General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Phillips Chemist, 84 High Street, Yiewsley, WEST DRAYTON, Middlesex, UB7 7DS

**Pharmacy reference:** 1035188

**Type of pharmacy:** Community

**Date of inspection:** 08/03/2023

## Pharmacy context

This is a community pharmacy in the centre of West Drayton. The pharmacy provides a range of services including dispensing private and NHS prescriptions. And it has a selection of over-the-counter medicines and other pharmacy related products for sale. It dispenses medicines into multi-compartment compliance packs for people who have difficulty managing their medicines. And it offers a blood pressure measuring 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 does not adequately identify the risks associated with all its services. And it does not take suitable action to properly investigate and resolve problems after it has identified them. |
| | | 1.6 | Standard not met | The pharmacy does not complete all of its records in the way it must. And it does not take sufficient action to investigate issues arising from them. |
| **2. Staff** | Standards not all met | 2.1 | Standard not met | The pharmacy does not have enough staff with the right skills to manage all its workload effectively. |
| **3. Premises** | Standards met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Standards not all met | 4.3 | Standard not met | The pharmacy does not ensure that it stores and manages all its medicines appropriately. |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance **Standards not all met**

### Summary findings

The pharmacy does not adequately identify and manage the risks associated with all of its services. And it does not take suitable action to prevent things going wrong in the future. The pharmacy does not do enough to ensure that it completes its records in the way it needs to by law. And where it identifies problems, the pharmacy is not thorough enough, or timely enough, in the actions it takes to resolve them. The pharmacy has adequate written procedures in place to help ensure that its team members work safely. But team members do not always follow them properly. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy has insurance to cover its services.

### Inspector's evidence

The team had a system for recording its 'near miss' mistakes and errors. But it did not always record them. And the records it did keep did not contain much detail. But the responsible pharmacist (RP) described how she highlighted and discussed near misses and errors with team members as soon as she discovered them. And she reviewed them each week. She then discussed them with the team in a weekly team meeting. She did this to ensure that team members had learned from their mistakes. And to reduce the chance of them making the same mistake again. The inspector discussed with the team the importance of recording what it had learned from its mistakes and any actions arising from them. They discussed how this would provide more information for reviews. And it would help the team to continually improve their dispensing procedures. They agreed that near miss mistakes should prompt staff to identify what they could do differently to help them avoid making a similar mistake again. But although the team had not kept full records of its near misses it had taken steps to reduce the risk of making mistakes. The pharmacist described how the team had reviewed its procedures for labelling. It had done this to ensure that its labels gave clear directions to people on how to take their medicines. And to ensure that the team did not print labels with abbreviated terms used by prescribers, which may not make sense to people. They also described how they took extra care with medicines which look alike and sound alike (LASA) such as atorvastatin 10mg tablets and amlodipine 10mg tablets to reduce the chance of dispensing the wrong one. The pharmacy also received regular updates from the superintendent. The updates highlighted areas of risk as well as providing general business information. And a recent update had prompted the team to review its prescription hand out procedures. The updates also provided details of what the company's expected of its pharmacists regarding the delivery of services.

The pharmacy had a set of standard operating procedures (SOPs) to follow. But the SOPs had not been fully updated for several years. And so, they were under review. But team members had not all read the SOPs relevant to their roles. And they did not always follow them. Stock put onto shelves was not always rotated so that newer stock was placed behind older stock. And while the SOP for dispensing multi-compartment compliance packs directed that the packs were labelled before a final accuracy check, this did not always happen. But team members generally understood their roles and responsibilities and the trainee medicnes counter assistant (MCA) was seen consulting 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 gave feedback directly to team members with their views on the quality of the pharmacy's

services. The Pharmacy also had a complaints procedure to follow. And the team knew how to provide people with details of where they should register a complaint if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. During the inspection, several people were unhappy that their prescription had not arrived or that their medicines were not ready or available. And some people took their frustration out on team members and were verbally unpleasant to them. The team chased prescriptions up when they had time, but staff shortages meant that this was not always possible. The trainee MCA and pharmacist were observed handling customers well under difficult circumstances. And they asked people to come back later if problems with their prescriptions could not be sorted out 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 responsible pharmacist (RP) record. The pharmacy did not have records for emergency supplies requested by patients as it did not make any. Instead, it supplied medicines in an emergency through the NHS Community Pharmacy Consultation Service (CPCS). But its records for emergency supplies requested by prescribers were in order. Its private prescription records were generally in order. But many entries did not show the address of the prescriber which was necessary to make them comply with requirements. And it had a backlog of records to make for private prescriptions received in the previous three weeks. The pharmacy had the appropriate records for controlled drugs (CD) register. And it had a CD destruction register for patient-returned medicines. But both the CD register and the CD returns register required the team to take action to ensure that they were accurate and up to date. The pharmacy maintained and audited its CD running balances. It was not clear that all team members understood the importance of ensuring that all the pharmacy’s essential records were complete and up to date.

