General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Carters Chemist, 524-526 High Road, WEMBLEY, Middlesex, HA9 7BS

Pharmacy reference: 1035203

Type of pharmacy: Community

Date of inspection: 17/11/2022

Pharmacy context

The pharmacy is on a busy road in a mixed commercial and residential area in Wembley, Middlesex. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include prescription delivery, supervised consumption, community pharmacist consultation service (CPCS), new medicines service (NMS) and seasonal flu vaccinations.

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 generally safe and effective. It reviews the risks involved in providing its services. Members of the pharmacy team follow suitable written standard operating procedures (SOPs) to help make sure they work safely. They can easily show who completed each step of the process for the services the pharmacy provides. The pharmacy team members keep the records they need to up to date. They safeguard people's private information and they are trained in how to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team discussed the mistakes they made when they were identified to learn from them and reduce the chances of them happening again. The responsible pharmacist (RP) explained that the near miss records were used to create the patient safety review. And that medicines involved in incidents, or were similar in some way, such as prochlorperazine and procyclidine tablets or ramipril tablets and capsules were generally separated from each other in the dispensary to reduce the chance of mistakes in picking medicines for prescriptions. The RP completed a dispensing incident report on the pharmacy computer system if needed. The pharmacy reported incidents to the NHS Learning from Patient Safety Events (LFPSE) service.

Members of the pharmacy team responsible for making up people's prescriptions used baskets to keep each person's medication and prescriptions together and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were clinically, and final checked by the RP. The pharmacy team checked interactions between medicines prescribed for the same person with the RP or the prescriber. Any interventions were recorded on the patient medication record (PMR). Team members highlighted prescriptions for medicines that the RP needed to discuss with the patient, so they had all the information they needed to take their medicines safely. They made sure the right medicines were given to the right person by asking people to write down their name and date of birth. And checking they matched the details on the prescription.

The pharmacy had standard operating procedures (SOPs) online for most of the services it provided. The SOPs were regularly reviewed and included a complaints procedure, roles and responsibilities of team members, safeguarding and supplying high-risk medicines. Members of the pharmacy team were required to read the SOPs relevant to their roles and training records were maintained for each team member. They knew what they could and could not do, what they were responsible for and when to seek help. A team member explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy displayed a procedure in the consultation room on how to complain or give feedback. And customers were asked to complete a community pharmacy patient questionnaire to get people's feedback and suggestions on how the pharmacy team could do things better.

The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. The pharmacy had fitted screens at the medicines counter and team members had access to fluid resistant face masks to help reduce the risk of infection with COVID. They used anti-bacterial spray to clean pharmacy surfaces and applied hand sanitising gel. The pharmacy team assessed the risks associated with providing services such as seasonal flu vaccination. They completed audits in line with the pharmacy quality scheme (PQS), such as people who were on anti-coagulant therapy and people of child-bearing potential taking valproates. And they kept records of their findings. The pharmacy had business continuity plans to deal with systems failures so they could still provide some services.

The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and displayed a notice that told people who the RP was. The pharmacy had a controlled drug (CD) register. And the stock levels recorded in the CD register were checked regularly. A random check of the actual stock of a CD matched the recorded amount in the CD registers. The team recorded unwanted CDs returned to the pharmacy by people. The pharmacy kept records of its supplies of unlicensed medicinal products, the emergency supplies it made and the private prescriptions it supplied. The RP had signed and dated the patient group direction (PGD) for the flu service. Records of administration of the flu vaccination were entered onto Sonar and the person's doctor's surgery was informed. Records were generally in order.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Members of the team had completed training in general data protection regulation (GDPR). They tried to make sure people's personal information could not be seen by other people and was disposed of securely. And they used their own NHS Smartcards. The pharmacy team had undertaken training in safeguarding procedures. And the RP was signposted to the NHS safeguarding App so members of the pharmacy team would have the current contact information to raise concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to deliver its services safely. Team members work well together and manage and share the workload. They undertake ongoing learning relevant to their roles and their knowledge is up to date. They are able to provide feedback to improve services.

Inspector's evidence

The pharmacy team consisted of one full-time pharmacist (the RP) and one part-time pharmacist to cover Saturdays, a full-time trainee pharmacist who had completed the overseas pharmacists' assessment programme (OSPAP), three full-time and one part-time dispensing and medicines counter assistants who had completed accredited training in both roles and one full-time trained delivery driver who was shared with another branch of the pharmacy. The pharmacy had recently recruited two new team members. At the time of the visit, the RP was supported in the dispensary by the trainee pharmacist and a dispensing and medicines counter assistant.

Members of the pharmacy team had completed accredited training relevant to their roles and both new starters would be enrolled on appropriate training on completion of the probationary period. The pharmacy team members worked well together so people were served quickly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an over-the-counter (OTC) sales SOP which its team needed to follow. One of the team members described the questions that they needed to ask people when making OTC recommendations. And why they should refer some requests to a pharmacist. Members of the team were provided with training in new pharmacy products and they completed training in topics in line with the PQS. Their training certificates were filed. And the RP had undertaken the required training to deliver the flu vaccination service. The RP was also the trainee pharmacist tutor. The trainee pharmacist was allocated protected learning time and enrolled on the PropharmAce training programme which provided training days on a monthly basis.

