General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gimmack Chemists, 177 Cricklewood Broadway, LONDON, NW2 3HT

Pharmacy reference: 1040558

Type of pharmacy: Community

Date of inspection: 22/03/2024

Pharmacy context

The pharmacy is on a busy high street 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, substance misuse, blood pressure case-finding, seasonal flu vaccinations and Pharmacy First.

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. The pharmacy can give examples of how it identifies and manage risks in providing its services and it has suitable written instructions for its team members to follow. Members of the team 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 medicines and services safely. Members of the pharmacy team protect people's private information. And they understand their role in helping to 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, members of the pharmacy team were encouraged to discuss and correct their mistakes. They identified the types of mistakes they made such as picking 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 and the RP used the records to compile a patient safety review regularly. A member of the team explained that medicines which were involved in incidents, or were similar in some way, such as gabapentin and pregabalin or propranolol and amitriptyline, were generally separated from each other in the dispensary. The pharmacy team members had identified a trend in picking errors between insulin cartridges and pens. They had grouped some medicines stock together such as fast-moving lines and medicines which were prone to picking errors. The pharmacy had a complaints procedure to report incidents to the superintendent pharmacist (SI).

A member of the team completed a legal check of prescriptions to make sure the required fields were completed. Members of the pharmacy team who made 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 and checked interactions between medicines prescribed for the same person with the pharmacist. They recorded interventions such as allergy status on the patient medication record (PMR). 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 prednisolone to make sure people had all the information, they needed to use their medicines effectively. A member of the team explained that the warning cards were in the process of being replaced after a recent flood which had caused some damage. There was a procedure for dealing with outstanding medicines. Members of the team who handed out prescriptions confirmed the person's details and the date of birth if needed.

In preparation for commencing the NHS Pharmacy First service the pharmacy had completed risk assessments. The risks identified and managed included pharmacist training and knowledge of the patient group directions (PGDs), the team dynamics to free up the pharmacist's time for consultations and getting in touch with local surgeries to inform them about the service. The pharmacy team recorded consultations on PharmOutcomes. The service was suspended at the time of the visit

following a recent flood pending some documentation which had to be replaced. The pharmacy completed risk assessments prior to commencing the annual flu vaccination service and checking if it had items such as adrenaline injection devices, surgical gloves and clinical waste bins. The pharmacy team had planned audits to monitor the services. 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 had recently reviewed standard operating procedures (SOPs) for the services it provided and included a complaints procedure. Team members trained in the updated SOPs relevant to their roles when it was quiet in the pharmacy. A member of the team described the sales protocol for recommending over-the-counter (OTC) medicines to people and how they would deal with 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 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 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 controlled drug (CD) registers and these were generally complete. CDs were regularly 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 but the name and address of the prescriber were sometimes incorrectly recorded. The pharmacy team recorded the daily fridge temperatures. The RP recorded notes on the initial and follow-up such as the outcomes for new medicines service (NMS) consultations.

The pharmacy was registered with the Information Commissioners Office (ICO). The pharmacy team members had completed general data protection regulation (GDPR) training. They collected confidential waste paper to be disposed of securely. And a member of the team described how they protected people's privacy. For instance, by writing down details rather than saying their details out loud at the counter. Members of the team used their own NHS Smartcards. The pharmacy had a safeguarding procedure so 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 had completed level 3 safeguarding training. The pharmacy team was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together to manage the workload and to deliver services safely. They are suitably qualified or in training for their roles. They are supported and encouraged to keep their knowledge up to date. The pharmacy team can provide feedback to improve the pharmacy's services.

Inspector's evidence

On the day of the visit, the pharmacy team consisted of the RP who was a locum pharmacist. Two other regular pharmacists were not present. The RP was supported by a trainee pharmacist, a trainee technician who was the pharmacy manager, a trainee medicines counter assistant and a part-time delivery person. Team members were enrolled on or had completed accredited training in line with their roles. Team members were allocated protected learning time if needed.

