General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pitchkins & Currans Pharmacy, 46 Chippenham Road, Maida Vale, London, W9 2AF

Pharmacy reference: 9012033

Type of pharmacy: Community

Date of inspection: 07/03/2024

Pharmacy context

This is a community pharmacy located in Maida Vale, London. It recently relocated from a smaller premises nearby. The pharmacy dispenses both NHS and private prescriptions. It mainly supplies medicines to people who reside in care homes. The pharmacy provides some other NHS services such as the New Medicines Service and the Discharge Medicine Service.

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 has written procedures to help make sure its team members provide services in a safe and effective manner. And it largely keeps the records it needs to by law. Mistakes that happen during the dispensing process are generally recorded, but the team does not always review them so common trends may not always be identified. Members of the pharmacy team effectively keep people's private information safe, and they take the correct action to safeguard people that may be vulnerable.

Inspector's evidence

Standard operating procedures (SOPs) which covered the services provided were available. They were last reviewed in April 2023 following the relocation of the pharmacy into a bigger premises. Training records were available to show all team members had read and accepted the SOPs that were relevant to their roles. Members of the team knew their role for the day and what work needed to be completed. And they were aware of the tasks that could and could not be carried out if the responsible pharmacist (RP) took a short leave of absence from the pharmacy. A correct RP notice was on display in the retail area. The pharmacy had professional indemnity insurance which covered the services that it provided.

A complaints procedure was in place. This was advertised in the retail area of the pharmacy so that people knew how to raise a concern, complaint or provide feedback. The pharmacy had a process to support the team with learning from mistakes that were identified during the final check by the accuracy checker, also known as near misses. The pharmacist completing the accuracy check asked the team member involved in the dispensing process, to identify the mistake and correct it. But a record of the error was not always made which meant team members may not always be able to identify common mistakes and take action to try and reduce similar mistakes happening again. Any mistakes identified after medicines had been handed out, also known as dispensing errors, were recorded, and shared with the pharmacy manager and superintendent pharmacist (SI). Dispensing errors were discussed with the team members to help reduce the risk of similar mistakes happening again.

The pharmacy largely kept the records it needed to by law. The RP record was kept electronically but there were some gaps where the pharmacist hadn't signed in or out of the record which meant that the record was inaccurate. The pharmacy manager provided an assurance that the regular pharmacist had assumed responsibility of the pharmacy on the days where a record was not made. The pharmacy supplied some medicines in accordance with a private prescription. The records of these were kept in a book but supplies made since November 2023 hadn't been recorded as the pharmacy was behind on some administrative tasks. The pharmacy manager provided an assurance that all records will be made up to date. Controlled drugs (CDs) records were in both paper and electronic format, both of which complied with the requirements. Running balances were maintained but they checked infrequently which meant any discrepancies may not be noticed promptly. The pharmacy manager explained they were in the process of transferring all paper CD records to the electronic format and provided an assurance that regular checks of the running balances would be completed. The physical stock of three CDs were checked against the recorded running balance and two were found to be incorrect. The pharmacy manager investigated the discrepancies and was able to correct them. CDs returned to the pharmacy were recorded in a book and signed when destroyed. The pharmacy had supplied some people with unlicensed medicines and a record of this was maintained.

The pharmacy had a confidentiality policy which all team members had read, and training was completed in accordance with the NHS Data Security and Protection toolkit. When questioned, members of the team described the ways in which they protected people's private information. For example, they knew not to have private conversations in the retail area, and they separated confidential waste into designated bins which was then collected by an authorised carrier. Members of the pharmacy team were aware of the safeguarding procedures that were in place, and they knew what to do if they had any concerns about the wellbeing of anyone who was potentially vulnerable. All of the pharmacists had completed level three safeguarding training. Details of the local safeguarding contacts were easily accessible.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to safely provide its services. It provides support to members of the team who are on training courses. Members of the team feel comfortable to raise concerns and provide feedback.

Inspector's evidence

The pharmacy team consisted of four regular pharmacists, one of which was the SI, six dispensing assistants, and one medicines counter assistant. There was also two trainee dispensing assistants. Three of the dispensing assistants were enrolled on to a pharmacy technician course. One member of the team was working as an administrator and answered phone calls. Team members covered each other during any absences to help make sure a consistent service level was achieved. The pharmacy team members were seen working well together and they supported each other to manage the workload safely.

