General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** B.A. Williams (Chemists) Ltd., 14-15 Albany Parade, High Street, BRENTFORD, Middlesex, TW8 0JW

**Pharmacy reference:** 1034833

**Type of pharmacy:** Community

**Date of inspection:** 17/05/2023

## Pharmacy context

This is a community pharmacy in the centre of a small, open air shopping centre in Brentford. The pharmacy provides a range of services including dispensing private and NHS prescriptions. And it has a selection of over-the-counter medicines and other pharmacy related products for sale. It dispenses medicines into multi-compartment compliance packs for people who have difficulty managing their medicines. And it offers a travel vaccination service. And a blood pressure measuring 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 suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy adequately identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

### Inspector's evidence

The pharmacy had a system for recording its mistakes. The regular responsible pharmacist (RP) had worked full-time at the pharmacy for approximately 10 years. She described how she highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistake from happening again. And in response to a near miss mistake, the team had been made aware of the risk of confusion between look-alike sound-alike medicines (LASAs). And it had identified the possibility that a mistake could occur between them. These included medicines such as such as prednisolone and propranolol. And amlodipine and atenolol. The team had separated these products so that they were not close to each other alphabetically. It did this to remind staff that they were dispensing a LASA. And to prompt an additional check of the item they were selecting. This approach had reduced the occurrence of LASA mistakes. But while the team usually recorded its mistakes, it had not recorded all of them. And it did not fully record what it had learned or what it would do differently next time. The RP reviewed the records periodically. But she agreed that if the team had more details of what it had learned from its mistakes. And she reviewed them more often, she could monitor them more effectively. And it would provide team members with a better opportunity to learn. And to identify follow up actions which would help and sustain improvement.

The pharmacy had put measures in place to keep people safe from the transfer of infections. It had a regular cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. It had hand sanitiser for team members and other people to use. And it had put screens up at its medicines counter. The pharmacy had a set of standard operating procedures (SOPs) to follow. The RP and superintendent (SI) had recently reviewed the SOPs and the RP was in the process of implementing them. For the previous set of SOPs, she had produced a more concise 'bite sized' summary of the key points for each one. And in them she had included pictorial references and diagrams to help the team to absorb the information. As the team had found this helpful, she proposed to repeat the exercise for the new SOPs. Team members had worked together at the pharmacy for many years. And it was clear that they understood their roles and responsibilities. The medicines counter assistant (MCA) was observed advising people about the medicines they were buying. And she consulted the pharmacist and her other colleagues when she needed their advice and expertise. She knew the questions to ask people so that she could give appropriate information to the pharmacist about their symptoms and any other medicines they were taking. She did this to help the pharmacist decide on the most appropriate course of action for them. The RP had placed her RP notice on display where people could see it. The notice showed her name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services directly to the pharmacy's team members. They could also give feedback directly to the SI who worked at the pharmacy twice a week. A

lot of the pharmacy's customers had been regulars for many years. And it was clear that the team had a good working relationship with them. Some people had been concerned when the pharmacy did not have their medicines in stock. Or when there were manufacturers' delays. But after gaining people's consent the RP regularly contacted the appropriate GP's surgery to request alternatives so that people did not run out of their essential medicines. The pharmacy also tried to keep people's preferred make of medicine in stock so that they were always available for them. And it had a shelf with several baskets of these brands set aside. The pharmacy had a complaints procedure in place. And team members could provide people with details of where they should register a complaint if they needed to. But the RP or SI generally dealt with people's concerns at the time. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy generally kept its records in the way it was meant to, including its controlled drugs (CD) register and its RP records. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. And this was complete and up to date. The pharmacy also kept records of its private prescriptions. And records of its emergency supplies. But its private prescription records were not fully up to date. And they did not show the date of the prescription. And its emergency supply records did not all give a clear reason for the decision to supply. The pharmacy team agreed that all the pharmacy's essential records should have all the necessary details. And that they should be kept up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They separated the pharmacy's confidential paper waste from its non-confidential waste. And they shredded the confidential waste daily. The pharmacy generally kept people's personal information, including their prescription details, out of public view. But to provide an audit trail for the pharmacy, people signed for the delivery of their medicines. And the signature sheet contained the names and addresses of several people which could potentially be viewed by the others. And while it was unlikely that someone would have time to read the details on the sheet, the RP and delivery driver agreed that the system should be adapted to protect people's information. The Pharmacy had a safeguarding policy. And the RP had completed appropriate level 2 safeguarding training. Remaining team members had read the policy and been briefed. This included the delivery driver. And they knew to report any concerns to the RP or the SI. The team could access details for the relevant safeguarding authorities online. It had not yet had any concerns to report recently. But it had made a referral to social services several years ago after the delivery driver had raised a concern about one of the pharmacy's delivery patients. A referral to social services several years ago but had made a referral to social services several years ago