The pharmacy team members had annual appraisals to monitor performance and identify training opportunities. The pharmacy had team meetings which included the other branches of the pharmacy and the teams discussed the PQS and its associated learning. They team tried to share the workload and were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are bright, clean and suitable for the provision of healthcare. The pharmacy is secured when it is closed to protect people’s private information and keep the pharmacy’s medicines safe.

Inspector's evidence

The registered pharmacy premises were bright and secure. And steps were taken to make sure all areas of the pharmacy were well lit and ventilated. The pharmacy had a spacious public area, a medicines counter, a small dispensary and storeroom. The dispensary had limited workspace and storage space but it was tidy and clean. The pharmacy had a sink and clean equipment. The consultation room was signposted so people could ask to have a private conversation with a team member. There were lockable cabinets to secure equipment used to provide services. Members of the pharmacy team took turns to keep the pharmacy clean.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team makes sure services are easily accessible to people with different needs. The pharmacy's working practices are safe and effective and it obtains its medicines from reputable sources. The pharmacy's team members make sure they store medicines securely at the right temperature. They highlight prescriptions with high-risk medicines and ensure that people have all the information they need to use their medicines safely. They know what to do if any medicines or devices need to be returned to the suppliers.

Inspector's evidence

The pharmacy had an automated door. And its entrance was level with the outside pavement. This made it easier for people who found it difficult to climb stairs, such as someone who used a wheelchair, to enter the building. The pharmacy team tried to make sure people could use the pharmacy services. The pharmacy had a notice that told people when it was open. And other notices in its window told people about flu vaccination and other services the pharmacy offered. Members of the pharmacy team were helpful. And they signposted people to other local pharmacies, dentists or doctors if a service was not available at this pharmacy. They could speak or understand Gujarati, Urdu, Punjabi, Hindi, Sri Lankan and Arabic to assist people whose first language was not English. They could print large font labels for people with impaired vision.

The pharmacy provided a delivery service to people who could not attend its premises in person. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The pharmacy supplied medicines in multi-compartment compliance aids to people who found it difficult to manage their medicines. The pharmacy team checked if a medicine was suitable to be re-packaged. Some high-risk medicines were suppled in compliance aids for a week at a time. The pharmacy provided a description of each medicine contained in the compliance aids and patient information leaflets (PILs). So, people had the information they needed to make sure they took their medicines safely. Members of the pharmacy team initialled the dispensing labels to show who had prepared a prescription. And they marked prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added. If the person had been in hospital, the pharmacy received discharge information such as changes in medication on PharmOutcomes.

The pharmacy team received referrals to supply some medicines for the community pharmacist consultation service via Sonar. The pharmacy team offered the new medicine service (NMS) to people to help them take their new medicines in the best way. They followed up the first conversation at set intervals in the pharmacy or by phone. And resolved problems such as side effects that might result in the person not taking their new medication.

The team members were aware of the valproate pregnancy prevention programme. They had completed an audit to monitor people in the at-risk group. And they knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The

pharmacy had valproate educational materials to give to people to support them taking their medicines.

The pharmacy provided the flu vaccination service via patient group direction (PGD). Team members had undertaken safeguarding training at an appropriate level to provide services. The RP had completed training in first aid, vaccination technique and dealing with anaphylaxis. The RP explained additional clinical checks and administration of flu vaccinations to people who were on anticoagulant therapy. The RP obtained consent and did the clinical assessment prior to the vaccination. The person was given a PIL, and their surgery was informed to update their records. There were adrenaline injector devices to treat anaphylaxis after the vaccine was administered. And appropriate disposal bins for sharps and clinical waste. The RP knew where the nearest defibrillator was located.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices in their original manufacturer's packaging. The pharmacy team was able to keep the dispensary benches clear as they completed prescriptions. They checked the expiry dates of medicines on a regular basis and highlighted short-dated medicines. In a random check no date-expired medicines were found. The pharmacy stored its stock which needed to be refrigerated in a fridge and kept records to show the temperature was between two and eight degrees Celsius. And it stored its CDs, securely in line with safe custody requirements. The pharmacy had procedures for disposing of the unwanted medicines people returned to it. And these medicines were kept separate from stock. When the pharmacy team members received alerts and recalls about medicines and medical devices, they printed the alert, checked stock for affected batches and annotated the alert before filing it.

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 had fitted a plastic screen on its counter to help protect against COVID infection and it had hand sanitiser for people to apply. And personal protective equipment if needed. The pharmacy team had access to up-to-date reference sources. The pharmacy had marked glass measures for use with certain liquids and it stored pharmaceutical stock requiring refrigeration in a fridge. Its team regularly checked and recorded the maximum and minimum temperatures of the fridge. Confidential wastepaper was disposed of appropriately. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they entered their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team and team members used their own NHS smartcards.

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.