

Registered pharmacy inspection report

Pharmacy Name: Cullimore Chemist, 13-15 Glengall Road, Edgware,
HA8 8TB

Pharmacy reference: 9011322

Type of pharmacy: Community

Date of inspection: 02/02/2022

Pharmacy context

The pharmacy was inspected during the COVID-19 pandemic. It is situated in a residential area in a parade of shops. It has a Post Office in the building. The pharmacy was one of the first pharmacies in the country to establish a COVID-19 vaccination centre. It offers NHS and private dispensing services, as well as selling medicines over the counter, both in the pharmacy and on the internet (General Sales List items only). It dispenses multi-compartment compliance packs for a number of people in the community, and some people living in care homes. It also provides medicines to some people who receive support from the drug and alcohol team.

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

Members of the pharmacy team work to professional standards and identify and manage risks effectively. They record or discuss mistakes they make during the dispensing process with the regular pharmacist. And they try to learn from these events to avoid problems being repeated. The pharmacy generally keeps its records up to date and these show that it is providing safe services. Its team members understand how they can help to protect the welfare of vulnerable people. And the pharmacy team members generally keep people's private information safe. But the shared use of electronic smartcards to access the NHS spine is contrary to the conditions of use and may pose a risk to patient privacy.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which covered the services that the pharmacy offered. The SOPs were signed by the pharmacy's team members to indicate they had been read. The SOPs said that team members should log any mistakes they made which were corrected during the dispensing process (known as near misses) in order to learn from them. They had logged some issues and discussed learning from these events. Following a mistake which involved picking the wrong strength of a medicine, two strengths of pantoprazole were separated and highlighted on the shelf edge where they were kept. This mistake had been detected before it was given to the patient.

The pharmacy displayed the Responsible Pharmacist notice where it could be seen easily. The Responsible Pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice when they were unsure of the information to give to people. The pharmacy had professional indemnity and public liability insurances in place. The pharmacy team recorded private prescriptions and emergency supplies on the computer, but the details of the prescriber were not always recorded. The controlled drugs registers were up to date and legally compliant.

Computers and labelling printers were used in the pharmacy. Information produced by this equipment was not visible to people in the retail area. Computers were password protected to prevent unauthorised access to confidential information. Other patient-identifiable information was kept securely away from public view. The staff had undertaken training about protecting people's private data, and confidential waste was disposed of by shredding. There was an NHS smart card in use belonging to a member of the team who was not present. These should not be shared and was removed from use and stored securely until that member of staff returned.

The staff had completed the appropriate levels of training about safeguarding vulnerable adults and children and had access to relevant telephone contact numbers for the local safeguarding boards. The superintendent pharmacist was completing a level 3 qualification.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to provide its services, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications, and training to deliver services safely and effectively. There is support for staff to progress in their training.

Inspector's evidence

There were two dispensers, a third-year pharmacy student and a counter assistant present during the inspection, as well as the pharmacist manager. All of whom had completed appropriate training for their roles. One of the dispensers had moved from a large chemist group and said that she had made some suggestions to the pharmacists about changes in processes which could improve the systems in the pharmacy. Some of these were being implemented. The team were seen to work well together and said they discussed within the team how changes could be made to improve the service given to those using the pharmacy. The team kept up to date using pharmacy magazines and training provided by a specialist training provider. There was also a member of staff in charge of the Post Office business. He had access to the pharmacy as the two businesses were integrated, but he had been informed of the need for confidentiality and did not take part in any of the dispensing processes.

There was also an assistant involved in the distance selling of General Sales List medicines (GSLs) using an on-line platform. There were no Pharmacy Only medicines sold via this route. It was discussed that repeated requests for some GSLs needed to be referred to the pharmacist for advice, as these could be an indication that the purchaser was in need of medical advice. The pharmacist said that he would look into how this could be done.

The superintendent pharmacist had completed COVID-19 risk assessments for all the staff. The team members were observed cleaning their hands regularly, using either hot water and soap or hand-sanitiser gel.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area. Fire exits must be kept clear of obstruction and be readily accessible at all times when the pharmacy is open.

Inspector's evidence

The pharmacy had level access from the pavement. It was spacious meaning that there was lots of room for air to circulate. The shop window displayed posters giving information about the pandemic. A member of staff or a volunteer sat at a table by the entrance door to direct people to the correct queue. There were different coloured floor markings denoting separate routes for the post office, counter, chemist counter and COVID-19 vaccinations. The central gondolas had been removed to make room for chairs to accommodate people being vaccinated, both pre and post vaccination.

The shop was clean, tidy and bright. There was a Perspex screen between the staff and the customers, to provide a barrier to reduce transmission of COVID-19. There was hand gel available as customers walked into the pharmacy, and staff encouraged people to use it. The three consultation rooms were available for use as vaccination rooms when they were needed.

The dispensary was clean, tidy and bright. There were two separate dispensing areas; one used for multi-compartment compliance packs and the second one for other prescriptions. Dispensed medicines were filed on a large range of shelves behind doors, which were easily accessible for staff. To the rear was a small, separate room which was used for orders from an on-line platform. There was also a separate staff room.

The Post Office was situated between the two dispensing areas.

Principle 4 - Services ✓ Standards met

Summary findings

Overall, the pharmacy delivers its services in a safe and effective way and it gets its medicines from reputable sources. Pharmacy team members are helpful and give advice to people. They could do more to make sure that people have all the information they need so that they can use their medicines safely. And this applies to when they supply valproate.

Inspector's evidence

The team members used baskets when dispensing to help ensure that prescription items were kept together and were easy to move from one area of the dispensary to another. Computer-generated dispensing labels included relevant warnings and were initialled by the dispenser and checker which allowed an audit trail to be produced. Multi-compartment compliance packs were labelled with the information the person needed to take their medicines in the correct way. The packs also had tablet descriptions to identify the individual medicines. There was a list of packs to be dispensed each week, with each person having a summary sheet showing any changes to their medicines and where the medicines were to be placed in the packs.

Prescriptions for warfarin, lithium or methotrexate were not flagged. This could make it harder for staff to know to ask about any recent blood tests or the person's current dose. And for the pharmacy to monitor the patients in accordance with good practice. If people in the at-risk group received prescriptions for valproate they would not routinely be counselled about pregnancy prevention. And appropriate warnings stickers were not available for use if the manufacturer's packaging could not be used. The dispenser said that she would order some stickers immediately. Schedule 4 controlled drug prescriptions were not always highlighted to staff who were to hand them out. This could increase the chance of these items being given out more than 28 days after the date on the prescription.

At the time of the inspection the COVID-19 vaccination service was performed in one of the consultation rooms. All three of the rooms were suitable for the task, and there were plans to use them for prescriber consultations in the future. The COVID-19 vaccination programme had been extremely busy. The pharmacy had also administered more flu vaccinations than in previous seasons.

The pharmacy got its medicines from licensed wholesalers and stored them on shelves in a tidy way. There were coloured dots on the shelves and boxes to indicate items which were short dated. Regular date checking was done, and no out-of-date medicines were found on the shelves. The fridge temperatures recorded showed that the medicines in the fridge had been consistently stored within the recommended range. Drug alerts were received and actioned appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy. And the pharmacy could demonstrate they had responded to these alerts.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy generally has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

The pharmacy had a separate triangle marked for use with methotrexate tablets, ensuring that dust from them did not cross-contaminate other tablets. There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. Electrical equipment was regularly tested. Stickers were affixed to various electronic equipment and displayed the next date of testing.

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.