General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Belmont Pharmacy, 4 - 5 Station Parade, Belmont Circle, HARROW, Middlesex, HA3 8SB

Pharmacy reference: 1035010

Type of pharmacy: Community

Date of inspection: 29/04/2024

Pharmacy context

This is a community pharmacy on a busy parade of shops in Harrow, London and serves a diverse community. The pharmacy dispenses NHS and private prescriptions. It offers the New Medicine Service (NMS), local deliveries, seasonal flu, COVID-19, and travel vaccinations. And it provides several people's medicines inside multi-compartment compliance packs if they find it difficult to manage their medicines at home.

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 identifies and manages the risks associated with its services in a satisfactory way. Members of the pharmacy team monitor the safety of their services by recording their mistakes and learning from them. Team members understand their role in protecting the welfare of vulnerable people. And the pharmacy largely keeps the records it needs to by law.

Inspector's evidence

The pharmacy was inspected as over the past year, the GPhC had received a few complaints, linked to dispensing incidents. The inspector had previously visited the pharmacy to verify the situation and found it to be largely operating appropriately. At that time though, staffing levels were observed to be significantly limited in comparison to the pharmacy's workload. At this inspection, the numbers of staff were still stretched but team members were managing the workload appropriately (see Principle 2).

The pharmacy had current standard operating procedures (SOPs) to provide its team with guidance on how to complete tasks appropriately. Staff at the inspection had read and signed them. They were clear on their roles and responsibility and knew what their tasks involved as well as which activities could take place in the absence of the responsible pharmacist (RP). The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

The pharmacy had systems in place to identify and manage risks associated with its services. Staff worked in designated areas and more than one person was usually involved in the dispensing and assembly process. Prescriptions were seen to be processed in an ordered way. The pharmacy prioritised and highlighted people waiting for prescriptions and prepared them in a separate area. Multi-compartment compliance packs were also assembled in a separate area which was to one side of the main dispensary activity. And the RP worked in a designated space. These measures helped minimise distractions.

At the point of inspection, dispensary benches were cluttered although this was observed to be work in progress, and the pharmacy's stock was stored in a haphazard way (See Principle 4). The pharmacy technician who was responsible for assembling compliance packs was observed to be routinely interrupted to process prescriptions for people who were waiting. This increased the risk of mistakes occurring. However, this member of staff explained that the compliance packs were finished first before initiating any other activity and the availability of other team members was hampered due to the presence of the inspector.

The RP's process to manage dispensing errors which reached people was suitable and in line with the pharmacy's procedures. This involved appropriate handling of the situation, formal reporting, and investigation to identify the root cause. Staff also routinely recorded mistakes that occurred during the dispensing process (near miss mistakes). The details were collated and regularly reviewed by the pre-registration trainee pharmacist. This helped identify any trends or patterns. The findings were subsequently discussed with the team to raise awareness. Medicines which looked-alike and sounded-alike (LASA) had been identified, highlighted, and separated with appropriate examples provided to verify.

The pharmacy had processes in place to ensure people's confidential information was protected. No confidential material was left on the front counter. The team shredded confidential waste, the pharmacy's computer systems were password protected and staff used their own NHS smartcards to access electronic prescriptions. Members of the pharmacy team had been trained to safeguard the welfare of vulnerable people. The RP and pre-registration trainee pharmacy were trained to level two and contact details were readily available for the local safeguarding agencies.

The pharmacy had current professional indemnity and public liability insurance. A sample of registers seen for controlled drugs (CDs) had been maintained in accordance with legal requirements. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Fridge temperatures were checked daily. Records verifying this and that the temperature had remained within the required range had been appropriately completed. The RP record was mostly complete, but some details of when the pharmacist's responsibility had ceased were missing. Within the electronic register for supplies made against private prescriptions, incomplete details of prescribers were seen. This was discussed during the inspection.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy provides its services using a team with various levels of experience. Team members are provided with additional resources which helps keep their skills and knowledge up to date. The pharmacy team is up to date with the workload. But just about adequate levels of staff are available to manage this safely. And members of the pharmacy team are under some pressure as a result.

Inspector's evidence

This was a busy pharmacy. Staff at the inspection included the RP who was also the pharmacist manager, a pre-registration trainee pharmacist, a pharmacy technician, and a very newly employed apprentice. All staff were said to be full-time. There were another two dispensing assistants, a medicines counter assistant and one of the dispensers worked as the delivery driver. One dispenser during the inspection was carrying out COVID-19 vaccinations off-site (see Principle 4).

The apprentice asked relevant questions before selling medicines. She knew which medicines could be abused or had legal restrictions and sales of these medicines were monitored. This member of staff had not read the pharmacy's SOPs yet but was being appropriately supervised and directed. Staff knew when to refer to the pharmacist appropriately. The trainee pharmacist confirmed that the RP was his tutor, he was given regular study time and had a training plan in place.

