General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Fairview Pharmacy, 293-295 Burnt Oak Broadway, EDGWARE, Middlesex, HA8 5ED

Pharmacy reference: 1034841

Type of pharmacy: Community

Date of inspection: 29/04/2024

Pharmacy context

This is a community pharmacy located on the South side of Edgware, Middlesex. The pharmacy dispenses NHS and private prescriptions. It's team members sell over- the-counter medicines, offer local deliveries, seasonal flu, and travel vaccinations. And the pharmacy supplies some people's medicines inside multi-compartment compliance packs if they find it difficult to take them. This includes people in their own homes and residential care homes.

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	1.1	Good practice	The pharmacy has efficient processes with additional audit trails in place. This helps the pharmacy team to actively identify and manage risks associated with the pharmacy's services.
		1.2	Good practice	The pharmacy regularly reviews and monitors the safety and quality of its services. The team routinely records, reviews and feeds back near misses and incidents.
2. Staff	Standards met	2.2	Good practice	Members of the pharmacy team have the appropriate skills, qualifications and competence for their role and the tasks they undertake.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy provides its services well and routinely ensures suitable checks are made for people prescribed higher-risk medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy operates effectively. It efficiently identifies as well as manages risks associated with its services. Members of the pharmacy team monitor the safety of their services by recording their mistakes and learning from them. They understand how to protect the welfare of vulnerable people. And the pharmacy generally maintains its records as it should.

Inspector's evidence

This was an organised pharmacy with efficient processes, and systems in place. The pharmacy team subsequently identified and managed risks associated with the pharmacy's services well. This included having additional audit trails in the pharmacy's processes which helped identify staff involvement at various stages. As a result, the pharmacy effectively highlighted who had processed the prescription(s), picked the required stock, checked the stock, prepared the prescription(s), accuracy-checked, handed out or delivered the prescription(s). This meant that relevant details could be cross-checked quickly when needed, for example during queries or incidents.

Team members were observed to concentrate on one task at a time. They took care when dispensing, used prescriptions to select medicines against and ensured a three-way check against the prescription, dispensing label and medicine took place during the assembly process. Different members of staff participated in printing and generating dispensing labels as well as preparing prescriptions. This helped identify any errors and enabled more than one accuracy check to take place. Multi-compartment compliance packs were also prepared in a separate section which helped minimise errors from distractions.

Pharmacists routinely identified prescriptions for antibiotics, high-risk medicines (see Principle 4), prescriptions for people with allergies or where changes in strength were seen so that people could be counselled accordingly. They also identified medicines which were prone to errors.

Members of the pharmacy team regularly recorded their near miss mistakes electronically by using a QR code which was on display for easy access. Details were routinely reviewed and fed back to help reduce the likelihood of mistakes recurring. In response, staff highlighted medicines that had been commonly involved in mistakes on shelves, prescriptions, and people's medication records so that this information was clearly identifiable when they generated dispensing labels and prepared prescriptions. This included those that looked alike and sounded alike (LASAs) and the form of the medicine to help prevent selection errors (for example where tablets had been selected instead of capsules or vice versa) as well as different forms of aspirin.

Pharmacists oversaw incidents, their process was suitable and in line with requirements. This involved appropriate management of the situation, formal reporting, and investigation to identify the root cause. The necessary changes were then implemented into the pharmacy's internal systems.

The pharmacy had current electronic standard operating procedures (SOPs). They provided the team with guidance on how to carry out tasks correctly. Staff had read and signed them. Members of the pharmacy team understood their roles well and worked in accordance with the pharmacy's set procedures. The correct notice to identify the pharmacist responsible for the pharmacy's activities was

on display. This provided details of the pharmacist in charge of the pharmacy's operational activities.

Staff had been trained to safeguard the welfare of vulnerable people and the responsible pharmacist (RP) was trained to level three. Team members could recognise signs of concerns, they knew who to refer to in the event of a concern and contact details for the local safeguarding agencies were on display. The pharmacy's team members had also been trained to protect people's confidential information. Details were on display in the retail area explaining the pharmacy's privacy policy. Staff described using the consultation room to discuss sensitive details. Team members used their own NHS smart cards to access electronic prescriptions. They stored and disposed of confidential material appropriately.

The pharmacy's records were largely compliant with statutory and best practice requirements. This included a sample of registers seen for controlled drugs (CDs). On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. The pharmacy had suitable professional indemnity insurance arrangements in place. Records of emergency supplies and records verifying that fridge temperatures had remained within the required range had been appropriately completed. However, incomplete details about prescribers had been documented within the electronic private prescription register and there were some gaps in the electronic RP record. The superintendent pharmacist (SI) was aware of this situation and had taken steps to help amend this.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to safely manage its workload. Members of the pharmacy team are suitably qualified for their roles. And the pharmacy provides them with resources so that they can complete regular and ongoing training. This keeps their skills and knowledge up to date.

Inspector's evidence

The pharmacy team included two regular pharmacists who provided overlapping cover, two dispensing assistants, one of whom was completing an accuracy checking course, a medicines counter assistant (MCA), a locum pharmacy technician who was used when needed, two part-time delivery drivers and two pre-registration trainee pharmacists who were working in three different settings. Other than the latter, staff were fully trained. Certificates to verify their qualifications were on display. The SI was also present during the inspection. The pharmacy was up to date with the workload and had enough staff to suitably manage the workload.

Staff knew which activities could take place in the absence of the RP and referred appropriately. Relevant questions were asked before selling medicines and medicines which could be abused were monitored. Team members were also trained to provide certain services (see principle 4). Team meetings and discussions took place regularly with informal performance reviews taking place. Staff were provided with resources for ongoing training through various pharmacy support organisations and e-learning platforms. This helped ensure they continually learnt and kept their knowledge up to date.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises provide a suitable environment for people to receive healthcare services. The pharmacy is kept clean, it is secure, and appropriately presented. And it has a separate space where confidential conversations or services can take place.

