General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sterling Chemist, 21-23 Wimbledon Hill Road, London, SW19 7NE

Pharmacy reference: 9011548

Type of pharmacy: Community

Date of inspection: 21/02/2024

Pharmacy context

This pharmacy is part of a local group of pharmacies. It is at the bottom of Wimbledon Hill Road in the centre of Wimbledon. It dispenses people's prescriptions and sells over-the-counter medicines. It dispenses some medicines in multi-compartment compliance packs for people who may have some difficulties managing their medicines. It also offers a delivery service to those who can't get to the pharmacy themselves. The pharmacy shares its premises with a separately owned private GP practice.

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	2.1	Good practice	Newer employees are fully supported by those in the team with more experience. The pharmacy has given all team members access to an online learning resource which they use to keep themselves up to date, and to complete the required training programmes.
		2.4	Good practice	All team members were well motivated and showed enthusiasm in their work. They appeared comfortable with discussing their mistakes and were keen to learn. And were working well together as a team
3. Premises	Standards met	3.1	Good practice	The pharmacy's premises are well designed and presented to a high standard. There was a spacious consultation room and the overall impression was very professional.
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 has well-organised and up-to-date written instructions which tell its team members how to complete their tasks safely. Members of its team are clear about their roles and responsibilities. They work to professional standards, identifying and generally managing risks effectively. The pharmacy manages and protects confidential information well. Its team members understand their role in helping to protect the welfare of vulnerable people. It has appropriate insurance in place to help protect people if things do go wrong. But the pharmacy doesn't always record things as fully as it should. This may make it harder to show what it has done if queries arise in the future.

Inspector's evidence

There were up-to-date Standard Operating Procedures (SOPs) in place to help the pharmacy's team members complete their tasks safely and effectively. They were in a well-organised folder and had last been reviewed in September 2023. They were next due for review in September 2024. There were signature sheets signed by most team members to show that they had read and understood the SOPs. One of the team pointed out that that some of the newer team members were still working their way through the SOPs so hadn't yet signed all of them but would do shortly.

The daily near-miss record sheet had not been completed since November 2023, a similar finding to that identified during the previous inspection. However, team members confirmed that they were challenged by the pharmacist to spot their mistakes and correct them. The pharmacist discussed them both individually and then with the whole team to make sure everyone learned from mistakes. The inspector emphasised the importance of recording them and then regularly reviewing them to identify trends or patterns. Upon reflection the team accepted the need to record all near misses or errors and to keep notes of the regular team meetings where they discussed their learnings. Staff were aware of 'Look Alike Sound Alike' (LASA) drugs, such as ramipril tablets and capsules, omeprazole and olanzapine, which had been placed on different shelves to minimise the risk of selecting the wrong product. The pharmacy subsequently sent the inspector evidence to show that they had restarted their near-miss and error recording.

Staff were able to describe what action they would take in the absence of the responsible pharmacist (RP), and they explained what they could and could not do. They outlined their roles within the pharmacy and where responsibility lay for different activities. Their job descriptions also set out their roles and responsibilities. All dispensing labels were signed by two people to indicate who had dispensed the item and who had checked it. The RP notice was correct and clearly displayed for people to see. All the entries examined in the electronic RP record correctly recorded the date and time the RP's responsibilities commenced, but many were missing the time at which they ceased. As the regular RP wasn't on duty during the inspection, the current RP made a note to point this out, reminding them of the need to sign out at the end of their shifts. Creating an automatic on-screen reminder was also discussed.

People could give their feedback about the pharmacy's services either verbally or via its website. Team members knew who to contact for assistance so they could maintain the pharmacy's services in the event of an unforeseen emergency. There was a certificate of professional indemnity and public liability insurance which was valid until the end of June 2024.