One of the four pharmacists worked as the pharmacy manager, and they managed the daily operations of the pharmacy. Another pharmacist was the regular RP, and they managed to prescription workload and oversaw team members' training. When questioned, the trainees felt well supported with their learning and development and they were provided with protected learning time to complete their training. Team members explained the questions they would ask when selling pharmacy medicines. And they identified medicines that are liable to misuse. In such cases, they would refer to the pharmacist if they felt the sale was inappropriate or if repeated requests were made. The pharmacy manager had asked all team members to refer all sales of pharmacy medicines to the RP to help make sure the supply was safe.

The pharmacy completed annual appraisals with its team members to discuss how they had performed and to help identify any future training needs. Members of the team also felt comfortable raising concerns or providing feedback to the pharmacy manager and SI. A team meeting was held every day to help plan the workload and delegate tasks to individuals based on their roles. Team members also discussed any process changes or new services when they were introduced.

Principle 3 - Premises ✔ Standards met

Summary findings

The environment is largely suitable for the provision of pharmacy services. However, some areas of the pharmacy are untidy and cluttered which detracts from the professional image and may create a trip hazard to members of the pharmacy team. The pharmacy premises are otherwise clean and large enough to manage the workload safely. A consultation room is available for people to have a private conversation with a member of the pharmacy team.

Inspector's evidence

The pharmacy was large, clean, and well-lit which made it suitable to supply medicines in an effective manner. It operated across two floors; the ground level floor had a retail area and suitable waiting area for people to wait to receive a service. The lower basement level was used as the main dispensary where prescriptions were assembled, and accuracy checked. There was enough clear workspace for its team members to assemble medicines safely. However, some areas within the pharmacy were untidy following the relocation of the pharmacy. The dispensary had some cluttered areas and boxes were stored on the floor which may create a trip hazard for members of the team. Some of the rooms within the pharmacy premises were still being arranged. One room was being used to store medicines that had been returned to the pharmacy for disposal. But the room was disorganised, and it was hard to enter safely. The pharmacy manager explained that the team were still working on arranging some areas of the pharmacy and provided an assurance that a general tidy up of the pharmacy would be completed.

A clean and tidy consultation was available and suitable for people to have a private conversation if needed. Another consultation room was available but was not in use as it was still being refurbished. The pharmacy had climate control available to help maintain a comfortable working temperature. The pharmacy was secured when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides the services it offers in a safe manner. The pharmacy gets its medicines and devices from appropriate sources. But it does not always carry out sufficient checks to make sure they are suitable to supply to people. Members of the team give advice to people when supplying higher-risk medicines to help make sure they are still appropriate for people to use.

Inspector's evidence

There was level access to the pharmacy which made it easy for people with mobility issues to enter. In some cases, team members would assist people with opening the door when necessary. The entrance led into the retail area of the pharmacy which had some seating for people to wait to receive a service. The opening hours of the pharmacy were displayed on the entrance door. A range of health information leaflets were situated in the retail area for people to access if they required additional health related information.

The pharmacy provided some NHS services including the New Medicine Service and the Discharge Medicines Service. It was also preparing to offer the new Pharmacy First service and one of the pharmacists had been trained in preparation. Pharmacy medicines were sold in the retail area which was on the ground level. The RP worked on this floor so that any sales of medicines were observed. Another pharmacist worked on the lower basement level and observed the workload being completed in the dispensary.

The main workload was dispensing NHS prescriptions and the pharmacy supplied many care home residents with medicines. Most of the care homes ordered the prescriptions they needed the pharmacy to dispense, and in such instances, the care home provided the pharmacy with a copy of the medicines that had been ordered. Where the pharmacy ordered medicines on behalf of the care home, or for people living in their own home, a copy of the request was retained so that any missing prescribed medicines could be queried with the GP practice.

