General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sogim Pharmacy, 102 Lordship Lane, London, SE22 8HF

Pharmacy reference: 9011313

Type of pharmacy: Community

Date of inspection: 14/03/2022

Pharmacy context

The pharmacy is located on a busy local high street. And it serves a population with a wide variety of ages. The pharmacy provides a range of services, including the New Medicine Service and flu vaccinations. It also supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications. The inspection was carried out during the Covid-19 pandemic.

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 to help provide them safely. It largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And it protects people's personal information. People who use the pharmacy can provide feedback about its services. When a dispensing mistake occurs, team members generally react appropriately. But they do not always make a record of dispensing mistakes. So, they might be missing opportunities to learn and make the services safer.

Inspector's evidence

The superintendent pharmacist (SI) said there were measures in place for identifying and managing risks associated with its services. Up-to-date standard operating procedures (SOPs) were in place but not all team members had signed to show that they had read and understood them. 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. But they were not recorded. The SI said she would encourage team members to record them in the future. The inspector discussed the benefits of recording and reviewing the near miss records, for example, to help the pharmacy to identify patterns and minimise the chance of mistakes. The SI described some changes that had been made to minimise near misses, such as the separation of medicines that looked or sounded alike. Baskets were used to minimise the risk of medicines being transferred to a different prescription, but workbenches were extremely cluttered, with limited space to dispense and check on. The inspector discussed the risks of this with the SI. Dispensing errors (where a dispensing mistake had reached a person) were reported on the National Reporting and Learning System and a copy of the completed form was held at the pharmacy for reference. A recent error had occurred where the wrong type of medicine had been supplied to a person. There had not been any recent errors, but the SI described a past error were ranitidine 75mg/5ml was dispensed instead of ranitidine 5mg/ml. The person's GP had been contacted and all team members had been informed about the error.

Some changes had been made in response to the Covid-19 pandemic. For example, a large, wrap-around screen had been fitted at the front counter, which was now accessible through a lockable door. Members of the team always wore masks and said they also wore gloves during the height of the pandemic. The pharmacy had stopped obtaining peoples' signatures when delivering their medicines to minimise the risk of cross-infection. The pharmacy had put in place a new SOP for the home delivery service to reflect changes in the process. Surfaces were disinfected regularly, and hand gel was available for staff and customers.

Team members understood their roles and responsibilities and were aware of the tasks they could and could not carry out in the absence of the Responsible Pharmacist (RP). The correct RP notice was displayed, and a sample of the RP record seen was in order. Other records required for the safe provision of pharmacy services were generally completed in line with legal requirements, including those for unlicensed medicines, emergency supplies and private prescriptions. A sample of controlled drug (CD) registers was inspected, and these were filled in correctly. The physical stock of a CD was checked and matched the recorded balance. The pharmacy had current professional indemnity and public liability insurance.

Members of the team had received some verbal training on protecting people's confidentiality and had signed a confidentiality agreement as part of their contract. Confidential waste was shredded on site, computers were password protected and smartcards were used to access the pharmacy's electronic records. The SI described ways in which the team tried to keep patient-sensitive information secure, for example, when delivering medicines to peoples' homes.

The pharmacy previously carried out yearly patient satisfaction surveys, but because of the pandemic it had not done one. People were able to provide feedback verbally or online.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training on safeguarding vulnerable people but not all support staff had not received training on the subject. The trainee dispenser had received some training several years ago and was able to describe some signs of abuse and neglect. The SI said she would provide the team with some refresher training on the subject.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. Staff do the right training for their roles. And they are provided with some ongoing training to support their learning needs and develop their skills. They can raise any concerns or make suggestions.

Inspector's evidence

There was the SI and one trainee dispenser working during the inspection. They worked well together and communicated effectively. Another two trainee dispensers and a medicine counter assistant covered shifts at the pharmacy. The SI's leave was covered by regular locum pharmacists. The trainee dispenser said that the workload had increased significantly in the last few months as another local pharmacy had closed. The number of prescription items dispensed at this pharmacy had now almost doubled but the team were managing the workload sufficiently. The SI was looking for additional staff and was in the process of interviewing people.

The trainee dispenser had completed all his training modules and was awaiting the certificate to confirm completion of the course. He was provided with some study time at work and completed his modules both at work and at home. He said he completed some ongoing training, though the last time he had done any was approximately six months ago. He described some ongoing training that he had completed, such as short courses on dementia, obesity and mental health.

The trainee dispenser described his responsibilities which included delivering medicines to peoples' homes, sorting deliveries, handing out dispensed medicines, serving at the medicines counter, ordering repeat prescriptions, and following up requests with GPs. He said that he would not hand out dispensed medicines or sell Pharmacy-only medicines (P-medicines) in the absence of the RP. He was observed referring to the pharmacist at times, for example, when receiving queries about prescription-only medicines. He was observed selling a painkiller for a child after asking one question and did not provide any further advice. So there may be the potential for refresher training for team members on the pharmacy's over-the-counter medicines sale protocol.

