different pack sizes, and the pharmacist explained that she now did an additional check if more than one pack size existed of a medicine.

A range of standard operating procedures (SOPs) were available, but there were a few versions and it was not clear which were the current ones. The SOPs in the folder in the dispensary had been signed by team members when they had read them, but the last review date on most of these was 2015. The pharmacist showed that there were alternative SOPs available electronically which staff were familiar with, but the implementation dates on some of these dated back to 2010. The pharmacist said that she would discuss the SOPs with the superintendent pharmacist (SI) and review them. And make it clearer which SOPs were to be used in practice. Following the inspection, she confirmed that she was working through the SOPs. The medicines counter assistant (MCA) trainee was clear about his own role and responsibilities. And what he could and couldn't do if the pharmacist had not turned up.

The pharmacy undertook an annual survey of people using the pharmacy. The results from the 2018 to 2019 survey were on the NHS website and were largely positive overall. Team members had read and signed the complaints procedure and there was a sign to inform people how they could make a complaint or provide feedback. The pharmacist was not aware of any recent complaints.

The pharmacy had a current indemnity insurance certificate. The responsible pharmacist (RP) record had been largely filled in correctly, and the right RP notice was displayed. Records examined for private prescriptions and emergency supplies had the required information recorded. Controlled drug (CD) registers seen had been completed in line with requirements, and the CD running balances were mostly checked regularly. Records of unlicensed medicines supplied had the necessary information recorded.

People's personal information was generally well protected. Some people's personal information was

potentially visible on the way to the consultation room, but the pharmacist confirmed that this had been addressed following the inspection. A shredder was used to destroy confidential waste, and the pharmacist had her own smartcard to access the NHS electronic systems. Only the pharmacist accessed these systems. The MCA trainee showed that he had signed a confidentiality agreement. The pharmacist had not yet done any training on the General Data Protection Regulation but said that she would look into it.

The pharmacist confirmed that she had completed the level 2 safeguarding training and she could describe what she would do if she had any concerns. She was not aware of any recent concerns about a vulnerable person. The MCA trainee said that he would refer any concerns to the pharmacist but had not completed any formal training on safeguarding yet. The pharmacist said that she would discuss safeguarding issues with the MCA trainee.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. And they do the right training for their roles. They feel comfortable about raising any concerns or making suggestions to help make the pharmacy's services safer. Team members can take professional decisions to help ensure people are kept safe. They do some ongoing training to help keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection there was the pharmacist and an MCA trainee. The trainee was able to show what accredited course he was undertaking. He said that he didn't usually get time in work to complete it but said that he was up to date with his training. The SI came into the pharmacy from time to time. The pharmacy was up to date with dispensing and its workload.

The pharmacist felt able to take any professional decisions. She gave an example of a prescribing error that she had identified, and the prescriber had been contacted and a new prescription issued. The MCA trainee could describe what questions he would ask someone who wanted to buy a medicine over the counter. He said that he undertook some ongoing training, but the records were not on the premises. He explained how the pharmacist regularly informed him of any new products and helped increase his knowledge by going through scenarios. The pharmacist was aware of the professional requirements for the revalidation process.

Staff had meetings usually twice a month and felt comfortable about raising any concerns or making suggestions. The SI was easily contactable. The staff did not have any numerical targets in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are secure, and generally suitable for its services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was generally clean and tidy, but some non-public facing areas were cluttered and disorganised in places. The dispensary was kept tidy and there was a sufficient amount of clear workspace to allow safe dispensing. Lighting throughout was good. There was a bench in the shop area for people to sit, but the bench was badly ripped, and the foam inside was exposed. The pharmacist said that the pharmacy had replaced it before, but it had been damaged again. She said that she would discuss this with the SI.

The consultation room was untidy in places and the pharmacist said that she would check with the SI where the unnecessary items could be moved. The room had a table and chairs and allowed a conversation to take place inside which would not be overheard. The room temperature was suitable for the storage of medicines and staff had access to handwashing facilities. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them appropriately. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. It obtains its medicines from reputable sources and largely stores them properly. People with a range of needs can access the pharmacy’s services. The pharmacy doesn’t always highlight prescriptions for higher-risk medicines. And this could mean that it misses out on opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was a ramp leading up to the medical centre and pharmacy, and at the entrance to the pharmacy there was a small two to three centimetre step. The MCA trainee could see people outside through the window from the counter and said that he went and assisted anyone when needed. A bell was outside for attracting attention, but this was set relatively high for people with wheelchairs to be able to reach. There was restricted space in the pharmacy for allowing people with pushchairs or wheelchairs to manoeuvre, but someone observed with a pushchair was just able to manoeuvre. A list of the pharmacy’s opening times was displayed in the door.

The pharmacist was observed using baskets when dispensing, to help isolate individual people’s medicines. She was observed doing this even when only dispensing one item. She was aware of the updated guidance around pregnancy prevention to be provided to some people taking valproate medicines. The pharmacy did not have any people in the at-risk group, and the associated information literature such as leaflets and stickers could not be located. The pharmacist said that she would order more in if they could not be found. Prescriptions for higher-risk medicines such as warfarin and methotrexate were not routinely highlighted. This could mean that the pharmacy misses out on opportunities to speak with people when they collected these medicines.

People were assessed for the multi-compartment compliance pack service by the local medicines optimisation service (LIMOS). LIMOS checked whether the packs would help people manage their medicines and undertook a degree of ongoing monitoring to see how they were managing with them. Dispensed packs seen were labelled with a description of the medicines inside to help people and their carers identify the medicines. And patient information leaflets were routinely supplied. The pharmacist was not aware of any recent changes to people’s medicines but showed how she would record them on the electronic record if there were any.

Medicines were obtained from licensed wholesale dealers and stored in an orderly manner. Stock was regularly date checked and this was supported with records. A date-expired medicine was found in with stock and this was immediately removed. Medicines for destruction were separated from stock and placed into designated destruction bins. CDs were kept securely. Medicines requiring cold storage were kept in a suitable fridge. The fridge temperatures were monitored and recorded daily; temperature records seen were within the appropriate range.

The pharmacist showed how the pharmacy received drug alerts and recalls from the MHRA, and she explained the action they had taken in response to a recent alert about gliclazide. A record was made of the action that had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for its services. It uses its equipment to help protect people's personal information.

Inspector's evidence

A range of calibrated glass measures was available for use with liquids. Tablet counting triangles were clean. A separate marked one was used for cytotoxic medicines, but recently this was rarely used as cytotoxic medicines usually came in foil strips. Staff had access to up-to-date reference sources and the internet. The phone was cordless and could be moved to a more private area 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.