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 bags. These bags were collected for destruction by a licensed waste contractor each week. The pharmacy kept people’s personal information, including their prescription details, out of public view. And it had a safeguarding policy. Team members had completed appropriate safeguarding training. And they understood their safeguarding responsibilities. They had a SOP to follow. And they knew to report any concerns to the pharmacist or head office for action. The team could access details for the relevant authorities online.

## Principle 2 - Staffing **Standards not all met**

### Summary findings

The pharmacy does not have enough staff to manage all its workload effectively. And so, it is behind with its tasks. Its team members work very hard to support one another. And to complete their duties. But while they are able to provide feedback to one another, the pharmacy doesn't give them enough additional support to improve the quality of its services.

### Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. The RP on the day of the inspection was a locum who had worked full-time at the pharmacy for two months. Other team members present included a dispensing assistant (DA) and the trainee MCA. But the pharmacy was behind with its overall workload. It had two days' worth of prescriptions to be dispensed. And it also had a large backlog of dispensed prescriptions waiting to be checked. It also had yet to put away stock which had been delivered the week before. The team reported that this was an ongoing situation. The team worked hard to complete its dispensing tasks. At the same time, it dealt with people waiting for prescriptions or advice. And the continuous queue of people waiting to be attended to. The team did not have time to answer the phone throughout the inspection. And so, it often rang out. The team reported that it was short staffed, with team members absent due to illness or holidays. So, on most days it had only two team members working alongside the RP. But this was not enough to keep on top of the dispensing workload and its other tasks. And while a neighbouring branch occasionally provided support staff to help, it did not always have enough staff available. During the inspection, the team tried several times to close the pharmacy so that they could take a break and have lunch. But the constant stream of people prevented them from doing so until 2.45pm. And while the team only closed the pharmacy for a short time, people continued to knock loudly on the door. Apparently frustrated that the pharmacy was closed.

The pharmacist did not have the opportunity to deal with the backlog of dispensed prescriptions waiting to be checked. And so, many prescriptions were not ready for people. And had to be dispensed and or checked when they came in for them. And so, it was clear that although the team managed the immediate workload sufficiently, it was under pressure to do so. And it was having difficulty in managing all its tasks in a timely way. Staff described feeling under pressure. And while they worked well with one another, they had raised concerns about staff shortages and workload to their line managers. Team members discussed issues as they worked. And the pharmacist made day-to-day professional decisions in the interest of people. She felt the pressures of such a busy prescription service. And while she felt under pressure to provide other services, she did not provide other services when the prescription service required her full attention. The team had not had any reviews about their work performance recently. But they discussed issues with each other as they worked.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy provides a minimally adequate environment for people to receive its services. And it is sufficiently secure. But while it provides an adequate amount of space for its services, the pharmacy's workspace and storage areas are not sufficiently clean, tidy and organised. And they are not properly maintained.

### Inspector's evidence

The pharmacy had a small retail area. It had a consultation room and a small waiting area. And it had a small medicines counter with the dispensary behind. The pharmacy had screens on top of its counter to help protect people from the transfer of infections. The dispensary had worksurfaces on all sides. And it had two islands in the middle. The pharmacist used an area of worksurface close to the counter to carry out clinical and accuracy checks on prescriptions. And from here she could easily go out to the counter to counsel people and give them advice. The pharmacy used its dispensary islands to make up multi-compartment compliance packs and repeat prescriptions. And to check off stock from wholesalers' deliveries.

The team cleaned the pharmacy's worksurfaces when it had time. And it tried to keep the premises tidy and organised. But it was clear that the team had not had much opportunity to carry out general housekeeping tasks for some time. The dispensary did not have much free worksurface due to a build-up of prescriptions and stock. Floors were also cluttered with tote, boxes, items for delivery, bulky stock and wholesalers' deliveries waiting to be put away. And the inspector found a pot of medicines which had fallen into a tote box of dispensed prescriptions on the floor. The dispensary floor was badly marked and scuffed, and it had a covering of dust and debris. And it did not look clean. The pharmacy's walls and fixtures and fittings were chipped, marked and scuffed. And they also did not look clean. The pharmacy's shelves also had a layer of dust and dirt. And it was apparent that the pharmacy had not had its general décor refreshed for many years.

