General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: G. Lowe Pharma Limited, 203 East Lane, WEMBLEY, Middlesex, HA0 3NG

Pharmacy reference: 1035199

Type of pharmacy: Community

Date of inspection: 19/03/2024

Pharmacy context

The pharmacy is on the high street in northwest London. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy prepares multi-compartment compliance packs to help people take their medicines at the right time. Services include delivery, substance misuse, blood pressure case-finding service and new medicine 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

Overall, the pharmacy's working practices are safe and effective. It has written procedures in place for the team members to follow but it has not reviewed them recently. So this may mean they no longer reflect current best practice and manage the risks associated with providing its services. The pharmacy keeps the records required by law showing it supplies its medicines and services safely. Members of the pharmacy team protect people's private information, and they know how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The responsible pharmacist (RP) and the pharmacy team discussed their mistakes although they did not always record them. They generally stored the medicines alphabetically on the shelves but they had separated fast moving medicines which were dispensed frequently. The RP explained that medicines involved in incidents, or were similar in some way, such as amitriptyline and amlodipine or both strengths of metformin, were separated from each other in the dispensary to minimise the chances of picking errors.

The pharmacy received the majority of its prescriptions electronically. Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medicines and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. Some dispensed prescriptions were placed on a shelf in the dispensary so the team could add a missing item when the medicines order arrived from the suppliers. Or the RP wanted to speak to the person collecting the prescription because it included a new medicine. Assembled prescriptions were not handed out until they were checked by the RP. The RP gave people advice about how best to take their medicines. And interventions, such as checking two medicines could be taken together, were recorded on the patient medication record (PMR). Members of the team checked the person's name, address and date of birth to help make sure they were giving out the prescriptions to the right person.

The RP explained that the regular locum pharmacist usually delivered the quality criteria which were required by the NHS Pharmacy Quality Scheme (PQS). For instance, risk assessments and auditing how people used their asthma inhalers to make sure they understood the difference between reliever and steroid inhalers. The RP was aware of the new rules for dispensing valproates and the pharmacy computer flagged up alerts when the team were labelling and dispensing valproates.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were due to be reviewed and updated at the time of the visit. Members of the pharmacy team were required to read the SOPs relevant to their roles and show they understood them and would follow them. A team member who served at the medicines counter knew not to hand out prescriptions or sell medicines if the RP was not present. And the team knew when to refer repeat requests for medicines liable to misuse to the RP. The pharmacy had a complaints procedure. And a folder where it had filed positive feedback received from people who used the pharmacy.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy displayed a notice to show who was RP and it kept a record to

show which pharmacist was the RP and when. The pharmacy had a controlled drug (CD) register which its team kept up to date. But the stock levels recorded in the CD register had not been checked recently. A random check of the actual stock of a CD did not match the recorded amount in the CD register. But the dispensing assistant quickly resolved the mistake which was due to a subtraction error. The pharmacy kept records for the private prescriptions it supplied. And these generally were in order. The fridge temperatures were monitored daily and recorded. And the pharmacy team maintained records relating to some services on PharmOutcomes.

The pharmacy was registered with the Information Commissioner's Office (ICO). It needed to reprint and display its notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. The pharmacy team members had trained in general data protection regulation (GDPR) and they tried to make sure people's personal information could not be seen by other people and was disposed of securely. The team member in the dispensary was using their own NHS smartcard. The RP needed to update the pharmacy's safeguarding policy and get the team to re-read the safeguarding modules so they know what to do if they have concerns about the wellbeing of vulnerable people. The RP was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team works well together to manage the workload and to deliver services safely. The pharmacy generally ensures its team members are suitably qualified for their roles. But their training does not always cover everything they do. The pharmacy team can provide feedback to improve the pharmacy's services.

Inspector's evidence

On the day of the visit, the RP was supported by one full-time trained dispensing assistant and two team members at the medicines counter. A second full-time pharmacist was not present on the day of the visit but generally overlapped with the RP so there was double pharmacist cover. Two part-time students, one of whom was studying pharmacy, helped late afternoons in the pharmacy. During the week, the weekday team members delivered medicines to people’s homes if needed and there was a delivery person who delivered on Saturdays. The RP explained that some members of the pharmacy team helped out with other tasks outside their roles if needed. The RP was signposted to the GPhC guidance on requirements for the education and training required for new pharmacy support staff or staff who were new to their role and who helped out.

