General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gill Chemists, 31-33 King Street, SOUTHALL, Middlesex, UB2 4DG

Pharmacy reference: 1035118

Type of pharmacy: Community

Date of inspection: 05/02/2020

Pharmacy context

This is an independently owned community pharmacy on a busy high street running through the centre of Southall. As well as the NHS Essential Services it provides Medicines Use Reviews (MURs), New Medicines Service (NMS), a delivery service and multi-compartment compliance aids for people living in the local community and the residents of local nursing homes. The pharmacy provides a seasonal flu vaccination service, a travel vaccination and malaria prophylaxis service and a supervised consumption service for substance misuse clients.

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's working practices are safe and effective. Its team members understand their responsibilities in helping to protect vulnerable people. They listen to people's concerns and keep their information safe. They discuss any mistakes they make and share information to help reduce the chance of making mistakes in future. The pharmacy has adequate insurance in place to help protect people if things do go wrong. But the pharmacy is not thorough enough in the way that it captures information which will help the team to learn and improve.

Inspector's evidence

Staff worked under the supervision of the responsible pharmacist (RP) whose sign was displayed for the public to see. There was a set of standard operating procedures (SOPs) in place. And staff had read and signed the SOPs relevant to their roles. The pharmacy had procedures for managing risks in the dispensing process. All incidents, including near misses, were discussed at the time and recorded. When a near miss was discovered the pharmacist challenged staff to identify what was wrong with what they had dispensed. Through discussion, staff were encouraged to identify what had led to the mistake and what could be done differently in future. But near miss records tended to repeat the same contributory factors and learning points, where the prescription had been misread and staff should check the product against prescription. This had been repeated on many occasions in consecutive months. So, it seemed that more specific guidance was required, to help the team to further reflect on what had gone wrong. And to help them identify any mistakes before transferring the dispensed item to the RP for an accuracy check.

However, it was clear that staff were aware of the risk of error. The pharmacist described how the stocks of various look-alike-sound-alike drugs (LASAs), such as amitriptyline and amlodipine, and azathioprine and azithromycin, had been re-organised and separated, non-alphabetically. This was done to help draw the attention of staff and focus their selection of the correct one. The team had also separated stock into branded, fast-moving and slow-moving lines. And had put warning stickers next to at-risk products to help reduce errors. The team had regular meetings in which they would review and discuss any mistakes. And identify ways of preventing a reoccurrence.

The team described how they ordered the same brands of medicines for certain people to help meet their needs. Customer preferences included the Almus brand of lansoprazole and omeprazole, the Teva brand of amlodipine, and the Wockhardt brand of levothyroxine. However, this was only done for patients for whom it was necessary as it was not always possible to get the same brands each time. Notes were added to patient medication records (PMRs) as a reminder for staff. The team also sought feedback through customer satisfaction surveys. A small number of respondents to last year's survey indicated that they would like support to stop smoking. So, even although the stop smoking service was no longer commissioned locally, staff still offered support and counselling, if required, to people buying stop smoking products. The pharmacy had a documented complaints procedure. A SOP for the full procedure was available for reference. Where possible, customer concerns were dealt with at the time by the regular pharmacist and superintendent. And formal complaints were recorded. But staff said complaints were rare. The pharmacy had professional indemnity and public liability arrangements so, they could provide insurance protection for staff and customers. Insurance arrangements were in place until 31 August 2020 when they would be renewed for the following year.

All the necessary records were kept and were generally in order including Controlled Drug (CD) registers and records for unlicensed 'Specials' and the RP. Records for emergency supplies were generally in order although several did not provide a clear reason for supply. And for emergency supplies requested by a prescriber, records did not always show the date on which the prescription was received. Records for private prescriptions were largely in order. But the pharmacy had yet to receive the original prescription for a supply made two months earlier, where the supply had been made against a prescription with a photocopied signature. The pharmacy had records for CDs, which had been returned by people, for destruction. Records of returned CDs were kept for audit trail and to account for all the non-stock CDs which RPs had under their control.

Staff had had been briefed on confidentiality, information governance and GDPR. Discarded labels and tokens were disposed of in a confidential waste bin, for collection by a licensed waste contractor. Completed prescriptions were stored in the dispensary where patient details could not be viewed from customer areas. The pharmacist had completed level 2 CPPE training for safeguarding vulnerable adults and children. Other staff had been briefed and knew to alert the pharmacist with any concerns. All staff had completed dementia friends training. The pharmacy team had not had any specific safeguarding concerns to report. Contact details for the relevant safeguarding authorities were available online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Team members can make suggestions and get involved in making improvements to the safety and quality of services provided. They work effectively together in a supportive environment. But not all pharmacy staff have the appropriate skills and qualifications for their roles or, are working towards obtaining these.