The pharmacy had staff facilities and a rear exit door from the dispensary. It used an area of counter-top for making drinks and preparing food. This area was also used for dispensing but was cleared of staff utensils and food before use. The pharmacy had storage areas above and below its work surfaces. And it had pull-out drawers and shelves for storing medicines and completed prescriptions awaiting collection. Dispensed items and prescriptions were stored so that people's information was kept out of view. The consultation room was close to the dispensary. And the team locked it after use.

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

### Summary findings

The pharmacy does not ensure that all its stocks of medicines are packaged and labelled correctly. Or managed appropriately. But it generally provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. And it ensures that it supplies its medicines with the information that people need to take their medicines properly. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing.

### Inspector's evidence

The pharmacy promoted its services and its opening times on its windows and doors. It had step-free access. And the team kept the retail area relatively free of clutter and unnecessary obstacles. The pharmacy had a chargeable delivery service for people who could not visit the pharmacy to collect their prescriptions. And it also ordered some people's repeat prescriptions for them. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing to help avoid errors.

The pharmacy provided medicines in multi-compartment compliance packs for people who needed them. The pharmacy's labelling directions on compliance packs gave the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines and with regular repeat medicines. And it labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. But one compliance pack which had not yet been checked gave an inaccurate description of one of the tablets. Team members gave assurance that the pack would not be issued. The pharmacy organised its compliance pack service in accordance with a rolling four-week cycle.

The RP gave people advice on a range of matters. And she explained how she gave the appropriate advice to anyone taking higher-risk medicines. The pharmacy dispensed prescriptions to a small number of people taking sodium valproate medicines. Team members were unsure if this included people in the at-risk group. The RP was aware of the counselling she would need to give when supplying the medicine to ensure that people taking it were on a pregnancy prevention programme. The pharmacy had the appropriate warning cards and leaflets, and staff could locate them. But it was not clear that all dispensary team members had a clear understanding of the risks associated with valproate medicines. And their responsibilities to provide counselling and the appropriate patient cards and information leaflets each time.

The pharmacy offered a hypertension case finding service. And the pharmacist used the pharmacy's patient medication record (PMR) system to identify people who might benefit from the service. These were often people on regular repeat prescriptions. The RP also referred people back to their GP where further medical intervention was required. The RP had referred several people to their GPs following a high blood pressure reading. And several of those had returned to the pharmacy with a prescription for blood pressure lowering tablets. The pharmacy, like many others, had been unable to obtain several commonly prescribed medicines in recent weeks and months. But during the inspection the RP contacted its neighbouring branch to obtain enough tablets to make a part supply for a prescription. This meant that the patient would not go without while the team tried to obtain the rest of the medicine.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And in general, the team stored its medicines, appropriately. And stock on the shelves was mostly tidy and organised. But it did not always rotate its stock according to expiry date. This meant that sometimes newer stock was dispensed before slightly older stock. It also had one pack of medicine with two distinct brands of the medicine inside it. And the strips had two different expiry dates. And so, the additional strip could be missed if it were part of a medicines recall or safety alert. The inspector discussed this with the team, and they agreed that team members should review their understanding of the correct procedures to follow when putting medicines back into stock after dispensing. RP and DA agreed that all medicines should be stored in the manufacturer's original packaging where possible. The pharmacy had not had time to date-check its stocks recently. But when it did it kept records to help the team manage the process effectively. The team also conducted an expiry date check as part of its dispensing process. Short-dated stock was generally identified and highlighted. But the inspector found a pack of capsules which had not been highlighted although it was due to expire at the end of the next month. Highlighting medicines with a short shelf life remaining allowed the team to identify them more easily. So, they could be dispensed only where they could be taken by the patient before the expiry date. Or removed from stock. The team put its out-of-date and patient returned medicines into dedicated waste containers. It stored its fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy received notifications about drug recalls and safety alerts by email. And the team checked its emails daily. It reported that it 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 services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's confidential information safe.

### Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources, including access to the internet to provide it with up-to-date clinical information. The team had access to personal protective equipment (PPE), in the form of sanitiser, face masks and gloves if they needed them. The pharmacy had several computer terminals which had been placed in the consultation room and the dispensary. Computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones to enable the team to hold private conversations with people.

## 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. |