The trainee pharmacist was enrolled on an external foundation training course and attended their monthly training days. The pharmacy allocated regular study time to read and revise topics such as sections of the British National Formulary (BNF) and the superintendent pharmacist (SI) was the trainee pharmacist's tutor. The trainee pharmacist was able to ask the RP for referrals to information sources appropriate to the role. The SI provided feedback to the trainee pharmacist via the required program of appraisals and reviews. The pharmacy relied upon its team to cover Saturdays and absences. The pharmacy team members were signposted to the GPhC knowledge hub. The pharmacists had completed training to deliver the Pharmacy First service such as using the equipment (the otoscope), reading through the SOPs, the patient group directions (PGDs) and the guidelines. One pharmacist had recently trained as an independent prescriber.

The pharmacy team members were provided with ongoing training such as flu vaccination service training or knowledge of conditions affecting the eyes and ears via eLearning for Healthcare (elfh). And product knowledge in the wholesalers' publications which they received. The SI maintained team members' training records and held regular team meetings and a WhatsApp group. Team members could discuss issues and provide feedback and suggestions to improve services. One team member had suggested re-locating the consultation room within the pharmacy layout to enhance people's privacy. 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 pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is undergoing a refit to improve the design and layout of its premises so they are more suitable for the provision of healthcare services. People can have a private conversation with a team member in the consultation room. The pharmacy prevents people accessing its premises when it is closed to protect people's private information and to keep its medicines stock safe.

Inspector's evidence

The registered pharmacy premises were bright and secure but undergoing a re-fit which was not yet finished. A member of the team explained that there had also been a flood recently from upstairs. 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 large 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 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. .

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people with different needs. And its working practices are generally safe and effective. The pharmacy obtains its medicines from reputable sources and it stores them securely at the right temperature to help make sure they are fit for purpose. People are provided with the information they need to use their medicines properly. The pharmacy team members can show their actions when they receive medicine alerts and recalls. They help make sure people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy had a single manual door and a step at the entrance as it was not level with the pavement. There was a wall handle for support and team members went to the door to help people. So, they 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. And it informed people that closed circuit television was operating. There was seating available for people who were waiting. Members of the pharmacy team were helpful. They could speak or understand Gujarati, Urdu, Hindi, Somali and Portuguese to assist people whose first language was not English. They could print large font labels, so they were easier to read. Members of the pharmacy team were helpful and tried to advise and help people. For instance, they asked the prescriber to adjust the dose of a medicine from four times daily to twice daily to support someone taking their medicine while observing Ramadan.

Regarding business continuity and helping to make sure people could access pharmacy services when there had been a systems failure, members of the team said they signposted people to another provider if a service was not available at the pharmacy especially during the refit when it had been necessary to suspend some services. 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.

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 pharmacist counselled people on how best to use their medicines. For people taking warfarin, the RP checked the 'yellow' book for blood test dates and the INR showing the person was monitored while taking the medicine. A member of the pharmacy team described checks they would make before supplying isotretinoin. 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 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 which was shared with the GP surgery.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It generally marked liquid medicines with the date of opening but there were some medicines and medical devices which were not in their original manufacturer's packaging so they might be missed in the event of a recall or date check. And then be supplied to people by accident. The dispensary was tidy. The pharmacy team carried out regular date checks of stock. 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 a member of the team described the actions they took and explained that records of returned medicines and medical devices were kept on their behalf at the pharmacy head office. On one occasion the pharmacy had to contact a patient to return an affected item which was replaced and organise a new replacement prescription to cover the supply.

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 pharmacy had blood pressure monitors and marking them with the date to show when they were due to be re-calibrated was discussed. The CD cabinets were fixed securely. There were bins for clinical waste disposal. And the adrenaline injection devices were in date. The pharmacy team collected confidential wastepaper to be disposed of securely. 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.