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy team has an appropriate range of skills and experience to support its services. And it manages its workload safely and effectively. Its team members support one another well. And they keep their knowledge up to date. Team members receive sufficient feedback to help them conduct their tasks satisfactorily. The pharmacy listens and responds well to the concerns of its team members, to improve the quality of the pharmacy's services. But the pharmacy does not always do enough to support its team members through their formal training.

### Inspector's evidence

The regular RP was on duty at the time of the inspection. The rest of the team consisted of a trainee dispensing assistant (DA), who was dispensing the pharmacy's multi-compartment compliance packs, a trainee DA who managed the pharmacy's administration tasks and completed the pharmacy's records on behalf of the SI. And two MCAs. One MCA worked on the counter and the other managed the pharmacy's disability aids section. The trainee DA had not yet completed a recognised DA training course although she had tried to do so on more than one occasion over the 10 years she had worked there. She described how she had now restarted the course after she had been unable to complete it previously within the required time. She described how this had been because she had not found the time to complete the training previously because of time constraints at work. The MCA who managed the disability aids, had also started DA training some time ago but had also not managed to complete it. And while not on a training course she still helped the RP in the dispensary by selecting stock and putting stock away when needed. The inspector and RP agreed that team members should not continually repeat their trainee status. And that to continue with their dispensing tasks they must progress through and complete their training. The working atmosphere was calm, efficient and organised. The pharmacy's team members had worked at the pharmacy for several years and were known to people in the local community. They worked regularly together. And they formed a close-knit team. Team members had a clear understanding of what their tasks were. And when they should do them. Staff were up to date with the daily workload of prescriptions. This included prescriptions for multi-compartment compliance packs. And they attended to people coming into the pharmacy promptly.

Although the pharmacy's team members did not have formal reviews about their work performance. They discussed issues as they arose while they worked. And they could also have a one-to-one with the regular RP or the SI when they wanted or needed one. The pharmacy also had a whistle blowing policy. The regular RP kept the team up to date with any changes affecting their work or any new work priorities. And team members were encouraged to keep up to date by reading training material in over-the-counter pharmacy publications. On new products for example. Staff could raise concerns and discuss issues with the regular RP, or the SI. The SI worked at the pharmacy three days per week, when he overlapped with the RP. And so, they had the opportunity to provide additional services. And catch up on any outstanding workload. This also gave the RP opportunities to discuss any concerns with the SI. And to make suggestions about how to make improvements. The RP described how the team had become concerned over the difficulties they were having when trying to contact the surgery. They had to wait too long to speak to someone who could help with queries especially at a time when they were trying to notify them of medicines shortages. And arrange alternatives. This in turn meant that people in the pharmacy had to wait unnecessarily or go back to the surgery. And so, the team had a meeting

with the practice nurse who arranged for a dedicated phone line to be set up between the pharmacy and the surgery. And this had improved the situation significantly. Pharmacists could make their own professional decisions in the interest of people and were not under pressure to meet business or professional targets.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. The pharmacy is tidy and organised. And it is sufficiently clean and secure. But it does not use its storage capacity effectively.

### Inspector's evidence

The pharmacy was in in a small, shopping centre which had flats above. It was situated just off the main street running through the centre of Brentford. The shopping centre and flats had been built approximately 60 years ago. They had been identified as needing refurbishment by the local council. And so, the centre was due to be redeveloped. And the pharmacy relocated. But the team did not know when this was due to happen. The pharmacy's fixtures and fittings had been well used and had not had an upgrade or refresh for many years. The team recognised that while the pharmacy was clean it did not look fresh. But it felt that these issues would be resolved when the pharmacy relocated.