The trainee dispenser felt comfortable about discussing any issues with the pharmacist or making any suggestions. He said that he had received appraisals every six months and had the opportunity to discuss the workload, any issues, queries, and complaints. Targets were not set for team members.

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 had moved into the current premises two years ago. The pharmacy was relatively small, but fittings were new and well maintained. The retail area was clean and tidy. There was sufficient work and storage space in the dispensary, but workbenches were cluttered and disorganised. The SI said that the benches would be tidied to create clear workspace. A small sink, with hot and cold water, was fitted in the dispensary. Pharmacy-only medicines were kept behind the medicines counter which was fitted with a large screen and clear, lockable Perspex door.

The consultation room was accessible to wheelchair users and was located next to the medicines counter. It was suitably equipped and conversations at a normal level of volume in the consultation room could not be heard from the shop area. The room was kept locked when not in use. There was a door behind the dispensary which led to a staff room and toilet. Stairs behind the dispensary led up to two empty rooms on the first floor.

The ambient temperature and lighting were adequate for the provision of pharmacy services. The pharmacy was secured from unauthorised access.

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 it orders its medicines from reputable sources and largely stores them properly. But it does not always show that it takes timely action in response to batch recalls. And this may increase the chance of supplying medicines that are not safe to use.

Inspector's evidence

There was step-free access to the pharmacy. A doorbell was fitted to alert the team when a person entered the pharmacy. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised, and a variety of health information leaflets was available. There was one chair available in the retail area for people wanting to wait for a service.

Dispensing audit trails to identify who dispensed and checked medicines were not always completed. This may make it difficult to identify who was involved in these processes, for example, if a dispensing mistake occurred. There was sufficient workspace, but it was cluttered. Baskets were used to separate prescriptions and prevent transfer between people.

Prescriptions were seen to be attached to bags of dispensed medicines. Part-assembled multi-compartment compliance packs were found on a back bench. The SI said that this was not normal practice, but a locum pharmacist had been covering the previous week whilst SI was off, and there was some backlog of work.

Multi-compartment compliance packs were prepared by the SI or regular locum pharmacist. The trainee dispenser managed the prescription ordering. He kept a record of all prescription requests sent to the GP and followed them up if they were not received in a timely manner. Packs were assembled on a bench in the dispensary and kept aside for a few minutes whilst the pharmacist took a short mental break. They were then checked and sealed. Completed packs were stored in individual baskets labelled with the person's name. Prepared packs observed were labelled with product descriptions and mandatory warnings, but patient information leaflets were not always supplied.

Prescriptions for higher-risk medicines, such as methotrexate and lithium, were not highlighted in any way. The SI said that she checked if a person taking these medicines were being routinely monitored by their GP but did not maintain records of these checks. Copies of a person's INR record were sent with repeat prescription requests for warfarin but disposed of once the prescription was received. The pharmacy supplied valproate medicines to a few people. But the SI said that there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy did not have the relevant patient information booklets or additional warning cards available. The SI said that she would order more cards from the manufacturer, so that these could be supplied to people when needed. The trainee dispenser was aware of the valproate guidance but could not describe the 'at-risk' group correctly. He said he would complete some refresher training on the guidance.

Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. A prescription for zopiclone and

pregabalin, dated 26th January 2022, and was therefore no longer valid, was found still in the retrieval.

A date-checking matrix was displayed on a notice board, but it had not been updated since January 2021. The SI said that the team regularly carried out expiry date checks, and that there was another record, but she could not find it during the inspection. Medicines with short expiry dates were not always highlighted. One expired medicine was found mixed with stock and was not marked in any way. Medicines removed from their original pack were not always labelled clearly. Tablets were found in an unlabelled amber medicine bottle which was elastic banded to the original box of medicine. Atorvastatin tablets placed in an amber medicine bottle were not labelled with expiry date or batch number. Both bottles were removed from the shelves for disposal. The fridge temperatures were checked and recorded daily. But there was no audit trail in place of any action taken when the temperature fell outside the range on a few occasions. The SI said that she normally rechecked the temperature after a short period of time. The fridge was suitable for storing medicines. CDs were stored in accordance with legal requirements, and they were kept secure.

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. But the latest alert actioned was in June 2021. The SI was advised to review alerts and recalls on the MHRA's website and check if the pharmacy held any affected batches.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

Suitable equipment for measuring liquids was available. A separate plastic measure was used to measure certain liquids only. The SI was advised to only use approved measuring equipment to measure liquids. She said she would dispose of the plastic measure. Triangle tablet counters were available but had tablet residue on them. Team members said these would be cleaned after use in the future. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. 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 SI said that the blood pressure monitor was replaced annually, and the weighing scales were no longer used. There were masks, gloves, and hand sanitiser available for team members to use to help minimise the spread of infection.

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.