Private prescription records were kept electronically and those checked were mostly complete other than several missing the required prescriber details. Following a brief discussion, the team agreed to rectify this and add in the missing details. Those sections of the Controlled Drug (CD) registers examined were generally in order. Some pages were missing the required header details. Again, the team agreed to rectify this and add them in. Stock balances were checked approximately once a month although a few months had been missed. According to the SOP, the stock balances should have been checked on a Monday, every 28 days. The inspector reminded the team of the need to either follow the SOP or discuss amending the SOP with the superintendent pharmacist (SI). Alterations were annotated with an asterisk and an explanation at the foot of the page. The footnote also included the initials and registration number of the pharmacy professional making the alteration. Stock balances of those CDs selected at random were checked and found to correspond with their respective entries in the CD register.

There was a book for recording controlled drugs (CDs) returned by people who no longer needed them. Those entries examined were all in order. But there were several outstanding items still awaiting safe destruction. They were kept in a clearly labelled bag in the CD cabinet, keeping them separate from stock available for dispensing. The technician agreed to contact the SI and arrange for their destruction. There was a folder for keeping records of unlicensed medicines (specials). Those certificates of conformity examined all contained the individual patient details and a copy of the dispensing label, but several were missing the prescriber's details as required. The team agreed to include these details in future.

All staff were able to demonstrate an understanding of data protection and they had signed confidentiality agreements. They were able to provide examples of how they protected people's confidentiality, for example not disclosing personal information over the phone or not leaving patient-sensitive information lying about for people to see. Completed prescriptions in the prescription retrieval system were not visible to people waiting at the counter. Confidential waste was kept separate from general waste and shredded onsite.

There were safeguarding procedures in place for both adults and children. And contact details of the local 'multi-agency safeguarding hub' (MASH) were available in the dispensary. The RP and the registered technician both confirmed that they had been trained to level 2 in safeguarding and knew how to contact the relevant authorities. The technician was able to describe some examples of signs which may suggest a potential safeguarding concern. They were also signposted to the NHS Safeguarding app as a useful additional resource.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are well trained and keep themselves up to date. They work well together, supporting each other as required. They have a clear understanding of their role and how they can help people with their medicines. They are suitably aware of the risks involved in selling some medicines and know when to involve the pharmacist.

Inspector's evidence

There were two dispensing assistants (one full-time and one part-time), two part-time medicines counter assistants (MCAs), a foundation year trainee pharmacist, a registered pharmacy technician and a locum pharmacist RP on duty at the time of the inspection. The technician confirmed that the staffing levels were reviewed when new services were introduced, and that they were well supported by the SI who frequently visited the pharmacy. They covered any unforeseen absences between themselves, usually with part-time team members flexing their working hours.

The trainee pharmacist appeared to be happy with his progress and was working through the various learning outcomes to be completed during the foundation year. His supervising pharmacist was the regular RP, who was also supported by the SI. He was due to sit the registration assessment in November 2024.

Both dispensing assistants had completed the necessary accredited NVQ2 training programme. One of the MCAs had just successfully passed the combined medicines counter assistant and dispensing assistant course. The technician described how she completed the necessary revalidation every year. The pharmacy provided each team member with online access to the Virtual Outcomes online training platform for their ongoing development. There were certificates for each team member who had completed training for the new pharmacy first service. Team members also described some of the training modules they had completed as required by the Pharmacy Quality Scheme (PQS). The pharmacists within the company have a whatsapp group they use for communicating with each other, including sharing tips and any new learnings.

Staff were seen asking appropriate questions when responding to requests or selling medicines. They demonstrated a clear understanding of medicines liable to misuse and would speak to the pharmacist if they had any concerns about individual requests. They also recognised when the same people made repeated requests and would refer them to the pharmacist. Most of the team were aware of the reclassification of codeine linctus that had been announced the previous day. The remaining team members were updated by the inspector and the RP during the inspection.

All team members appeared open and comfortable with discussing any concerns and supported each other. They also prompted each other when appropriate, with more experienced team members helping those who were newer to their roles. Those questioned knew who they could speak to if they had any concerns and were aware of the pharmacy’s whistleblowing policy. There were some targets, or expectations in place, but they were managed sensibly and didn’t influence the registrants’ professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are well designed and provide a very professional, safe and secure environment for people to receive its services. The team keeps them well maintained, clean and tidy so they still appear very new. There is a well-designed consultation room which the team makes good use of for the pharmacy's services.

