General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medics Pharmacy, 11 Dawley Road, Harlington, HAYES, Middlesex, UB3 1LS

Pharmacy reference: 1035024

Type of pharmacy: Community

Date of inspection: 27/07/2022

Pharmacy context

This is an independently owned, community pharmacy. The pharmacy is on a parade of shops and businesses serving the local community in Harlington. It provides a range of services including dispensing prescriptions. And it has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a range of other services, including a COVID-19 vaccination service and a winter flu vaccination service.

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 has suitable procedures to identify and manage risk. It has written procedures in place to help ensure that its team members work safely. And it has insurance to cover its services. The pharmacy team listens to people to improve the quality of the pharmacy's services. And it keeps people's private information safe. The pharmacy's team members know how to protect the safety of vulnerable people.

Inspector's evidence

The team recorded its dispensing 'near misses' on people's patient medication records. It did this to highlight what had gone wrong. And to help prevent the same mistake happening with that person's medicine again. But it did not keep a specific record of its mistakes. The responsible pharmacist (RP) was one of two regular pharmacists. She and the accredited checking technician (ACT) described how they highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. They did this to enable them to reflect on what had gone wrong and learn from it. The team had placed a warning sticker on the shelf edge in front of its stocks of pregabalin to draw attention to the risk of error between it and gabapentin. Team members had also separated look-alike sound-alike medicines (LASAs), such as prednisolone and prochlorperazine, to different areas of the dispensary. They did this to heighten awareness and reduce the risk of selecting the wrong one. But the RP and ACT agreed that if they had a specific record of the team's mistakes it would be easier to review them effectively. And it would provide the team with a better opportunity to learn as much as possible from them. It would also help identify what individuals could do differently next time to prevent mistakes and promote continued improvement.

The pharmacy had put measures in place to keep people safe from the transfer of infections. The team had a regular cleaning routine, and it cleaned the pharmacy's work surfaces and contact points daily. The pharmacy had hand sanitiser for team members and other people to use. And it had put screens up at its medicines counter. The pharmacy had reduced the range of its usual services during the pandemic. It had done this because of staff shortages from time to time and to concentrate on delivering a safe dispensing service and a safe vaccination service. The pharmacy had a set of standard operating procedures (SOPs) to follow. The SOPs were up to date. And team members had read the SOPs relevant to their roles. They understood their roles and responsibilities. The medicines counter assistant (MCA) understood the different hay fever products which the pharmacy had for sale. She knew the advice to give people and which products they could use safely together. She also consulted the pharmacist when she needed her advice and expertise. 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 superintendent pharmacist (SP) who also worked regularly at the pharmacy. Recent customer comments indicated that many people were unhappy if the pharmacy did not have their medicines in stock. And so team members spent time contacting GPs to arrange alternatives so that people did not go without their medicines. And to help this process they had established a direct line with the surgeries' pharmacists where possible. The pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints procedure online. But pharmacists 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 record. 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 pharmacist could not locate any emergency supply records. But she could not recall making any emergency supplies in recent times. This was due to them being able to supply medicines in an emergency under the community pharmacy consultation service (CPCS). The pharmacy generally kept up-to-date records of its private prescriptions. But it was in the process of transferring to an electronic register, so it had several prescriptions still to record. The superintendent agreed that all of the pharmacy’s essential records should have all the necessary details and that they should be up to date. The pharmacy had a CD destruction register for patient-returned medicines.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed training on confidentiality. They discarded confidential paper waste into separate waste bins. And they shredded confidential paper waste as they worked. The team kept people’s personal information, including their prescription details, out of public view. Team members had completed appropriate safeguarding training. And they knew to report any concerns to one of the pharmacists. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's service. The pharmacy generally trains its team members satisfactorily for the tasks they carry out. But it does not do enough to ensure that its temporary staff complete an appropriate training course.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. And the pharmacy had one of its regular part-time pharmacists on duty. The superintendent pharmacist (SP) joined the team part-way through the inspection. The pharmacists worked alongside the ACT, the MCA and a university student. The university student was studying medicine and had completed one year of his course. He was working at the pharmacy, including in the dispensary, for the summer before returning to university for his second year. The student had not had any formal training but instead worked under the supervision of the ACT. The inspector and SP discussed the importance of ensuring that non-pharmacy students undergo an appropriate training programme for the tasks they undertake. Overall, team members were seen to work effectively with one another. And they supported one another to complete their tasks. The pharmacy had a small close-knit team who worked regularly together. They kept the daily workload of prescriptions in hand and they attended to customers promptly. Pharmacists were able to make day-to-day professional decisions in the interest of patients. The RP explained that during the pandemic the pharmacy had felt the pressures of a heavier-than-usual workload. And it had also had staff shortages. But its team members covered extra shifts to help out when they could. And the pharmacy had not had any unplanned closures. Team members could discuss their concerns with the RP and the SP. And they felt supported in their work. They kept their knowledge up to date by reading training material. Pharmacists could make their own professional decisions in the interest of people and did not feel 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. And they are sufficiently clean and secure. The pharmacy has made sensible adjustments to help reduce the risk of the spread of viral infections. And its workspace is tidy and organised.

