General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rushton Pharmacy, 275-277 Preston Road, HARROW, Middlesex, HA3 0PS

Pharmacy reference: 1034997

Type of pharmacy: Community

Date of inspection: 28/06/2023

Pharmacy context

This is a high street pharmacy in a mixed commercial and residential area in northwest London. It dispenses NHS and private prescriptions and provides health advice. Services include delivery, flu and travel vaccinations, blood pressure case finding service, new medicine service, discharge medicines service and community pharmacist consultation service (CPCS). The pharmacy supplies medicines in multi-compartment compliance packs for people who have difficulty managing their medicines. The pharmacy changed ownership in March 2023.

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

Overall, the pharmacy's working practices are generally safe and effective. The pharmacy team members follow suitable written instructions to help them manage risks and work safely. They record their mistakes to learn from them and take appropriate action to help prevent the same mistakes happening again. The pharmacy keeps all the records it needs to by law, and this shows that medicines are supplied safely and legally. The pharmacy team members keep people's private information safe and understand how they can help safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. The RP explained that medicines involved in incidents, or were similar in some way, such as different strengths of atenolol were generally separated from each other in the dispensary. Members of the team had arranged the most frequently used medicines together to improve dispensary workflow. They checked interactions between medicines prescribed for the same person. A member of the team described recording interventions on the patient medication record (PMR) after contacting a doctor about an interaction. The doctor's reply by email was attached to the person's records for future reference. The team members did not hand out assembled prescriptions until they were checked by the responsible pharmacist (RP). And they asked for details such as part of the address and date of birth to help make sure prescription medicines were given to the correct person.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these had been reviewed since the change of ownership of the pharmacy. Team members were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. They knew what they could and could not do, what they were responsible for and when they might seek help. And their roles and responsibilities were described in the SOPs. A team member explained that they knew not to hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse to a pharmacist. The pharmacy had a complaints procedure and it displayed details of how to complain, comment or make suggestions about how the pharmacy could improve its services. And people left feedback about the pharmacy via Google reviews.

The pharmacy had risk-assessed the impact of COVID-19 upon its services and the people who used it. At the time of the visit, the pharmacy had removed most measures which were installed early during lockdown to help reduce the risks associated with the virus. Team members cleaned surfaces and washed their hands regularly and used hand sanitising gel when they needed to. The pharmacy had completed the sodium valproate audit and had information cards and leaflets to give to people. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. It displayed a notice that told people who the RP was, and it kept a record to show which pharmacist was the RP and when. The pharmacy had a controlled drug (CD) register. CDs were audited regularly and a random check of the actual stock of a CD matched the recorded amount in the register. The pharmacy kept records of medicinal products it supplied on private prescriptions. And these generally were in order. The RP explained that they rarely supplied unlicensed medicines or made emergency supplies of medicines due to availability of other services via NHS 111. Following the visit,

the RP confirmed that travel vaccinations and medicines were administered via online patient group directions (PGDs) provided by Voyageur and Citydoc.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Its team tried to make sure people's personal information could not be seen by other people and was disposed of securely. Team members were using their own NHS smartcards. The pharmacy had a safeguarding SOP. And the RP had completed a safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. The team was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together to manage the workload. And they feel able to make suggestions to the pharmacist on how to improve the pharmacy and its services. The pharmacy enrols members of its team on training courses relevant to their roles so they can develop their skills and knowledge.

Inspector's evidence

The pharmacy team consisted of the RP, one regular locum pharmacist, one full-time dispensing assistant, two full-time medicines counter assistants, one part-time dispensing and medicines counter assistant and a part-time delivery driver. The delivery person had undertaken some in-house training about data protection and what to do with failed deliveries. The pharmacy relied upon its team members to cover each other's absences. The superintendent pharmacist (SI) was training to be an independent prescriber (IP). And team members were enrolled on or had completed accredited training courses relevant to their roles. Where possible they had protected learning time to study and read industry publications with information on new or current OTC products. The RP planned to access NHSE e learning for healthcare (elfh) as a training resource. Team members had not had an appraisal to help identify their training needs and monitor performance, as it was too soon after the pharmacy had changed ownership.