Inspector's evidence

The pharmacy's premises still appeared very new. They were clean and tidy, presenting a very professional image. The retail area was airy, well organised with a clear layout. The dispensary had several workstations around its perimeter enabling the team to work with plenty of space around them. There was also a central island where some baskets of prescriptions were awaiting attention. The dispensary sink was clean and equipped with hot and cold running water. The temperature in the pharmacy was maintained at a comfortable level by an air-conditioning system and was suitable for the storage of medicines.

There was a perspex screen at the counter to help minimise the spread of airborne viruses. Worksurfaces were cleaned by team members at least twice daily. The pharmacy employed a weekly cleaner for the floors and there was a checklist of tasks for her to tick off in the consultation room. Stock shelving was cleaned during the date checking process.

There was a large consultation room available for confidential conversations and the provision of some services. Conversations inside the room could not be heard from outside. The door from the dispensary was open but the other door into the retail area was closed when the room was not in use. There were lockable storage cupboards with no confidential material visible. The computer was password protected so that only authorised personnel could access it. There was also a sink with hot and cold running water.

The pharmacy shared its premises with a private GP practice which operated completely independently of the pharmacy. There was an electric shutter between the registered pharmacy premises and the GP practice reception area. This was closed when the pharmacy shut so that people accessing the GP practice wouldn't have unauthorised access to the pharmacy. The GP practice directed its patients to the rear entrance when the pharmacy was closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which it delivers in a safe and effective manner. And people with a range of needs can easily access them. The team is well organised and makes sure that it plans ahead for any changes to its services. The pharmacy sources, stores and manages its medicines safely. Its team members identify people supplied with high-risk medicines so that they can be given extra information they need to take their medicines safely. The pharmacy makes sure that all the medicines it supplies are fit for purpose, responding adequately to drug alerts or product recalls.

Inspector's evidence

The pharmacy provided a range of services which it highlighted using signs by the entrance and posters in the windows. The company owning the pharmacy had a website which also highlighted the services available from each of its pharmacies. There was step-free access through double doors directly from the street.

There were controls in place to help reduce the risk of errors, such as using baskets to keep individual prescriptions separate. People were given an owing ticket when their medicines could not be supplied in their entirety. One of the dispensing assistants explained that if people were likely to run out of their medicine, they would contact the GP on their behalf to seek an alternative. Completed prescriptions awaiting collection were marked to indicate if further intervention was required when handing them out, such as additional counselling from the pharmacist, or if there were additional items in the fridge. CD stickers were placed on the bags, and on the prescription token for schedule 2 CDs, so that team members would know to look in the CD cupboard. The date on which the prescription expired was written on the stickers so that they wouldn't be handed out after 28 days. Team members explained that they also highlighted the dates on lower schedule CDs although most were collected within a day or two of dispensing. They monitored the expiry dates of all uncollected CD prescriptions on the patient medication record (PMR) system, removing any that had expired. The items were then returned to stock and the prescriptions returned to the NHS spine. One of the dispensing assistants explained that she checked all the bagged prescriptions on their retrieval shelves every three months, removing any that had remained uncollected over that period. They would text a reminder to people before returning the items to stock and the prescription to the spine.

Multi-compartment compliance packs were mainly assembled at the rear of the dispensary, away from distractions. There was a noticeboard with a forward planner detailing a re-ordering schedule and the delivery schedule for the compliance packs. The technician explained how they used this to ensure people received their medicines on time. The compliance packs were labelled with product descriptions and Patient Information Leaflets (PILs) were provided. The technician described how they would contact the prescriber if any prescriptions were missing or if doses had changed. Once confirmed, they would update their own record sheets which they kept in a file. They also explained that the pharmacy would shortly be introducing a centralised dispensing hub for assembling compliance packs. In preparation for this, the technician was checking that the dosage times and quantities recorded on their PMR were all correct so that the automated system at the hub would place each tablet or capsule in the correct pocket of the compliance pack.

