

Registered pharmacy inspection report

Pharmacy Name: Millennium Pharmacy, Unit 12-14, Cromwell Road, Myatts Field, London, SW9 7RX

Pharmacy reference: 9010960

Type of pharmacy: Community

Date of inspection: 14/09/2023

Pharmacy context

This NHS community pharmacy is set on a small row of shops within a residential area in the London borough of Lambeth. The pharmacy opens seven days a week. It sells medicines over the counter. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy supplies multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. And people can get their flu vaccinations (jabs) at the pharmacy too.

Overall inspection outcome

✓ Standards met

Required Action: None

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 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 manages its risks appropriately. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy talk to each other about the mistakes they make to try to stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

Members of the pharmacy team knew what to do if the pharmacy needed to close. And they understood what they should do to make sure people could access the care they needed if the pharmacy was closed. The pharmacy had a plastic screen on its counter to try and stop the spread of airborne infections such as coronavirus. And hand sanitising gel was also available for people to use. The pharmacy had standard operating procedures (SOPs) for the services it provided. But a few procedures haven't been reviewed for a while. Members of the pharmacy team were required to read and sign the SOPs to show they understood them and agreed to follow them. They knew what they could and couldn't do, what they were responsible for and when they might seek help. And the pharmacy displayed a notice that told people who the responsible pharmacist (RP) was at that time. A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to the pharmacist. The team members who were responsible for making up people's prescriptions kept the dispensing workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by the RP. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). And its team had separated some look-alike and sound-alike drugs from one another in the dispensary to help reduce the risks of the wrong product being picked. Members of the pharmacy team discussed the mistakes they made to learn from them and help them stop the same sort of things happening again. But they didn't always record them.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. People could share their views and make suggestions to the pharmacy team about how the pharmacy could do things better. And, for example, the pharmacy team tried to order a person's preferred make of a prescription medicine when it was asked to do so. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had a controlled drug (CD) register. But the stock levels recorded in the register weren't checked as often as the SOPs asked them to be. And the details of where a CD came from weren't always completed in full. The pharmacy kept adequate records to show which pharmacist was the RP and when. It kept records for the supplies of the unlicensed medicinal products it made. But it could do more to make sure its team routinely recorded all the necessary details. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied. And a sample of these were looked at during the inspection and were mostly found to be in order.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy had arrangements to make sure confidential information was stored and disposed of securely. And its team had completed training on information governance and the General Data Protection Regulation. The pharmacy had a safeguarding procedure. And the RP had completed safeguarding training. Members of the pharmacy team knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has just enough people in its team to deliver safe and effective care. Members of the pharmacy team work well together and use their judgement to make decisions about what is right for the people they care for. They know how to raise a concern if they have one. And they could give feedback to help the pharmacy do things better.

Inspector's evidence

The pharmacy team consisted of a pharmacist (the RP), a dispensing assistant and a trainee dispensing assistant. The pharmacy depended upon its team, two regular locum pharmacists and team members from one of the company's other pharmacies to cover any absences. The people working at the pharmacy during the inspection included the RP and the dispensing assistant. The pharmacy didn't set any targets or incentives for its team. And it was up to date with its workload. Members of the pharmacy team helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they felt able to make decisions that kept people safe. The RP managed the pharmacy team. And they supervised and oversaw the supply of medicines and advice given by the team. A team member described the questions they would ask when making over-the-counter recommendations. And they explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist. People working at the pharmacy needed to complete accredited training relevant to their roles after completing a probationary period. They could ask the RP questions, discuss their development needs, read pharmacy-related literature and familiarise themselves with products when they had the time to do so. They knew who they should raise a concern with if they had one. They were comfortable about making suggestions on how to improve the pharmacy and its services. And their feedback led to an additional patient medication record (PMR) terminal being installed.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver its services from. Its premises are clean and tidy. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was air-conditioned, bright and modern. And its public-facing area was professionally presented. The pharmacy had the workbench and storage space it needed for its current workload. It had a consulting room for the services it offered that required one. Or if someone needed to speak to a team member in private. People's conversations in the consulting room couldn't be overheard outside of it. The consulting room couldn't be locked. So, the pharmacy team needed to make sure its contents were kept secure when it wasn't being used. The pharmacy had some sinks and a supply of hot and cold water. And its team members cleaned the pharmacy as often as they could when it wasn't busy.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy has working practices that are safe and effective. And its team is friendly and helps people access the services they need. Members of the pharmacy team usually dispose of people's unwanted medicines properly. And they generally carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources. And it stores them appropriately and securely.

Inspector's evidence

The pharmacy didn't have an automated door. But its entrance was level with the outside pavement. And members of the pharmacy team helped people who couldn't open the door easily, such as someone with a pushchair or a wheelchair, access the building. The pharmacy had a seating area people could use if they wanted to wait in the pharmacy. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. The pharmacy dealt with CPCS referrals. People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses. Members of the pharmacy team were friendly. They took the time to listen to people. So, they could help and advise them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery. And this showed it had delivered the right medicine to the right person. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. It kept an audit trail of the person who had assembled and checked each prescription. And patient information leaflets and a brief description of each medicine contained within a compliance pack were usually provided. So, people had the information they needed to make sure they took their medicines safely. The pharmacy team marked prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items, such as a CD or a refrigerated product, needed to be added. But it could do more to make sure assembled CD prescriptions awaiting collection were marked with the date the 28-day legal limit would be reached to ensure supplies were made lawfully. Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept most of its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team marked the containers of liquid medicines with the date they opened them. They generally marked products which were soon to expire. And they checked the expiry dates of medicines as they dispensed them and at regular intervals. But they could do more to make sure they recorded when they had done a date check. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody

requirements, securely. The pharmacy kept out-of-date CDs separate from in-date stock. It had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But the pharmacy didn't have an appropriate waste bin for the hazardous waste people brought back to it. The pharmacy had a process for dealing with the alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And, for example, the pharmacy team had removed and returned pholcodine-containing cough and cold medicines following the receipt of an MHRA medicines recall. One of the team members described the actions they took and showed what records they made when they received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's personal information is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team checked and recorded the refrigerator's maximum and minimum temperatures on most days the pharmacy was open. The pharmacy restricted access to its computers and PMR system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were stored securely when they weren't working.

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. |