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: 01/11/2023

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 met**

Required Action: None

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 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 written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it generally completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy adequately identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The pharmacy had systems in place for recording its mistakes. The responsible pharmacist (RP) described how she highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. She did this to help prevent the same mistake from happening again. The team had been made aware of the risk of confusion between look-alike sound-alike medicines (LASAs). And it recognised that mistakes could occur between them. These included medicines such as such as ramipril tablets and ramipril capsules. The team was aware that when they were dispensing a LASA it should prompt an additional check of the item they were selecting. But while the team usually recorded its mistakes, and discussed them, the records did not all show what team members had learned or what they would do differently next time. So that they could prevent the same or a similar mistake. The pharmacy did not have a formal process for reviewing its near miss records. But it reviewed the records periodically. The RP agreed that if the team had more details of what it had learned from its mistakes, along with more frequent reviews, she could monitor them more effectively. She agreed that this would provide team members with a better opportunity to learn. And it would allow them to identify steps in their dispensing procedures which would help avoid mistakes in future. As well as any other follow up actions which would lead to individuals improving their procedures. And this would contribute to their overall learning and improvement.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) for its team members to follow. Team members had all read the SOPs. And they generally understood their roles and responsibilities. The trainee medicines counter assistant (MCA) had been trained on the procedures to follow when selling pharmacy medicines and general items. And when handing out people's prescriptions. She consulted the pharmacist and her other colleague regularly when she needed their advice and expertise. And she asked people appropriate questions about their symptoms and any other medicines they were taking. She did this to ensure that the medicines she sold to people were right for them. And when appropriate, to help the pharmacist decide on the best course of action for them. She could also access the pharmacy's patient medication record system (PMR) to help her to find people's prescriptions. The dispensing assistant (DA) consulted the RP when he needed her advice and expertise. And he accessed, used and updated the pharmacy's PMR system competently. The RP had placed her RP notice on display showing her name and registration number as required by law.

The pharmacy 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. And people could provide feedback with their views on the quality of the pharmacy's services

directly with the team if they needed to. The RP commented that, the pharmacy had experienced a lot of medicines shortages over recent months. And at times, people were unhappy that the pharmacy could not get their medicines for them. These issues were often out of the pharmacy's control, as the problem often arose with medicines which were unavailable from the manufacturer. But, to help the situation, the team referred people back to their GP for an alternative as soon as they recognised a prescription for an unavailable item. And when someone had already waited for an item to come back into stock team members called the surgery to arrange for alternatives on their behalf. The trainee MCA was observed handling people's queries well. And the pharmacist stepped in to support her when needed or asked her colleague to. 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 RP record and its records for emergency supplies. The pharmacy kept its controlled drug (CD) registers properly. And in recent months it had improved the organisation of each of its registers so that they were easier to find and to complete. It also kept a record of its CD running balances. And in general, it audited its running balances each week. A random sample of CD stock checked by the inspector matched the running balance total in the CD register. The pharmacy also had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. This was generally complete and up to date. The pharmacy's private prescription records were generally in order. But they did not all include the full prescribing details. After discussing record keeping with the RP, it was clear that she understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. Throughout the day they discarded confidential paper waste into a large, clearly labelled, basket. And when this was full, they discarded the contents into confidential waste bags. These bags were then collected for destruction by the company. The team kept people's personal information, including their prescription details, out of public view. Following the last inspection, the team relocated its dispensed prescriptions awaiting collection, to the back of the dispensary where they could not be seen by the public. The RP had completed appropriate training on safeguarding vulnerable adults and children. And team members had been briefed. And they knew to report any concerns to the pharmacist. The RP had recently updated contact details for the local safeguarding authorities and had placed these on a notice on the wall, where they could be easily seen. The team could also access details for the relevant safeguarding authorities online. But it had not had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just enough staff to manage all its workload effectively. And its team members work hard to support one another. And to complete their duties. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's service.

Inspector's evidence

The RP on the day of the inspection was the regular RP who had worked full-time at the pharmacy for approximately four months. Other team members present included the DA and the trainee MCA. The pharmacy was up to date with its prescription workload. This was because the team worked hard to complete its dispensing tasks. At the same time, it dealt with people waiting for prescriptions or advice. And the steady queue of people waiting to be attended to. The team reported that over the last few months it had caught up with many of the tasks that it previously had not had the time or staff numbers to attend to. And it had managed this by working hard to do so. The pharmacy had recently used the services of the company’s dispensing hub for larger repeat prescriptions which had also eased some of the pressures. Problems occasionally arose if the dispensing assistant was called away to work elsewhere. This put pressure on the pharmacist and the whole team, particularly where other team members were absent due to illness or holidays. And so, when this happened, the team fell behind again.

