General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hatcham Pharmacy, 399-401 Queens Road, London, SE14 5HD

Pharmacy reference: 9012182

Type of pharmacy: Community

Date of inspection: 04/03/2024

Pharmacy context

This is a community pharmacy on a busy main road intersection in Lewisham. It is close to a railway station and an NHS polyclinic. The pharmacy offers NHS services such as dispensing and the New Medicine Service. And it supplies medicines in multi-compartment compliance packs to some people who need this additional support. It delivers medicines to some people's homes. The premises were previously a Lloyds Pharmacy.

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 manages the risks associated with its services. People using the pharmacy can provide feedback or raise concerns. And there are written procedures for team members to follow. On the whole, the pharmacy keeps the records it needs to by law. And it adequately safeguards vulnerable people. Team members protect people's private information appropriately.

Inspector's evidence

Team members explained that the nearby branch had closed, and they and the pharmacy's inventory had transferred to this premises over the course of the previous weekend. The inspection took place on the day after the weekend. There were standard operating procedures (SOPs) which the current team was in the process of reading and signing. The SOPs covered a range of topics including the responsible pharmacist (RP) requirements, complaints, and safeguarding.

The RP explained how near misses (where a dispensing mistake happened which was identified before the medicine was handed out) were recorded on a log. She was unable to find the log during the inspection but said that near misses had been routinely recorded at the previous premises and said that she would set a new log up if needed. She said that the recent transfer from the previous premises meant that some paperwork had been moved. She was not aware of any recent dispensing errors (where a dispensing mistake happened and the medicine was handed to a person). If one occurred, she said she would record it and discuss with the superintendent pharmacist (SI).

The trainee technician was able to explain what she could and could not do if the pharmacist had not turned up in the morning. During the inspection, team members were seen referring queries to the RP as appropriate.

The RP said that people could complain in person or in writing. Complaints were usually dealt with at a local level and escalated to the SI if necessary. There was a complaint procedure that team members could refer to. The pharmacy had current indemnity insurance.

The wrong RP notice was initially displayed, but this was changed to the right one when it was highlighted. The RP records seen largely complied with requirements, but there were a few times when the RP had not entered the time they signed out. A few private prescription records did not have the prescriber's details. And a few records about emergency supplies said 'rx to follow' and did not indicate the nature of the emergency. Controlled drug (CD) registers seen had the necessary information recorded. A random check of a CD found that there was a discrepancy between the physical quantity and the recorded balance. This was later investigated and following the inspection the SI confirmed that the discrepancy had been resolved. A further three checks made during the inspection found that the physical quantities matched the recorded balances. The necessary details were recorded when an unlicensed medicine was supplied.

No confidential material was readable from the public area. Confidential waste was separated from general waste and disposed of with a shredder. Staff had individual smartcards to access the electronic NHS systems, and computer terminals were password protected.

The RP confirmed that she had completed level 3 safeguarding training and could describe what she would do if she had a concern. The pharmacy had a safeguarding SOP, and staff were in the process of reading and signing the SOPs.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just enough team members to provide its services. They feel comfortable about raising any concerns, and they are not set any numerical targets. Team members get some ongoing training to help keep their knowledge and skills up to date.

Inspector's evidence

At the start of the inspection there was the part-time RP, a trainee dispenser, and two trained dispensers. One of the trained dispensers was training to be a pharmacy technician. Later on, the shift changed and then there was the RP, another trainee technician (who usually worked at another branch), and a trainee medicines counter assistant (MCA). The pharmacy was busy throughout the inspection, but the team was generally up to date with its workload. The recent move to the new premises had resulted in more queries from people who received regular medicines, and the team members were observed trying to resolve the issues where possible.

The pharmacy had a whistleblowing procedure, and team members felt comfortable about raising any concerns or making suggestions. Team members were not set any numerical targets. The trainee MCA said that they were currently working on their training course, and the regular pharmacist made the team aware of any new products and services on an ad hoc basis.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally suitable for its services and they are kept secure. People can have a conversation with a team member in a private area. The pharmacy has limited storage space which it generally uses well. But it could do more to keep all areas tidy and free from unnecessary clutter.