The pharmacy used a courier firm to deliver medicines to those who couldn't visit the pharmacy in

person. They provided the courier with delivery sheets and kept a photo as the pharmacy's copy. The courier then planned the most efficient route, obtaining a proof of delivery at each drop. Any failed deliveries were brought back to the pharmacy. The pharmacy would then contact the person to rearrange one more delivery, and after that they would have to collect the medicine themselves. People were also asked to collect their CDs from the pharmacy as they didn't deliver CDs.

Those team members questioned were aware of the risks involved in dispensing valproates to people who could become pregnant, and the need to check whether they had long-term contraception in place. They were also aware of the recently updated requirement to dispense valproates in the manufacturer's original packaging, and to avoid covering any of the warnings with their dispensing label. The pharmacy didn't currently supply any valproates to people in the at-risk group but were reminded of the need to record each intervention on the PMR should the need arise. They were signposted to the MHRA website for further details. Team members were aware of the need to avoid handling cytotoxic medicines and were reminded of the need to check whether people had had a recent blood test. The team also acknowledged the need to ask about blood tests for other high-risk medicines such as lithium. And again, to record each intervention on the PMR.

Medicines, including unlicensed specials, were obtained from recognised licensed pharmaceutical wholesalers. Fridge temperatures were recorded daily and seen to be within the correct temperature range. In addition to the temperature record held on the PMR system, there was also a checklist on the fridge door for the person completing the check to initial. All medicines were kept in manufacturers' original packs, and open containers of liquid medicines were annotated with the date of opening. Pharmacy medicines were displayed behind the medicines counter to avoid unauthorised access or self-selection. There was a clearly laid out chart recording when staff had completed date checks on their stock.

Unwanted medicines returned by people were screened to ensure that any CDs were appropriately recorded by the pharmacist, and that there were no sharps present. There was a record of all returned CDs that had been destroyed within the pharmacy. The pharmacy received drug alerts and recalls from the MHRA via email. The team was unable to locate an up-to-date file containing the records of those alerts recently actioned, but the technician explained how the regular pharmacist kept them in a separate folder on the computer. She subsequently provided the inspector with an example and confirmed the details of any action they had taken. The team was signposted to the NHS Central Alerting System (www.cas.mhra.gov.uk) as a useful additional resource.

The pharmacy offered a locally commissioned smoking cessation service which appeared to be well utilised by people. There were records to show what had been supplied, to whom and when, along with signed consent forms. The pharmacy also offered the hypertension case-finding service where people within the specified age range were asked if they would be interested. The pharmacy kept the necessary records and signposted people to their GP if necessary. The RP recalled several people who had subsequently returned to the pharmacy with a prescription to help lower their blood pressure.

The pharmacy had prepared for the recently introduced Pharmacy First service. Several members of the team had been trained so knew when they could refer people to the pharmacist for the service. There were valid signed PGDs for each of the Prescription-Only Medicines (POMs) that the pharmacy could supply under the service. The online PharmOutcomes platform was used for recording the consultations, taking the pharmacist through each step and highlighting any red flags they needed to be aware of. There were also valid PGDs in place for the seasonal influenza vaccination service. There were files containing details of each vaccination, along with the relevant SOP and service specification.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for the range of services it provides, and it makes sure that it is kept clean and suitably maintained. The pharmacy keeps people's private information safe. But it doesn't always make sure its team members are accessing that information in the way they should.

Inspector's evidence

The pharmacy had a set of crown-stamped conical measures, which although clean did have some limescale. There was also a separate counting triangle for cytotoxics such as methotrexate. The blood pressure monitor appeared to be new, as they were replaced at the start of every new year. The pharmacy had recently received an otoscope for the new Pharmacy First service. Its consultation room was spacious and regularly used for some of the pharmacy's services.

All computer screens were positioned so that they were not visible to the public and were password protected. NHS smartcards were in use, but team members were sharing cards. When this was pointed out, they immediately removed the absent person's card and replaced it with their own. The pharmacy made use of online reference sources such as the electronic medicines compendium and the BNF online.

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.