Because the pharmacy was so busy, the trainee MCA often helped with some basic dispensing tasks such as locating prescriptions, reading them and locating stock. The RP accepted that these activities required DA training. And it was accepted that the trainee MCA should cease these activities immediately or begin training on a recognised DA training course as soon as possible. It was also accepted that the pharmacy would need additional dispensing help if the trainee MCA did not help in the dispensary. And so, the RP agreed that she would discuss this with her line managers as a priority.

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, such as the hypertension case finding service when the prescription service required her full attention. The team had not had any formal reviews about their work performance recently. But they discussed issues with each other as they worked. And the RP hoped to begin a formal process for annual reviews next year.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises generally provide a suitable environment for people to receive its services. And they are adequately clean, organised and secure. But the pharmacy premises are tired and dated in areas. And its storage facilities are insufficient.

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 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 the dispensary did not have much free worksurface or storage space. This meant that floors were used to store baskets of bulky prescriptions waiting to be checked and bulky items of stock. The floor throughout was badly marked and scuffed. And while it was cleaned regularly it did not look well maintained. The pharmacy’s walls and fixtures and fittings were chipped, marked and scuffed. And they also did not look clean. 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 met

Summary findings

The pharmacy generally provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. The pharmacy team gets its medicines and medical devices from appropriate sources. And, in general, team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy generally stores its medicines correctly, but it does not do enough to ensure that it stores all its medicines in the appropriate environment. It generally ensures that it supplies its medicines with the appropriate information. But it is not thorough enough in ensuring that it supplies all its medicines with all the information that people need to take their medicines properly.

Inspector's evidence

The pharmacy had information on its windows promoting its services. And it had a doorway with a slight ramp which provided step-free entry. Its customer area was free of unnecessary obstacles, making it suitable for people with mobility issues. The team could also order people's repeat prescriptions if required. And it had a delivery service. It prioritised the service for people who had no other way of getting their medicines. And it used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors.

The pharmacy owner had recently established a centralised dispensing hub for several of its branches. And the RP reported that the team sent many of its bulky repeat prescriptions there to be dispensed. The team still dispensed any unusual items and items which the hub may not have. After being dispensed at the hub, the prescriptions were returned to the pharmacy where the RP re-checked them. And she reconciled them with any additional items dispensed at the pharmacy. The RP found that the system worked well and had reduced much of the work pressure which the team had experienced in the past. But the pharmacy still dispensed medicines in multi-compartment compliance packs on its premises. It did not send them to the hub. It supplied compliance packs for people living at home who needed them. And for people living in nursing homes. In general, it labelled the packs with the required advisory information to help people take their medicines properly. It supplied patient information leaflets (PILs) with new medicines, but not with regular repeat medicines. It tried to label its compliance packs with a description of each medicine, including colour and shape, to help people, including other healthcare professionals, to identify them. But the descriptions were not sufficient to differentiate one tablet or capsule from another. And one of the descriptions was inaccurate. The team agreed with the inspector that it was important to ensure that people had all the information they needed about their medicines. And that they should be able to identify what they are taking.

The pharmacist gave people advice on a range of matters. And she would give appropriate advice to anyone taking higher-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 described how she would counsel at-risk people when supplying the medicine to ensure that they were on a pregnancy prevention programme. The pharmacist was aware of the recent changes which required a full pack, with all the necessary information, to be supplied each time.

The pharmacy offered a hypertension case finding service. The RP had referred several people to their

GPs following a high blood pressure reading. And when those people returned with a prescription for blood pressure medication the RP followed up with a New Medicines Service consultation. She did this to ensure that people understood how to take their medicines so that they would benefit from them as much as possible. The RP kept records of each consultation and submitted them on the required NHS platform. The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And it generally stored its medicines appropriately. Stock on the shelves and in drawers was tidy and organised. The pharmacy checked the expiry dates on all stock items every three months. And it kept records. The team identified all short-dated items with an expiry date of three months or less. And it removed them from stock. It only dispensed them with the person's agreement where they could use them before their expiry dates. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date.

The team stored its CD items appropriately. And it stored its fridge items in two separate fridges. The RP generally read and recorded the temperatures of each fridge every day. But recently the temperature readings for both had been erratic. And often strayed outside of the required temperature range. The RP had reported this to head office, but it had not yet been able to establish whether it was the thermometers or the fridges which were faulty. The RP and the inspector agreed that the team must monitor fridge temperatures properly to ensure that the medication inside was kept within the correct temperature range. The RP agreed that she would take action to rectify this as soon as possible. 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 services safely. And it generally 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. Team members had access to a range of up-to-date reference sources. The pharmacy had enough PMR computer terminals in the dispensary. And a non-PMR computer in the consultation room which it rarely used. Computers were password protected. Team members had their own smart cards. But occasionally they shared each other's. The inspector and RPs discussed the importance of staff using their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in shelves which were out of people's view.

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.