Inspector's evidence

The pharmacy was generally clean and tidy, and although storage space was limited it was generally used well. The dispensary was a little cluttered and the worktop had some baskets awaiting checking, but there was enough clear space to dispense. The dispensary was long and narrow in places which made it harder for staff to move around when there were several people in the dispensary. But for most of the time during the inspection only the RP and another team member were there. Lighting throughout was good, and the ambient temperature was suitable for the storage of medicines. The sink in the dispensary was clean, but the worktop surrounding it was cluttered. The premises were kept secure from unauthorised access.

The pharmacy had two consultation rooms, but only one was being used to see people who came into the pharmacy. The one people used was generally clean and tidy. It was set away from the shop floor, and provided a good level of soundproofing.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy delivers its services in a safe way and people with a range of needs can access them. The pharmacy gets its medicines from reputable sources and generally stores them appropriately. Team members take the right action in response to safety alert to help ensure that people get medicines and medical devices that are safe to use.

Inspector's evidence

There was step free access from the street via a manual door. The pharmacy was relatively small, but there was enough space in the public area to help people with wheelchairs or pushchairs manoeuvre. Several team members were multilingual. The pharmacy computers were able to generate large-print labels if needed.

Baskets were used during the dispensing process to help prevent different people's prescriptions becoming mixed up. The baskets were colour-coded to help identify when people were waiting for them. The RP was seen using one area of the worktop for checking prescriptions.

The RP described how prescriptions for higher-risk medicines were highlighted, so that there was an opportunity for the pharmacist to speak with people when they collected them. No examples of prescriptions for these medicines were found awaiting collection at the time of the inspection. Prescriptions for CDs were seen to be highlighted to help team members handing the medicines out to know if the prescription was still valid. Team members were aware of the guidance about pregnancy prevention for people taking medicines containing valproate. The RP knew about the more recent guidance about supplying the medicine in its original pack. And said that the pharmacy did not have any people who were taking the medicine and were currently in the at-risk group.

The RP explained that the regular pharmacist provided the Pharmacy First service, but they were not working on the day of the inspection and the RP did not deal with the service. A team member said that the pharmacy had previously provided flu and Covid vaccinations under National Protocols but that the season had now ended. Some people had their medicines delivered to them in their own homes. The pharmacy maintained a diary of which people had their medicines delivered on a particular day.

Dispensed multi-compartment compliance packs seen were labelled with a description of the medicines inside to help people and their carers identify them. Patient information leaflets were seen to be usually supplied with the packs, but one set of packs did not have the leaflets with it. The packs were not labelled with the mandatory warnings that some medicines needed, and the RP said that she would investigate how this could be done on the pharmacy's computer system. The trainee technician described how any changes of medicines were recorded on the person's patient medication record and the examples she showed were clear and comprehensive. People were assessed to see if they needed their medicines in the packs by the local medicines optimisation service (LIMOS).

The pharmacy got its medicines from licensed wholesalers and specials suppliers and generally stored them in a tidy way in the dispensary. Some medicines were found in boxes which had just arrived in from a wholesaler. The boxes were not in the dispensary, and they were moved into it immediately when this was brought to the RP's attention. CDs were stored securely. Fridge temperatures were

monitored and recorded daily, and the temperature records seen were within the appropriate range. One box containing mixed batches was found in stock and it was immediately removed. Storing medicines in this way could make date checks or responding to safety alerts less effective. Bulk liquids were marked with the date of opening to help staff know if they were still suitable to use. Medicines for destruction were appropriately separated from current stock. The RP said that the stock had been date checked over the previous weekend as part of the move but was unable to find any records. A random check of stock did not find any date-expired medicines.

The RP said that team members checked the pharmacy's stock in response to drug alerts and safety recalls but she was unsure how the pharmacy received or filed them since moving to the new premises. Following the inspection, the SI confirmed that the alerts from the MHRA were received to the pharmacy's NHS email and would then be printed off and actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. It uses it in a way which helps protect people's personal information.

Inspector's evidence

There were clean calibrated glass measures for use with liquids. Computer screens were turned away from people using the pharmacy to help protect people's private information. The phone was cordless and could be moved to a quieter area.

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.