Inspector's evidence

The pharmacy’s premises were appropriately presented, bright, and suitably ventilated and adequately maintained. Some of the fixtures and fittings were worn and dated in appearance, but this did not appear to pose any additional risks. The SI explained that a re-fit was pending. The ambient temperature in the premises was suitable for the storage of medicines and the pharmacy was secured against unauthorised access. The dispensary had an adequate amount of space for staff to carry out dispensing tasks safely, there was additional space to one side and dispensing benches were kept clear of clutter. A clean sink in the dispensary was available to prepare medicines with hot and cold running water. The pharmacy’s retail space had a signposted consultation room for services and private conversations. Conversations at a normal level of volume could take place inside without being overheard. The room was spacious and of a suitable size for its intended purpose.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are delivered safely. Its team members can make suitable adjustments to ensure everyone can use the pharmacy's services. The pharmacy sources its medicines from reputable suppliers. It stores and manages its medicines well. The pharmacy has verifiable processes in place to ensure medicines are suitably dispensed and delivered. Team members routinely identify people who receive higher-risk medicines. This helps ensure people take their medicines correctly. And the pharmacy provides useful services.

Inspector's evidence

People could enter the pharmacy from an automatic front door with sloped access leading to it. The retail area consisted of wide aisles which helped people with restricted mobility or using wheelchairs to easily access the pharmacy's services. Seating was available inside the pharmacy if people wanted to wait for their prescriptions and staff could make suitable adjustments for people with diverse needs. This included staff who were multi-lingual, physically assisting people if needed, providing written information, and speaking slowly to allow people to lip read. Details about the pharmacy's services as well as its opening times were clearly advertised, and the pharmacy had various leaflets and posters on display to provide information about various health matters. Team members were aware of the local health facilities to signpost people accordingly if this was required.

Team members were aware of risks associated with valproates. This included the recent updates and educational material was readily available to provide upon supply. Staff ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them, and had identified people at risk, who had been supplied this medicine. People were counselled accordingly. The team routinely identified and knew which people had been prescribed higher-risk medicines. Staff asked details about relevant parameters, such as blood test results for people prescribed these medicines and regularly recorded this information. This included residents in the care home.

People requiring compliance packs had been identified through their GP as having difficulty in managing their medicines. The pharmacy ordered prescriptions on behalf of people for this service and specific records were kept for this purpose. Any queries were checked with the prescriber and the records were updated accordingly. Descriptions of the medicines inside the packs were provided and patient information leaflets (PILs) were routinely supplied. All medicines were removed from their packaging before being placed inside the compliance packs.

The pharmacy provided medicines as original packs to residents inside the care home. The care home ordered repeat prescriptions for the residents themselves and sent a copy of the order to the pharmacy. Once prescriptions were received, missing items were documented and queried appropriately. Interim or medicines which were needed mid-cycle were dispensed at the pharmacy. Staff had not been approached to provide advice regarding covert administration of medicines to care home residents, but the SI was aware of the process to take and which relevant guidelines as well as resources to use to assess the suitability of this kind of administration. The SI also explained that after visiting the care home, they had ensured staff could receive drug alerts direct from the Medicines and Healthcare products Regulatory Agency (MHRA).

The pharmacy provided local deliveries and the team kept records about this service using a specific electronic application. CDs and medicines requiring refrigeration were highlighted. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended.

The pharmacy offered the New Medicine Service (NMS). This was said to be beneficial as it had helped identify and better enabled pharmacists to advise, face-to-face, on inhaler technique for people with asthma. The pharmacy was providing the recently commissioned Advanced NHS service, Pharmacy First. Suitable equipment was present which helped ensure that the service was provided safely and effectively (see Principle 5). The service specification, SOPs and PGDs to authorise this were readily accessible, they had been signed by the pharmacists and more referrals were described as now being seen. The pharmacy also offered an ear wax removal service which one of the dispensers and pharmacists were trained to provide. They had completed relevant training. The service involved using an otoscope with technology that produced a video of the ear canal, this could be provided to people using the service and other relevant health care professionals. The pharmacy also had access to an ear, nose, and throat (ENT) surgeon who provided answers to queries within 24 hours.

The workflow involved prescriptions being prepared by staff in set locations and the RP checked medicines for accuracy from a separate area. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. They were also colour coded to highlight priority and different workstreams. After the staff had generated the dispensing labels, there was a facility on them which helped identify who had been involved in the dispensing process. Team members routinely used these as an audit trail.

The pharmacy's stock was stored in an organised way. Licensed wholesalers were used to obtain medicines and medical devices. The team date-checked medicines for expiry regularly and short-dated medicines were routinely identified. There were no date-expired medicines seen. CDs were stored under safe custody. Medicines returned for disposal, were accepted by staff, and stored within designated containers. This did not include sharps which were re-directed accordingly. Drug alerts were received electronically and actioned appropriately. Records were kept verifying this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. And team members use them appropriately to keep people's confidential information safe.

Inspector's evidence

The pharmacy's equipment was suitable for its intended purpose. This included standardised conical measures for liquid medicines and triangle tablet counters, an appropriately operating pharmacy fridge, legally compliant CD cabinet and access to current reference sources. A few of the FAMA drawers used to hold the pharmacy's stock were broken but they were clearly highlighted. Additional equipment for the pharmacy's services included a blood pressure (BP) machine, otoscope, tongue depressors, and a thermometer which were new. The ambulatory BP machine had been calibrated last year. Portable telephones helped conversations to take place in private if required. The pharmacy's computer terminals were password protected and their screens faced away from people using the pharmacy.

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.