The pharmacy had a spacious, elongated shop floor with enough space to accommodate a full range of mobility and disability aids at one end. At the other end it had used a proportion of its floor space to store boxes of excess medicines for dispensing, rather than storing them away from customer areas. The remainder of its retail space was sufficient to stock its general sales medicines, beauty products, baby products and items related to healthcare. And it had chairs for people to sit on if they were waiting. It had a long counter with a small dispensary behind. And network of further rooms. At one end, behind the disability aids section, it had a consultation room. The room was sufficiently soundproof to ensure that private conversations held inside it could not be heard by other people. Pharmacists used the room for private conversations with people and when providing certain services including vaccinations. People could access the consultation room from the retail area. The room was also used for chiropody services every two months. The pharmacy also had an office plus a storage cupboard and toilet facilities here. Towards the other end it had a room for making up multi-compartment compliance packs, a further large stock room, a staff area and staff toilet facilities.

The pharmacy kept its pharmacy medicines behind the medicines counter. An open doorway from the counter led to the compliance pack room, the stock room and staff area. A door from behind the counter led to the dispensary which was used for most of the pharmacy's dispensing activities. The main dispensary had work surfaces on all sides. And it had storage shelves and drawers. In general, team members tidied up as they worked. They did this to make sure they had enough space to work safely. The dispensary had a sink. But the team did not use it. It had covered it to provide additional work surface. Instead, the team used the staff sink for making up medicines and washing equipment. The RP gave assurances that the team cleaned the sink and any cleaning equipment thoroughly after each use. The team cleaned the pharmacy regularly to ensure that contact surfaces were clean. Stock on shelves was generally tidy and organised. And work surfaces were free from unnecessary clutter. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. And it ensures that it supplies its medicines with the information that people need to take their medicines properly. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. But it does not ensure that all its medicines are packaged, labelled and stored properly.

### Inspector's evidence

The pharmacy had step-free access. And its main customer area was generally free of unnecessary obstacles. But some areas at either end of the customer area were cluttered with boxes and stock. The pharmacy had a delivery service for people who had no other way of collecting their medicines. And it could also order people's repeat prescriptions if required. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them and for the residents of a residential home nearby. The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. And it updated people's records. The pharmacy also had a system for managing any changes made to people's prescriptions within the monthly cycle. And through its NHS discharge medicines service it received hospital discharge letters and information so that it could make any necessary changes to packs for people after they had left hospital. The team labelled its compliance packs with the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. So that people could find the information they needed if they wanted to. But it did not label its packs with a description of each medicine, including colour and shape, to help people to identify them. The RP agreed that this information could be useful for patient and their families. And for healthcare professionals when helping people to manage their medicines. The pharmacist gave people advice on a range of matters. And she would give appropriate advice to anyone taking high-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines. The RP described how she counselled at-risk people when supplying the medicine to ensure that they were on a pregnancy prevention programme. The pharmacy also supplied the appropriate patient cards and information leaflets each time. The pharmacy offered a hypertension case finding service for people over 40 years old. The service had led to a positive outcome for several patients where RP had referred them to their GPs following a high blood pressure reading. And some of those had returned to the pharmacy with a prescription for blood pressure lowering tablets. The RP kept records to manage the process appropriately. The pharmacy also offered a travel service, where it supplied a range of travel vaccinations and medicines to prevent malaria. And it had up to date protocols against which it supplied these treatments appropriately. And it kept appropriate records about each consultation and the medicines supplied or administered.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. It generally stored its medicines appropriately and in their original containers. But it had

several packs of medicine with more than one brand of medicine strip inside. The strips did not all have the same expiry date and some had no expiry date at all. And so, the additional strips could be missed if they were part of a medicines recall or an expiry date check. The inspector discussed this with the RP, and they agreed that team members should review their understanding of the correct procedures to follow when putting medicines back into stock after dispensing. The pharmacy also had a procedure for de-blistering medicines in bulk for dispensing into multi-compartment compliance packs. But several of the packs used to store the de-blistered medicines did not contain the required manufacturer's labelling information, such as batch number, product licence number or expiry date. In general, the pharmacy stored its medicines stock in a tidy and organised manner. And it date-checked its stock regularly. But it did not keep records of its date checking. The team agreed that if it kept records, it could use them to track what had been checked and what had not. The team identified and highlighted any short-dated items. And it removed them from stock. It only dispensed them with the patient's agreement where they could use them before the expiry date. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. And following a patient level recall from the previous week, it had contacted a patient to request that the item be returned. The item had then been quarantined before returning to the wholesaler.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's confidential information safe

### Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. And they had access to personal protective equipment (PPE), in the form of sanitiser, face masks and gloves. The pharmacy had several computer terminals which it had placed at a workstation in the dispensary, in the compliance pack room and in its offices. Computers were password protected team members had their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions out of people's view.

## 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. |