Inspector's evidence

The pharmacy was on a small parade of shops and local businesses close to Heathrow airport. Its customer area stocked a variety of items related to health care or personal beauty and grooming. It had a pharmacy counter topped with transparent plastic screens to help reduce the risk of transmitting viruses. And it had a small waiting area. It kept its pharmacy medicines behind the counter. And people could also hand in or collect their prescriptions here. The pharmacy had a doorway from the counter area into the dispensary behind. And it had measures in place to prevent unauthorised access.

The dispensary was compact, but it had additional working and storage space alongside it between the counter and the rear exit. The dispensary had a workbench along two sides. And storage shelves on its other walls. Workbenches also had storage areas above and below. And they were tidy and free of clutter. The pharmacy stored its dispensed items and prescriptions so that people’s information was out of view. The pharmacy also had a consultation room. The consultation room had an entrance from the customer area next to the counter. The team kept the consultation room locked when not in use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And it has appropriate procedures to ensure that it supplies its services safely and effectively. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacy had a doorway which provided step-free entry. And its customer area was free of unnecessary clutter, making it suitable for people with mobility issues. The pharmacy could also order people's repeat prescriptions if required. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. The pharmacy also supplied medicines against private prescriptions, some of which came from private online prescribing services. The pharmacy had a vaccination service which it delivered at its premises. But it did not have any demand for the service at the time of the inspection.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. And pharmacists would explain to people how to use their compliance packs when they first started having their medicines this way. The RP described how the pharmacy had limited the number of people who could have their medicines this way. It had done this due to the team's workload and the amount of work involved in preparing the packs. The team had also reviewed how it assessed people's needs before giving them a compliance pack. It did this to ensure that a compliance pack was suitable for them. The pharmacy managed the service according to a four-week rota. And it checked and verified any changes to prescriptions every month. 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. The team labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. But its labelling directions did not give the required advisory information to help people take their medicines properly. The pharmacy supplied patient information leaflets (PILs) with new medicines, but not always with regular repeat medicines. The inspector and the RP discussed the importance of ensuring that people had all the information they needed about their medicines.

The pharmacists gave people advice on a range of matters. And they 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, none of whom were in the at-risk group. The RP knew about the precautions she would need to take, and counselling she would give, if the pharmacy was to supply it to someone new. The pharmacy also had specific procedures for dispensing other high-risk medicines such as lithium. The procedures included guidance on counselling patients on how to recognise signs of toxicity.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And its stock was tidy and organised. It stored its medicines appropriately and in their original containers. The pharmacy team date-checked the pharmacy's stocks regularly. And it kept records to

help it manage the process effectively. A random sample of stock checked by the inspector was in date. Team members identified and highlighted short-dated stock. And they put the pharmacy's out-of-date and patient-returned medicines into dedicated waste containers. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that it kept the medication inside within the correct temperature range. The pharmacy's delivery driver understood the pharmacy's delivery procedures. He knew to ask the pharmacist for any CD items or fridge items which were due for delivery. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And for dispensing into multi-compartment compliance packs. And its equipment was clean. The pharmacy team had access to PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies if they needed them. The pharmacy had several computer terminals which had been placed in the consultation room and in the dispensary. Computers were password protected. Team members had their own smart cards to maintain an accurate audit trail. And to ensure that team members had the appropriate level of access to records for their job roles.

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.