Inspector's evidence

On the day of the inspection the RP was supported by a qualified pharmacist who had chosen to come off the GPhC register and was working as a dispenser, a second dispenser, a pre-reg, two medicines counter assistants (MCAs) and a newly appointed trainee MCA. However, one of the MCA's had worked at the pharmacy for five years and had not completed a formal training course. And another was observed putting dispensary stock away even although she had not received any formal dispensing training. But team members were observed to work well together. They assisted each other when required and regularly discussed matters relating to the business of the day. The daily workload of prescriptions was in hand and customers were attended to promptly.

The pharmacist was observed supervising and overseeing the sales, supply and advice given by staff and staff were observed to be working well as a team. Staff were observed asking appropriate questions and providing advice when making recommendations and were also seen referring patients to the pharmacist when necessary. The dispenser described being able to raise concerns. He said he had regular informal discussions with the superintendent and pharmacists, whom he found to be approachable. He described how he and his colleagues had become concerned over groups of people repeatedly requesting sales of items which could be abused. The sales were referred to the pharmacist and refused. Staff would have informal discussions during which they could make suggestions and raise concerns and give encouragement to one another. The pharmacist said that the pharmacy was not set targets for NMS and MURs. And she felt able to make her own professional decisions in the interest of patients. She described how she would offer an MUR or NMS when she felt it would be of real benefit someone.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, organised and professional looking. They provide a safe, secure environment for people to receive healthcare services. The pharmacy has laid out its premises in a way which protects people's privacy, dignity and confidentiality.

Inspector's evidence

The pharmacy was in a built-up area of north west London. It was on a busy main road, in the centre of the town. It had a bright modern appearance with a double front, full height windows and a double glass door to provide natural light. The shop floor was to the front with the dispensary behind. The shop floor was clear of obstructions and wide enough for wheelchair users. There was a small seating area for waiting customers. Items stocked included a range of baby care, healthcare, beauty and personal care items.

The pharmacy had a consultation room which the pharmacist used for private conversations and services such as MURs. It also had a separate room which was used by an optician for optical services. The doors to these rooms were adjacent to the dispensary but behind the counter. The pharmacy had a gate between the counter and consultation room and dispensary, to prevent people from venturing behind the counter unsupervised. The dispensary was on a raised plinth allowing staff to oversee the counter and shop floor. This was useful when counter staff got busy and or needed extra help. The dispensary was relatively spacious. It had a six to seven metre curved dispensing bench to the front. And an island in middle with a sink. The island had a Perspex barrier running down the middle which created in two distinct working areas.

The pharmacy had a separate room behind the dispensary, where the pharmacist dispenser did the multi-compartment pack dispensing. And it had another room on the opposite side which was used for dispensing nursing home compliance packs. This room had a nine to ten metre u-shaped run of dispensing bench and a sink. The area of dispensing work surface overlooking the shop was where staff dispensed and checked 'walk-in' prescriptions. Work surfaces were free of unnecessary clutter and there was a clear work flow. Overall, the dispensary was clean, tidy and organised. To the basement of the premises the pharmacy had a staff area, toilet and a storage room with a fire door to the outside. Staff areas were clean. The pharmacy was tidy and organised and had a professional appearance. Shelves, worksurfaces, floors and sinks were clean.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally delivers its services in a safe and effective manner. And, people can easily access them. The pharmacy generally sources, stores and manages medicines safely. And it carries out checks to make sure its medicines are fit for purpose. But it does not label all of its medicines with enough detail, once they have been removed from their original packs. Staff try to make sure they give people the advice and information they need to help them use their medicines safely and properly. But they do not do this for all services.

Inspector's evidence

The pharmacy's services were advertised at the front window, but the list needed updating. The list included smoking cessation and minor ailments services which were no longer available and did not include the travel vaccination service which was. There was a small range of information leaflets available for customer selection. The pharmacy had step-free access and its shop floor was wide enough for wheelchair users to move around. And, although the consultation room was small, it was just big enough for wheelchair access, which meant that wheelchair users could access services requiring a private consultation, such as an MUR. The pharmacy offered a prescription collection service although the need was rare. It also had a prescription ordering service for those who had difficulty managing their own prescriptions such as patients using multi-compartment compliance packs. The pharmacy's healthy living pharmacy display area was displaying the NHS message on antibiotics awareness.