Team members had access to resources for ongoing training. This helped members of the pharmacy team to keep their knowledge up to date, but the training did not appear to be delivered or monitored in a structured way. The inspector was told that there was no contingency cover for staff absence, long-standing staff had not had any performance reviews for some time, they were stressed at times and team meetings despite being held previously no longer occurred. Staff explained that they now had huddles as and when they were required to keep them informed. This was said to be due to being short staffed. The team was however, up to date with the workload and people were observed to be served promptly and efficiently. The inspector was also aware that the RP had recently moved to this pharmacy from another pharmacy owned by the same company.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a suitable environment for the delivery of its services. The pharmacy is presented appropriately. And it has a separate space for private conversations and services to take place.

Inspector's evidence

The pharmacy was based on the ground floor of the building. It was professional in appearance and clean. The pharmacy premises consisted of a large retail area and an appropriately sized dispensary, with the stock room and staff rest rooms towards the rear. The dispensary had enough bench space for staff to carry out dispensing tasks safely. The pharmacy also had a separate consultation room to hold private conversations and provide services. The room was signposted and of an adequate size for its purpose. The lighting and ambient temperature within the pharmacy was appropriate for storing medicines and safe working. The dispensary was screened well which provided appropriate privacy when dispensing prescriptions.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services appropriately. Members of the pharmacy team can make appropriate adjustments to ensure people easily access the pharmacy's services. The pharmacy obtains its medicines from reputable sources. Team members routinely identify people who receive higher-risk medicines, make relevant checks, and record the details. This helps ensure people are provided with appropriate advice when these medicines are supplied. And it largely keeps the appropriate records to verify how its services are being run. But the pharmacy could do more to ensure some of its services are administered in accordance with set protocols.

Inspector's evidence

People could enter the pharmacy through automatic front doors, from the street which were step-free. The pharmacy's main retail area consisted of wide aisles and clear, open space but the area leading to the consultation room was on a higher level and could only be accessed by steps. However, a separate entrance in this area assisted people with restricted mobility or using wheelchairs to easily enter and access the pharmacy's services. Seating was also available for people waiting for their prescriptions. The team said that speaking clearly helped people to lip read, written communication was used for people who struggled to hear easily, or the consultation room was used. Staff were also multilingual and used Google translate if needed. This assisted people whose first language was not English.

The workflow involved prescriptions being prepared by staff in one area before the pharmacist checked medicines for accuracy from another section. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. The baskets were also colour coded which helped identify priority. 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.

Staff routinely identified prescriptions for people with certain medicines or specific situations. This included fridge lines, CDs, if pharmacist intervention was required and for prescriptions with higher-risk medicines. Staff asked details about relevant parameters, such as blood test results for people prescribed these medicines, they recorded this information and referred appropriately when required. Team members were also aware of the additional guidance when dispensing sodium valproate. They ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them, full packs of these medicines were dispensed, and staff had identified people in the at-risk group who had been supplied this medicine. A poster highlighting the risks was on display, but no educational material was readily available to provide upon supply.

The pharmacy supplied medicines inside compliance packs to many people who lived in their own homes, after this was considered necessary and an assessment had taken place. This helped people to manage their medicines more effectively. The team ordered prescriptions on behalf of people. They identified any changes that may have been made, maintained individual records for people who received their medicines in this way. Any queries were checked with the prescriber and the records were updated accordingly. The compliance packs were sealed as soon as they had been prepared. 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. Team members also wore gloves when assembling compliance packs.

People's medicines were delivered to them, and the team kept records about this service to verify who had received their medicines in this way. CDs and fridge lines 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 had begun providing the Advanced NHS service, Pharmacy First Service. The service specification and Patient Group Directions (PGDs) to authorise this were readily accessible and had been signed by the pharmacist. Suitable equipment was present which helped ensure that the service was provided safely and effectively (see Principle 5). The RP had been trained on how to use them. As stated in Principle 1, one dispensing assistant was administering COVID-19 vaccinations to people who were housebound after contacting them by telephone. The RP was said to be in the vicinity to hear the conversation. However, this process was not in line with the National Protocol which enabled administration of these vaccines to be delegated to appropriately trained staff. This was discussed with the RP during the inspection and the team was advised to familiarise themselves with the legal mechanisms underpinning administration as well as to seek further advice from the NHS.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Some medicines stored in the dispensary, however, were stored haphazardly. The team stated that they checked medicines for expiry regularly but there were no current records to verify when this had taken place. Short-dated medicines were identified and on randomly selecting some of the pharmacy's stock, there were no medicines seen which were past their expiry date. CDs were stored securely and the keys to the cabinet were maintained in a way which prevented unauthorised access. Medicines requiring refrigeration were also stored in a suitable way. Out-of-date and other waste medicines were separated before being collected by licensed waste collectors. Medicines which were returned to the pharmacy by people for disposal, were accepted by staff, and stored within designated containers. This did not include sharps or needles which were referred elsewhere appropriately. Drug alerts were received electronically via email. Staff explained the action the pharmacy took in response and relevant 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. The pharmacy also had an appropriately operating pharmacy fridge, a legally compliant CD cabinet and access to current reference sources. Additional equipment for the pharmacy's services included an otoscope and tongue depressors, and blood pressure machines which were new. 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. This helped prevent unauthorised access. Lockers were available for staff to store personal belongings.

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.