The RP was aware of the training requirements for the NHS Pharmacy First service and the second pharmacist had undertaken the training. The pharmacy team read publications supplied by the wholesalers on topics such as product knowledge. The RP was signposted to the knowledge hub on the GPhC website. Members of the team were able to provide feedback which they believed would improve services. And the dispensing assistant described changes she had suggested to manage preparing the multi-compartment compliance packs improving workflow. The pharmacy had a whistleblowing policy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are secure, clean and suitable for the provision of its services. The pharmacy prevents people accessing the premises when it is closed to keep its medicines stock and people's information safe.

Inspector's evidence

The pharmacy entrance had a wide manual door and a step from the pavement. The public area of the pharmacy had seats for people waiting for prescriptions and there were screens at the medicines counter to help protect people from infections. The pharmacy had sufficient lighting and it had measures in place to help prevent members of the team or medicines stock from getting too warm. The dispensary work bench space was limited in size and members of the team kept it as tidy as possible. The pharmacy was cleaned twice a week. There was a consultation room where people could have a private word with a member of the team. The consultation room was used to store paperwork and some bagged prescriptions awaiting collection. The prescription bags were turned round during the visit so the bag labels with people's details were not visible to people using the consultation room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy tries to make sure its services are accessible to people with different needs. The pharmacy team members give advice to people about where they can get other support. The pharmacy gets its medicines from reputable sources and manages them so they are safe to use. And it mostly makes sure that people have the information they need to use their medicines safely. Pharmacy team members respond to recalls and alerts for medicines or devices to be returned to the suppliers, but they do not always keep a record to show they have taken the right action.

Inspector's evidence

The pharmacy had a step at the entrance but team members could go to the door to assist people. The pharmacy could print large font labels which were easier to read and the team members could converse in Gujarati, Swahili and Hindi to assist people whose first language was not English. The team signposted people to other local services if the pharmacy could not help.

Members of the team initialled dispensing labels so they could identify who prepared and checked prescriptions. The team highlighted prescriptions where fridge and CD items might need to be added. And prescriptions which the RP wanted to speak to the person about the medicines they were collecting. The RP counselled people on how best to use their medicines and arranged a follow-up call if the prescription was for newly prescribed medicines. The RP explained that fewer people took warfarin and had been switched to a newer preparation to thin the blood, but for people who took warfarin the RP monitored INR and recorded it on the PMR. The RP reminded people about foods and medicines which may affect their INR.

The RP was aware of the new up-to-date guidance and rules for supplying valproate-containing medicines which must always be dispensed in the manufacturer's original full pack. And no-one under the age of 55 – both men and women - should be started on a valproate unless two specialists independently agree and document that there is no other safe and effective medication, or that there are compelling reasons why the reproductive risks linked to valproate, do not apply. Medicines and medical devices were delivered outside the pharmacy on weekdays by members of the team and a delivery person on Saturdays.

The pharmacy supplied medicines in disposable multi-compartment compliance packs for people who had difficulty taking them on time. The pharmacy team re-ordered prescriptions for these people and checked them for changes in medicines since the previous time. Members of the team provided a brief description of each medicine contained in the compliance packs but did not always provide patient information leaflets (PILS). So, moving forward, they gave assurances that they would supply PILs with each set of packs to help ensure people had the information they needed to take their medicines safely. High-risk medicines were generally supplied separately to the compliance pack. Following a hospital stay, the pharmacy sometimes received a discharge summary via PharmOutcomes. When people returned compliance packs they had finished or no longer required the team noted if any medicines were not taken.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It generally kept

medicines and medical devices in their original manufacturer's packaging. Liquid medicines were marked with the date of opening. The dispensary was tidy. The pharmacy team carried out date checks of stock. The pharmacy stored its stock, which needed to be refrigerated, and recorded maximum and minimum readings between two and eight Celsius. And it stored its CDs securely in line with safe custody requirements. The pharmacy's waste medicines were kept separate from stock in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. When the pharmacy received a concern about a product, the team checked the stock for affected batches to remove and return to the suppliers. But they did not always make a record to show their actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy team had access to up-to-date reference sources. The pharmacy had clean glass measures to measure liquids and the dispensary sink was clean. Fridge temperatures were recorded and the CD cabinets were securely fixed. The blood pressure monitor was used to measure people's blood pressure and results were sent to their GP if appropriate. Checking when the monitor was due for replacement or recalibration was discussed. The pharmacy team disposed of confidential wastepaper appropriately. The pharmacy computer was password protected and backed up regularly.

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.