General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Station Pharmacy New Cross, 2 Amersham Vale, New Cross, LONDON, SE14 6LD

Pharmacy reference: 1105192

Type of pharmacy: Community

Date of inspection: 13/07/2023

Pharmacy context

This is a community pharmacy close to a railway station. It mainly provides NHS services such as dispensing. And it runs an NHS-funded anticoagulant clinic and supplies medicines as part of it under patient group directions (PGDs). It provides the New Medicine Service, and a range of vaccinations under PGDs. The pharmacy provides vitamin D to pregnant people under a locally-funded NHS scheme. It offers a supervised administration service to people receiving treatment for substance misuse.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

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 not all met	4.3	Standard not met	The pharmacy cannot sufficiently demonstrate that it keeps its medicines requiring cold storage within the right temperature range.
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. Team members know about their own roles and responsibilities. And they know how to protect people's personal information. The pharmacy largely keeps the records it needs to, to show that medicines are supplied safely and legally. People using the pharmacy can provide feedback or raise concerns. Team members work to written procedures. But the procedures are not regularly reviewed, so they may be less likely to reflect current best practice.

Inspector's evidence

Team members had read and signed the pharmacy's standard operating procedures (SOPs). But the SOPs were overdue for review and the superintendent pharmacist (SI) said that they would be reviewed. The trainee dispenser could explain what she could and could not do if the pharmacist had not turned up in the morning.

There were logs to record near misses (where a dispensing mistake occurred and was identified before the medicine was handed to a person), but the last records found were from 2019. The SI thought that there were more recent records but was unable to locate them during the inspection. He explained how near misses were discussed in the team if they happened so that any improvements could be identified. He said that the pharmacy was going to use a new system to record dispensing errors (where a dispensing mistake occurred and the medicine was handed out). The new system was not yet used, and the SI said that he had previously reported errors on the National Reporting and Learning System. He was not aware of any recent dispensing errors.

There was a sign in the public area to inform people how they could make a complaint or provide feedback. The SI was not aware of any recent complaints or feedback. He described how he would make a record of any complaints and discuss it with the team to see if there were any learnings which could be identified.

The pharmacy had current indemnity insurance. The wrong responsible pharmacist (RP) notice was initially displayed, but this was changed when discussed with the SI. The RP record had generally been filled in properly. Controlled drug (CD) registers seen largely complied with requirements, but some headings had not been filled in. One CD running balance checked at random showed that the recorded balance did not match the physical stock found. The SI said that he would investigate this and report to the CD Accountable Officer. Two further random checks showed that the recorded balance matched the amount of physical stock. Records of private prescriptions dispensed did not clearly show who the prescriber had been, and this was discussed with the SI. The records of emergency supplies made were available on the NHS 'Sonar' system, and the nature of the emergency was recorded. Not all the records of unlicensed medicines supplied contained all the required information.

No confidential information was visible from the public area, and computer terminal screens were turned away so that people using the pharmacy could not read information on them. Computers were password protected, and team members had individual NHS smartcards. Confidential waste was separated and shredded, and staff had signed individual confidentiality agreements.

The RP confirmed he had completed the level 3 safeguarding training and, with some prompting, was able to describe what he would do if he had concerns about a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

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

Inspector's evidence

At the start of the inspection there was the SI and the RP, and a trainee dispenser arrived later. The pharmacy also employed a trained dispenser, who was not present during the inspection. Team members were up to date with the pharmacy's workload.

Team members felt comfortable about raising concerns or making any suggestions. The SI regularly worked in the pharmacy and was easily contactable. Team members undertook some ongoing training, which included mandatory training packages and optional ones that the SI made them aware of. Staff were able to do training at work during quieter times, but often preferred to do it at home. The trainee dispenser could explain what she would do if someone wanted to purchase a medicine which was liable to abuse. Team members were not set any numerical targets for the services they provided, and they felt able to take professional decisions.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are generally suitable for the services it provides, and they are kept secure. People receiving supervised administrations have an area they can use to help protect their privacy. And people can have a conversation with a team member in a separate private area.

