General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peace Pharmacy, 14 The Broadway, Preston Road, WEMBLEY, Middlesex, HA9 8JU

Pharmacy reference: 1035215

Type of pharmacy: Community

Date of inspection: 20/03/2024

Pharmacy context

The pharmacy is in a parade of businesses in a mixed commercial and residential area in northwest London. It sells medicines over the counter and provides health advice. The pharmacy dispenses private and NHS prescriptions. It supplies medicines in multi-compartment compliance packs for people who have difficulty taking their medicines at the right time. Its other services include delivery, blood pressure case-finding, seasonal flu and travel vaccinations and Pharmacy First

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	1.1	Good practice	The pharmacy actively identifies and manages the risks associated with providing its services.
2. Staff	Standards met	2.4	Good practice	The pharmacy team members are encouraged and supported to learn from their mistakes and share what they have learned.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy can show how preparation and planning help make sure services are effective and improve health outcomes
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. It has suitable written instructions for members of the team to follow. The pharmacy can give examples of how it identifies and manage risks in providing its services. Team members are encouraged to learn from their mistakes and take action to prevent the same thing happening again. The pharmacy keeps the records it needs to by law to show it supplies its medicinee s and services safely. Members of the pharmacy team protect people's private information. And they can describe an action taken to help safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. When the responsible pharmacist (RP) identified near misses, he encouraged members of the pharmacy team to spot and correct their own mistakes. They discussed the types of mistakes they made such as quantity errors to learn from them. And they agreed actions they could take to reduce the chances of them happening again. The pharmacy team recorded near misses on the pharmacy computer system. The RP explained that medicines involved in incidents, or were similar in some way, such as hydroxyzine and hydralazine, were generally separated from each other in the dispensary. The pharmacy had a complaints procedure and details of what to do were in the practice leaflet. And the team could report incidents to the superintendent pharmacist (SI) by email.

A member of the team completed a legal check of prescriptions to make sure the required fields were filled in. 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 medicines. They checked interactions between medicines prescribed for the same person with the pharmacist. And assembled prescriptions were not handed out until they were checked by the RP. Team members who prepared and checked prescriptions initialled the dispensing labels to create an audit trail. They highlighted prescriptions for high-risk medicines. For instance, controlled drugs (CDs) prescriptions which were only valid for 28 days. And they supplied warning cards such as for warfarin or prednisolone to make sure people had all the information, they needed to use their medicines effectively. Team members recorded interventions such as the outcomes for a new medicines service (NMS) consultation or the INR value on the patient medication record (PMR). Members of the team who handed out prescriptions confirmed the person's details on the address label on the prescription bag and checked the date of birth if needed.

The pharmacy had standard operating procedures (SOPs) for the services it provided. The RP explained that these were being reviewed and members of the pharmacy team would re-train in the updated SOPs relevant to their roles. A member of the team described the sales protocol for recommending over-the-counter (OTC) medicines to people. The sales protocol poster was displayed near the medicines counter detailing reminders about requests for certain medicines. The team members knew what they could and could not do, what they were responsible for and when they should seek help. They 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 medicines, such as medicines liable to abuse to a pharmacist.

The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it.

In preparation for commencing the NHS Pharmacy First service the RP completed risk assessments and devised a checklist with a colleague. The risks identified and managed included pharmacist training, reading and signing patient group directions (PGDs), knowledge of the exclusion criteria for treatments, the consultation room dimensions and record keeping. The RP liaised with the local surgeries during their regular meetings. The RP had planned future audits to monitor the service which included compliance with the PGD pathway, signposting people elsewhere, missed diagnosis and general data protection regulation (GDPR) with increased access to people's medical records. The RP described the clinical pathway for prescribing antibiotics appropriately to treat a urinary tract infection, checking that the person met the gateway criteria with at least two symptoms to be eligible for the PGD. And checking there were no exclusion criteria which would have resulted in a referral to their GP instead.

The RP had conducted an audit of people prescribed antibacterial medicines for five days or for seven days to treat urinary tract infections (UTIs). He compared their treatment with current National Institute for Health and Care Excellence (NICE) guidance on UTI. An audit of people taking anticoagulants identified people who were prescribed clopidogrel with omeprazole instead of lansoprazole. And this resulted in switching them from omeprazole. which may reduce the effect of the clopidrogrel. The pharmacy team had completed a clinical audit of people taking valproates and they were aware there were new rules when dispensing a valproate.

The pharmacy displayed a notice that told people who the RP was, and it kept a record to show which pharmacist was the RP and when. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It maintained an electronic controlled drug (CD) register and CDs were audited to check how much stock it had of each CD. A random check of the actual stock of a CD matched the amount recorded in the register. The pharmacy kept records for the supplies it made of private prescriptions and these were generally complete. The pharmacy provided travel vaccinations which were administered via PGDs. And records for vaccinations included the person's details, the vaccine details such as batch number and expiry date and when they were administered. The pharmacy team recorded the daily fridge temperatures.

The pharmacy was registered with the Information Commissioners Office (ICO). The pharmacy team members had completed GDPR training. They tried to make sure people's personal information was disposed of securely. Members of the team used their own NHS Smartcards. The pharmacy had a safeguarding procedure. The RP had completed level 3 safeguarding training. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. The RP described how he had identified a potential safeguarding incident and the actions taken. The pharmacy team 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 team members are generally suitably qualified or in training for their roles. The pharmacy team can provide feedback to improve the pharmacy's services.