The pharmacy received prescriptions electronically and were clinically checked by the pharmacist. Once the clinical check was complete, the prescription was processed by a dispenser. A dispenser selected the medicines from the shelves according to the prescription and then scanned the 2D barcode on the medicine packaging to generate a dispensing label. This helped to make sure that the correct medicine had been dispensed. If all was correct, a label was generated and attached to the medicine box. If there was a mismatch between the dispensed medicine and the prescription, a warning box would appear on the computer to prompt the team member to double check the medicine. The pharmacy manager explained that this had helped reduce the number of near misses considerably. Medicines that required an accuracy check were put into a basket and placed on a designated bench assigned to the pharmacist. The pharmacy computer system also completed some accuracy checks if the prescriptions and medicines were all scanned in properly. Any prescriptions that were manually changed by a member of the team, for example a change in dosage instructions from the details on the prescription, required an accuracy check by a pharmacist. And CDs also had to be checked by the pharmacist. Baskets were used to separate people's prescriptions and to prevent the transfer of medicines. Each dispensing label had a 2D barcode printed on it and when scanned it showed who was involved in the dispensing and checking process. This meant that the pharmacy could easily identify which members of the team were involved

in the assembly of a prescription if a dispensing mistake was to occur.

The pharmacy supplied some medicines in single medicine compliance packs to people in care homes. Medicines supplied in the packs were de-blistered by a member of the team and then dispensing into disposable packs. The packs were labelled and then accuracy checked by the pharmacist before being supplied to the care homes. Some medicines were also supplied in multi-compartment compliance packs to people who resided in their own homes. A record of the medicines that people were supplied with in the packs was maintained on the patient medicine record (PMR). And it used the records to check any changes that the prescriber had made. Copies of discharge letters for people leaving hospital were retained so that an audit trail was created. The prescriptions were ordered by the pharmacy team and checked against each person's record to make sure their medicines had been prescribed correctly. The pharmacist clinically checked the prescriptions before the packs were labelled and assembled. They then completed an accuracy check to make sure medicines had been dispensed correctly. Completed packs had the appropriate warning labels printed on them. The description of the medicines supplied were not routinely included which may make it harder for people to identify the individual medicines. However, patient information leaflets were supplied each month so people could access additional information about their medicines.

Education materials were provided to people taking valproate containing medicines to highlight the risks. And the pharmacist was aware of the requirement to supply people with original packs so that the warning card and patient information leaflet were supplied each time. The pharmacist attached 'speak to the pharmacist' stickers to any medicines awaiting collection when they felt the need to provide additional advice to help make sure medicines were taken safely.

Medicines were delivered to people's homes and to care homes. A same day delivery service was offered to the care homes for any urgent medicines if the prescriber had generated a prescription before the cut-off time. The pharmacy used an electronic system to record and track deliveries which created an audit trail in the event a query arose regarding the delivery of a medicine. Stickers were used to highlight if a CD or fridge item needed to be supplied to people. And the CD stickers acted as a prompt for team members to check the date on the prescription to help make sure it was legally valid at the time of supply.

The pharmacy obtained its medicines from licensed sources, and it stored them securely to prevent unauthorised access. A date checking process of medicine stock was in place, but the team had fallen behind with this task. The last recorded date check was completed in August 2023. Medicines that were short dated were highlighted with a red sticker. Liquid medicines that had been opened had the date of opening written on the packaging to help team members make sure they were safe to supply to people. The expiry dates of some medicines were checked, and a few were found to be expired. And some medicines were stored out of the original pack and without some key identifiable information such as the strength, batch number or expiry date. These were separated for destruction when highlighted to the pharmacy manager and they provided an assurance that a full date check of stock would be completed. Medicines with special storage requirements were stored appropriately. CDs were stored in several secure cabinets and obsolete stock was clearly marked and separated. Medicines that required cold storage conditions were stored in a suitable fridge. The temperature of the fridge was seen to be in the required range and the pharmacy kept a daily record of the temperatures.

The pharmacy received drug alerts and safety recalls by email. Its team members checked the pharmacy for any affected stock, but a record was not routinely made which may make it harder to respond to a query following a recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains the equipment appropriately and keeps it securely.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting triangles. There were five medicine fridges with thermometers. Members of the team had access to electronic resources such as the British National Formulary (BNF) and the electronic medicines compendium. This meant the pharmacy team could refer to the most recent information on medicines.

Electrical equipment looked to be in good working order. A pharmacy computer was available for team members to use on the retail counter. The screen was positioned in a way so that any confidential information could not be seen by people waiting in the pharmacy. All other computer systems were placed in the dispensary which was only accessible to members of the team. And access to people's electronic data on the pharmacy's computers were password protected.

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.