Inspector's evidence

The pharmacy had a long and relatively narrow design and was generally clean and tidy. As well as the main entrance, there was a side entrance which opened into a small area with a counter. This was used for people who had supervised administration and helped provide them with some privacy. There was a consultation room which allowed conversations inside at a normal level of volume not to be overheard. The room was a little cluttered, and contained some confidential material which was not kept secure. The SI started moving this out of the room when it was highlighted and said that he would get the lock on the door to the room fixed. The ambient temperature in the pharmacy was suitable for storing medicines and there was air conditioning. The premises were secure from unauthorised access.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy cannot sufficiently demonstrate that it keeps its medicines requiring cold storage within the right temperature range. However, on the whole it stores its other medicines properly and gets them from reputable sources. People with a range of needs can access the pharmacy's services. And team members provide healthy living advice and signpost people to other services. The pharmacy takes the right action in response to safety alerts. But it does not always make a record of what it has done in response. And this could make it harder for the pharmacy to show the action it has taken to protect the health and wellbeing of people who use its services.

Inspector's evidence

The pharmacy had step-free access from outside, and there was enough space inside to help people with pushchairs or wheelchairs manoeuvre. The pharmacy's computer system could provide large-print labels if needed. And there was a seating area for people who wanted to wait. People who received supervised administration could use the additional side entrance, which helped provide them with a degree of privacy.

Baskets were used during the dispensing process to help isolate individual people's medicines, and there was a clear workflow through the dispensary. The pharmacy provided several services such as vaccinations under PGDs, and this included Yellow Fever vaccinations. A selection of PGDs were examined and they were in-date, with the electronic copies available for staff to consult.

Dispensed prescriptions for Schedule 3 and 4 CDs were not always highlighted, which could make it harder to know if the prescriptions were still valid when the medicines were handed out. A dispensed prescription for diazepam was found on the shelves and the prescription had expired. Prescriptions for higher-risk medicines were not routinely highlighted, but the RP was able to explain the additional counselling information he would provide to people taking these medicines. Team members knew about the additional guidance about pregnancy prevention to be given to people taking medicines taking valproate. There were spare cards and warning stickers for use with split packs. The SI was not aware of any people who were currently in the at-risk group.

People were assessed about their need for medicines in multi-compartment compliance packs by the local medicines optimisation service (LIMOS). Dispensed packs seen had a description of the medicines inside and the labels were initialled to indicate who had checked them. Patient information leaflets were not always supplied, which could make it harder for people to have up-to-date information about their medicines. The pharmacy kept a record of when people's medicines changed or stopped. And hospital discharge notes were emailed to the pharmacy or available on the Discharge Medicines Service portal.

The trainee dispenser described health and wellbeing advice she provided to people and how she made a record of it. This included advice about stopping smoking, healthy eating, and also signposting people to other services such as mental health services. The SI explained how this fed into the other services the pharmacy offered such as vitamin D supplementation, vaccinations and the blood pressure testing.

The pharmacy delivered medicines to some people in their own homes. The trainee dispenser showed

how the pharmacy computer kept a record of when a medicine had been supplied, and whether the person had their medicines delivered or not.

Medicines were ordered from licensed wholesale dealers and specials suppliers, and were stored in a generally organised way in the dispensary. Some medicines had been removed from their original packs and put into labelled bottles, but the labels did not indicate the batch number. This could make date checks or responding to safety alerts less effective. The bottles were removed for destruction. Bulk liquids which had a limited shelf life when opened were marked with the date of opening. CDs were kept secure. Medicines for destruction were separated from regular stock. Several date-expired medicines were found in with stock, but all had been marked to indicate that they were going out of date soon. The trainee dispenser showed the records of date checks in the dispensary and the counter. But it was not clear from the records which sections had been checked. So, it could be harder for the pharmacy to get assurances that all the stock is regularly date checked.

The pharmacy had two fridges for medicines which required cold storage. The larger fridge upstairs displayed minimum and current temperatures which were in the appropriate range. But the maximum temperature was around 20 degrees Celsius. The fridge temperature records found with this fridge had the most recent entry made in June 2022. There was a smaller fridge downstairs in the dispensary. Again, the minimum and current temperatures were in range, but the maximum temperature was around 19 degrees Celsius. The records found with this fridge had the last entry made on 1 June 2023. The SI said that the thermometers would be reset and he would monitor the temperatures.

Drug alerts and recalls were received via email, and the SI said that none of the recent ones had been applicable to the stock the pharmacy held. A record of the action taken was not routinely 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 generally has the equipment it needs to provide its services safely. It uses its equipment in a way which helps protect people's personal information.

Inspector's evidence

There were calibrated glass measures, with separate ones marked for use with certain liquids. One of the measures was plastic, which was less suitable to use. However, there were sufficient calibrated glass measures. This was discussed with the SI. There was an in-date anaphylaxis kit in the consultation room which was easily accessible for when vaccinations were done. The blood pressure monitor was less than a year old, and the SI showed the calibration certificate which had been obtained for the new weighing scales. 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.