General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: A.C. Curd (Isleworth) Ltd, 55 South Street, ISLEWORTH, Middlesex, TW7 7AA

Pharmacy reference: 1035045

Type of pharmacy: Community

Date of inspection: 25/11/2019

Pharmacy context

An independent pharmacy located in a parade of shops in Isleworth. The pharmacy dispenses NHS and private prescriptions, sells a range of over-the-counter medicines and provides health advice. The pharmacy also provides Medicines Use Reviews (MURs), a New Medicine Service (NMS), multicompartment compliance aids for patients in their own homes, substance misuse and sexual health services and a delivery service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy is not adequately assessing or managing the key risks to patient safety.
		1.2	Standard not met	The pharmacy does not keep adequate records of the mistakes it makes, and it does not review or learn from them.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is very cluttered and untidy. This increases the likelihood of a mistake occurring.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy is not recording the fridge temperatures on a daily basis. So cannot provide sufficient assurance that all of its medicines are safe for people to take.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy is not working in a sufficiently safe manner. As a result, it is unable to satisfactorily manage all the risks associated with its services. It does not record all its near misses or errors, so it may be missing opportunities to prevent similar mistakes happening again in the future. The pharmacy does not keep all records it is required to by law. This may make it harder to easily detect and correct any discrepancies. Its team members understand their role in protecting vulnerable people, and they generally keep people's private information safe

Inspector's evidence

Near misses were recorded in a log held in the dispensary, but in 2019, only 7 entries had been made. The pharmacist explained that it had been a while since they had recorded a near miss. The pharmacist explained that errors which left the premises would be recorded on patient records, but they did not have any errors as two pharmacists were always working in the dispensary completing the dispensing and checking.

Standard operating procedures (SOPs) were in place for some off the dispensing tasks but had not been updated since 2015. The pharmacy had a new set of SOPs from the NPA, but these had not yet been implemented. The lack of up-to-date SOPs had been raised in the last inspection, but improvements had not been made. A certificate of public liability and professional indemnity insurance from the NPA was available and valid until the 31st July 2020. There was a complaints procedure in place and staff were clear on the processes they should follow if they received a complaint. All complaints would be referred to the pharmacist and the team completed the Community Pharmacy Patient Questionnaire (CPPQ) annually.

Records of controlled drugs and patient returned controlled drugs were complete and accurate. A sample of Sevredol 10mg tablets was checked for record accuracy and was seen to be correct. The pharmacy held the responsible pharmacist recorded in a book, but it had not been completed for a week. The responsible pharmacist notice was displayed in the pharmacy where patients could see it, but two responsible pharmacist notices were on display during the inspection and one of the notices was for a pharmacist not present. The maximum and minimum fridge temperatures had not been recorded since August 2019, but during the inspection, the maximum and minimum fridge temperature were in range. The private prescription records were completed accurately. Specials records were complete with the required information documented.

The computers were all password protected and the screens were not visible to the public. Confidential information was stored away from the public and conversations inside the consultation room could not be overheard. There were cordless telephones available for use and confidential waste paper was shredded. The locum pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) Level 2 training programme on safeguarding vulnerable adults and children and the team members were aware of things to look out for which may suggest a safeguarding issue. A list of the contact details for all the local safeguarding authorities was available electronically on the NHS website.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services safely. Team members have access to training materials to ensure that they have the skills they need. Pharmacy team members make decisions and use their professional judgement to help people.

Inspector's evidence

During the inspection, there were two pharmacists and two medicines counter assistants present. Certificates of completed training were available and staff were seen to be working well together. One of the medicines counter assistance was observed using an appropriate questioning technique to find out more information when someone presented at the pharmacy with symptoms of a migraine. She described different products allowing the person to make an informed decision before counselling them effectively. The team did not have a formal on-going training programme, but they completed training on Alphega tablets. The team members had their own login details where they could complete training modules and receive certificates. The team also received information from various sources such as Pharmacy magazine and Training Matters.

The team members were able to raise anything with one another whether it was something which caused concern or anything which they believed would improve service provision. A whistleblowing policy was in place in the SOPs which the team had signed. There were no targets in place and the team explained that they would never compromise their professional judgement for business gain.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy’s premises are cluttered and untidy which increases the risk of mistakes happening. Pharmacy team members use a private room for some of its services and for sensitive conversations with people. The pharmacy is secure when closed.

Inspector's evidence

The pharmacy was based on the ground floor of the building and included a retail area, medicine counter, dispensary, consultation room, a treatment room and a staff area. The pharmacy had not been refitted or redecorated for many years and the general clutter compromised the professional appearance of the pharmacy. Workspace was limited due to the workbenches being cluttered with stock, paperwork and prescriptions.

The products for sale around the pharmacy area were healthcare related and relevant to pharmacy services. The ambient temperature was suitable for the storage of medicines and lighting throughout the pharmacy was appropriate for the delivery of pharmacy services. Medicines were stored on the shelves in a suitable manner. There was a sink available in the dispensary which was very stained and had signs of mould growth.

The dispensary was screened to allow for the preparation of prescriptions in private and the consultation room was available for private conversations. Conversations in the consultation room could not be overheard.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy cannot give adequate assurance that all its medicines are safe for people to take. Although it gets its medicines from reputable sources, it does not satisfactorily record the temperatures of both of its fridges. But the pharmacy does ensure that its services are accessible to people with different needs.

Inspector's evidence

Pharmacy services were not displayed in the pharmacy or online on the nhs.uk website. There was step-free access into the pharmacy and seating was available should people require it when waiting for services.

The pharmacy team prepared multicompartment compliance aids for domiciliary patients. The compliance aids did not include the descriptions, but the pharmacist explained he would include descriptions if a patient received a new medicine or their regular brand changed. The pharmacy team was aware of the requirements for women in the at-risk group to be on a pregnancy prevention programme if they were taking valproates. They had checked the PMR to see if they had any patients in the at-risk group and placed notes on their PMR regarding counselling. There was an information pack about the risks of valproates in the dispensary which the team would use when dispensing prescriptions for valproates to patients in the at-risk group. The pharmacist explained that they would ask patients taking warfarin if they were aware of their dose and if they were having regular blood tests, but they did not always document details of the blood test results. Dispensing labels were signed to indicate who had dispensed and who had checked a prescription.

The pharmacy was not yet compliant with the European Falsified Medicines Directive (FMD). The pharmacist explained they had a scanner in place and an FMD program, but they were not currently using it. The pharmacy obtained medicinal stock from Alliance, AAH, Phoenix, NWOS and Sigma. Invoices were seen to verify this. Date checking was carried out regularly by the team, but they did not keep records of this. There were denaturing kits available for the destruction of controlled drugs and designated bins for the disposal of waste medicines were available and seen being used for the disposal of medicines returned by patients. The fridge appeared to be in good working order, but the team did not record the maximum and minimum fridge temperatures. The CD cabinets were appropriate for use and secured to the wall of the pharmacy in line with regulations. Expired, patient returned CDs and CDs ready to be collected were segregated from the rest of the stock. MHRA alerts came to the team via email and they were actioned appropriately. The team had recently actioned a recall for folic acid.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities to provide its services safely. These are clean and fit for purpose.

Inspector's evidence

There were several clean crown-stamped measures available for use, including 100ml, 50ml and 10ml measures. Amber medicine bottles were seen to be capped when stored and there were counting triangles available as well as capsule counters. Up-to-date reference sources were available such as a BNF and a BNF for Children as well as other pharmacy textbooks. Internet access was also available should the staff require further information sources and the team could also access the NPA Information Service. The computers were all password protected and conversations going on inside the consultation room could not be overheard.

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.