Members of the pharmacy team worked well together. So, people were served quickly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an OTC sales and self-care SOP which its team needed to follow. This described the questions the team member needed to ask people when making OTC recommendations. And when they should refer requests to a pharmacist. If the pharmacy could not offer people assistance, they were signposted to another provider such as their own doctor or another local doctor.

The pharmacy team members were comfortable about making suggestions on how to improve the pharmacy and its services. And they had suggested a way of speeding up the process for re-ordering repeat prescriptions. They knew who they should raise a concern with if they had one. The pharmacy team was signposted to GPhC guidance on requirements for the education and training of support staff and the Knowledge Hub.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are secure and suitable for the provision of healthcare. The pharmacy protects people’s private information and keeps the pharmacy’s medicines stock safe.

Inspector's evidence

The registered pharmacy premises were bright and secure. And steps were taken to make sure there was sufficient ventilation in the pharmacy to help prevent its team and medicines stock from getting too hot. The pharmacy consisted of a double unit, so it had a large retail area, a counter, a smaller dispensary and some storage. Its fixtures were dated but the pharmacy was generally clean. The pharmacy had a consulting room which was signposted. So, people could have a private conversation with a team member. The dispensary had workspace and storage available. Some items were stored on the floor. The RP and the dispenser kept worksurfaces in the dispensary clear when the pharmacy was busy. The pharmacy had a sink.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy tries to make sure its services are easily accessible to people with different needs. Its working practices are generally safe and effective. The pharmacy team members highlight prescriptions for high-risk medicines so they can make sure people get the information they need to use them properly. And the pharmacy obtains its medicines from reputable sources so they are fit for purpose. The pharmacy stores medicines securely at the right temperature and it keeps records of regular checks to show medicines are safe to use. The pharmacy team knows what to do if any medicines or devices need to be returned to the suppliers.

Inspector's evidence

The pharmacy had a single door which was not automated. But its entrance was level with the outside pavement. This made it easier for someone who used a wheelchair, to enter the building. But the pharmacy team tried to make sure these people could use the pharmacy services. The pharmacy had a notice that told people when it was open. And other notices in its window told people about some of the other services the pharmacy offered. The pharmacy had seating for people who wanted to wait. Members of the pharmacy team were helpful. And they could speak or understand Gujarati and Romanian to help people whose first language was not English. So, they could advise and help them. And they signposted people to another provider if a service was not available at the pharmacy.

The pharmacy provided a delivery service to people who could not attend its premises in person. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The pharmacy used a disposable pack for people who received their medicines in multi-compartment compliance packs. The pharmacy team checked whether a medicine was suitable to be re-packaged. Each person had a record sheet containing information on the medicines they were prescribed and how they were supplied. It was checked against the person's summary care record (SCR). The backing sheet also acted as an audit trail and it provided a brief description of each medicine contained within the compliance packs. The pharmacy provided patient information leaflets. So, people had the information they needed to make sure they took their medicines safely.

Members of the pharmacy team initialled dispensing labels to show who prepared a prescription. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added. They were aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed. The RP described counselling people and what checks were made before dispensing isotretinoin and what checks were made and recorded before giving people warfarin. The pharmacy team provided the new medicines service with follow up consultation by phone and this service was to help people maximise the benefit of taking a new medicine. The pharmacist helped people overcome problems which prevented them taking their new medicines. The CPCS service sent very few referrals from the NHS 111.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. A pack containing several strips with mixed batches of the same tablets was discussed. Because a member of the team may only check the date and batch number of the outer container and not each strip when checking stock in

response to an alert or when date-checking stock. The dispensary was reasonably tidy. The pharmacy team checked the expiry dates of medicines when it dispensed them and a few times a year. And it generally recorded when it had done a date-check. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs securely in line with safe custody requirements. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy had hand sanitisers for people to use if they wanted to. The pharmacy had a glass measure for use with liquids, and some were used only with certain liquids. The pharmacy team had access to up-to-date reference sources for information and guidance. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And its team members demonstrated how they checked the maximum and minimum temperatures of the refrigerator. They disposed of confidential waste appropriately. They restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members were using their own NHS smartcards.

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.