There was a set of SOPs in place. But they were in need of review and update. The SOP for multi-compartment compliance pack dispensing had not been reviewed since 2013. And the RP could not locate a SOP or service level agreement for the health checks service. In general, staff appeared to be following the SOPs. They carried out a full CD stock audit on a regular basis although not every week end as described in the SOP. But the quantity of stock checked (Zomorph 30mg capsules) matched the running balance total in the CD register. Multi-compartment compliance packs were provided for people who needed them. The labelling directions on compliance packs gave the required BNF advisory information to help people take their medicines properly. Product information leaflets (PILs) were offered to patients with new medicines although not with repeat medicines. And compliance packs didn't give a description of the medicines they contained, including colour and shape, which means that people may not have been able to identify their medicines. The pharmacy had conducted national NHS audits for sodium valproate and NSAIDs and were currently conducting a diabetes check audit for foot and eye screening and asthma inhaler use. In each case, several patients had been appropriately counselled and referred back to their GPs.

The pharmacist understood the risks to people in the at-risk group taking sodium valproate. Packs of sodium valproate in stock bore the updated warning label. The pharmacist had warning cards and leaflets for any new patients and extra warning labels for supplies made in plain white cartons. Additional warning labels had been added to shelves and drawers next to valproate products to act as a reminder for staff. The pharmacy's audit on NSAIDS had identified that all patients taking an NSAID had also been prescribed with a PPI. The pharmacy ordered the same brands of medicines for certain people to help with compliance. Notes were added to individual patient medication records (PMRs) to ensure they were dispensed for those who needed them.

The pharmacy had up-to-date PGDs and service specifications for both the private and NHS flu vaccination services. People were briefed on what to expect when receiving a vaccination and asked to complete a consent form. Records were kept of the consultation for each vaccination, including details of the product administered. The pharmacy had procedures in place for managing an anaphylactic response to the vaccination. The pharmacy had the equipment and software for scanning products in accordance with the European Falsified Medicines Directive (FMD) and were scanning packs with a unique barcode. Medicines and Medical equipment were obtained from: AAH, Alliance Healthcare, DE South and Sigma. Unlicensed 'specials' were obtained from IPS. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion.

The pharmacy had several substance misuse clients. Each supply was made up when the client came into the pharmacy for it. The pharmacy used a Methameasure automatic methadone dispensing system. But the same container had been in use for several months and required changing. The Thornton and Ross brand of methadone used had an expiry date of 28 days after opening. When a bottle was opened staff marked it with the date, to indicate that it would expire 28 days from that date. The pharmacy had a loose strip of senna tablets on its shelf which had no visible expiry date. It also had a large glass bottle bearing a dog-eared label describing the contents as ranitidine 150mg tablets. The label also gave their batch number and expiry date. But the packaging did not show any manufacturer's information such as a PL number. When questioned the pharmacist said that it was unlikely that this bottle of ranitidine had been checked as part of recent MHRA recalls for certain brands and batches of ranitidine.

A CD cabinet and a fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read and recorded daily. General stock was regularly date checked and records kept. Stock within six months of its expiry was highlighted by applying a rubber band. This made the packs easier to identify and remove from storage when the time came. Expired and patient returned medicines were put in the Doop bin for collection by a licensed waste contractor. CDs for disposal were denatured first. But, in the CD cabinet, there was a pack of Temgesic 200mcg which had expired at the end of the previous month. And a pack of BuTrans 5mcg patches which was due to expire at the end of the current month. Neither pack had a rubber band around it nor were their expiry dates highlighted. But they had been placed in the door away from other stock. Staff did not have a list of hazardous waste to refer to, which would help ensure that they were disposing all waste medicines appropriately. The RP received MHRA alerts for drug safety alerts and recalls. She also received a personal email from the RPS. And so, recalls and safety alerts were generally responded to promptly. The RP described responding to the January recall for levothyroxine tablets. A recall for ranitidine tablets from the day before had also been checked and no stocks found. The bottle of loose ranitidine tablets were checked during the inspection. They did not appear to belong to any of the recalled batches.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. In general, the pharmacy uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures and tablet triangles were of the appropriate BS standard and clean. And amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris. CD denaturing kits were used for the safe disposal of CDs. The pharmacy team had access to reputable and up-to-date information sources such as the BNF, the BNF for children and the drug tariff. Pharmacists also used NPA advice line service. The RP had access to the BNF online and a range of reputable online information sources such as EMC, NHS and NICE.

There were six computer terminals available for use in the dispensary. All computers had a PMR facility. They were password protected and were out of view of patients and the public. The RP and staff were using their own smart cards when working on PMRs. Staff used their own smart cards to maintain an accurate audit trail and to ensure that access to patient records was appropriate and secure. Patient sensitive documentation was stored out of public view in the pharmacy. And the pharmacy had a shredder for disposing of confidential paper waste.

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.