Inspector's evidence

The pharmacy team consisted of the RP who was a full-time regular locum pharmacist and the SI who covered the remaining hours each week. There were five further full-time support staff and a part-time delivery driver. Team members were mostly enrolled on or had completed accredited training in line with their roles. The RP confirmed the remaining team members were enrolled during the visit. Team members were allocated protected learning time if needed.

The pharmacy mostly relied upon its team to cover absences. The pharmacy team members were signposted to the GPhC knowledge hub. The RP described training completed to deliver the Pharmacy First service such as using the equipment, reading through the SOPs, the patient group directions (PGDs) and the guidelines. The master authorisation sheet was signed and retained with other Pharmacy First documentation. The RP was a trainee independent prescriber.

The RP discussed the near misses for the previous month, during regular team meetings, so the team could learn and improve together. The RP used a red pen to highlight prescriptions prepared by trainee's who may need additional support. He planned the day 's activity to prioritise the workload. For instance, delivery prescriptions were prepared at a certain time to be ready for when the delivery person arrived. Members of the pharmacy team 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 OTC sales and self-care SOP which described the questions the team member needed to ask people when making OTC recommendations. And when they should refer to the RP.

The RP gave team members informal verbal feedback. And members of the team were able to feedback how they could improve pharmacy services to the RP. They had suggested how they could improve medicines storage. And team members could raise concerns through the whistleblowing SOP.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are bright, clean and secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed to protect people's private information and to keep its medicines stock safe. People can have a private conversation with a team member in the consultation room.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. There were chairs for people who wanted to wait. And action had been taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a retail area and a medicines counter where people could buy medicines or other sundry items. The dispensary was behind the retail area. There was room for storage. The pharmacy had a consultation room which was signposted, clean and tidy where people could have a private conversation with a team member. Team members kept worksurfaces clear to help avoid them becoming cluttered when the pharmacy was busy. The pharmacy team maintained records of when the pharmacy was cleaned. The dispensary sink was clean.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy and its services are easily accessible to people with a variety of needs. And its working practices are safe and effective. The pharmacy obtains its medicines from reputable sources so that they are fit for purpose. It stores them securely at the right temperature to help make sure they are safe to use. People are provided with the information they need to use their medicines properly. The pharmacy team members respond to medicine alerts and recalls to help make sure people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy had double doors and the entrance was level with the pavement. The team tried to make sure people with different needs could access the pharmacy services. The pharmacy displayed its opening hours and service information at the front entrance. There was seating available for people who were waiting. Members of the pharmacy team were helpful. They could speak or understand Farsi, Urdu, Dari and Pashto to assist people whose first language was not English. They could print large font labels, so they were easier to read. And they signposted people to another provider if a service was not available at the pharmacy. Such as the local general practitioner or NHS 111. The pharmacy's delivery person delivered medicines for people who could not attend the pharmacy in person and maintained an audit trail to help show the medicines had been delivered to the correct person.

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 said they would make sure medicines were suitable to be re-packaged if necessary. They 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. The team recorded messages from the prescribers on the people's PMR. Following a hospital stay, the pharmacy sometimes received a discharge summary via PharmOutcomes.

In the event of a systems failure people would be signposted to another pharmacy and their nomination switched to that pharmacy. Members of the team initialled dispensing labels so they could identify who prepared a prescription. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting. The RP counselled people on how best to use their medicines. For people taking warfarin, the RP checked the INR was monitored and recorded the value on the PMR. The RP reminded people about foods and medicines which may affect their INR. The RP and the pharmacy team members were 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.

The RP had created a checklist in preparation for setting up the Pharmacy First service. He liaised with the local surgery and a colleague ahead of commencing the Pharmacy First service. In preparation, the RP had completed training and operational requirements, and read the clinical pathways. Treatment was recorded on Sonar. The pharmacy was busy with customers at certain times of the day so the RP tried to see patients when it was quieter. The RP described the clinical pathway for urinary tract infection and checked for gateway and exclusion criteria such as allergy status or breastfeeding. The pharmacy had already treated people through the new service. The pharmacy offered the blood pressure case-finding service. And it had a duplicate form for submitting the blood pressure reading to the person's surgery. During the visit, the RP was available at the counter as much as possible to counsel, act as a safety net and signpost people if appropriate. And follow up where possible. The RP had trained to supply emergency hormonal contraception (EHC) via PGD to people aged 13 years and over. People who had accessed the new medicines service generally had follow up consultations by phone. The pharmacy offered travel vaccinations including yellow fever and malaria service via PGDs.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It generally kept medicines and medical devices in their original manufacturer's packaging and marked liquid medicines with the date of opening. The dispensary was tidy. The pharmacy team carried out regular date checks of stock which was rotated. The pharmacy stored its stock, which needed to be refrigerated, 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. And the pharmacist described the actions they took and explained what records they kept when the pharmacy received a concern about a product.

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 and keeps people's private information safe.

Inspector's evidence

The pharmacy team had access to up-to-date and online reference sources. It had clean measures to measure liquid medicines. The pharmacy had a fridge to store its pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures for the fridge. The CD cabinet was fixed securely. There were bins for clinical waste disposal. The pharmacy team disposed of confidential waste appropriately. The pharmacy restricted access to its computers and PMR system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure they 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.