General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: G.B. Patel & Sons Ltd., 27 Northcote Road, Clapham, LONDON, SW11 1NJ

Pharmacy reference: 1041121

Type of pharmacy: Community

Date of inspection: 15/06/2022

Pharmacy context

This is an NHS community pharmacy set on a parade of shops and businesses in Battersea. The pharmacy opens six days a week. It sells over-the-counter medicines and some health and beauty products. It dispenses people's prescriptions. And it delivers medicines to people who can't attend its premises in person. The pharmacy provides multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. And people can get a flu jab (vaccination) from the pharmacy too.

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 adequately manages its risks. It has procedures to help make sure its team works safely. And it keeps the records it needs to by law. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They mostly keep people's private information safe. And they talk to each other about the mistakes they make. So, they can learn from them. People using the pharmacy can provide feedback to help improve its services.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. And the responsible pharmacist (RP) gave an assurance that the SOPs would be reviewed following the inspection as they hadn't been for a while. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. The pharmacy had considered the risks of coronavirus. And, as a result, it completed an occupational risk assessment for its team members and put a plastic screen on its counter to try and stop the spread of the virus. Members of the pharmacy team were encouraged to self-test for COVID-19. They had the personal protective equipment they needed. And hand sanitising gel was freely available.

Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication 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 checked by the RP. The pharmacy had processes to review the dispensing mistakes that were found before reaching a person (near misses) and dispensing mistakes where they had reached the person (dispensing errors). Members of the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. But they didn't routinely record them or the lessons they learnt from them. So, they could be missing opportunities to spot patterns or trends with the mistakes they made. The pharmacy team reviewed and strengthened its processes for making up people's compliance packs following some near misses when too many tablets were dispensed. The RP explained that medicines involved in dispensing mistakes or were similar in some way, such as medicines available as capsules and tablets, were generally separated from each other in the dispensary.

The pharmacy displayed a notice that told people who the RP was. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. A team member explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't 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 had a complaints procedure. And it had a leaflet that told people how they could provide feedback about it and its services. The pharmacy had received feedback from people online. It asked people for their views and suggestions on how it could do things better. And, for example, it tried to keep a person's preferred make of a prescription medicine in stock when its team was asked to do so.

The pharmacy had insurance arrangements in place. And the RP had their own, including professional indemnity, for the services they provided. The pharmacy kept a record to show which pharmacist was

the RP and when. It had a controlled drug (CD) register which was generally in order. But stock levels in the CD register hadn't been checked for some time. So, the pharmacy team could have missed opportunities to spot and correct mistakes. The pharmacy kept adequate records of the supplies of the unlicensed medicinal products it made. It recorded the emergency supplies it made and the private prescriptions it supplied electronically. And most of these were in order. But the nature of the emergency wasn't always appropriately recorded in the emergency supply records. And the details of the prescriber were sometimes incorrect in the private prescription records.

People using the pharmacy couldn't see other people's personal information. But their details weren't always removed or obliterated before the medicines they returned to the pharmacy were disposed of. The pharmacy gave information governance assurances to the NHS each year using an online data security and protection toolkit. It had an information governance policy which its team needed to read and sign. And arrangements were in place to make sure confidential information was stored and disposed of securely. The pharmacy had a safeguarding process. And team members knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. They generally work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy team consisted of the RP, a part-time pharmacist, a full-time dispensing assistant, a full-time trainee medicines counter assistant (MCA), a part-time MCA and a part-time delivery driver. The RP was the superintendent pharmacist. And they were responsible for managing the pharmacy and its team. The pharmacy relied upon its team members and locums to cover absences. The RP, the dispensing assistant and the trainee MCA were working at the time of the inspection. Members of the pharmacy team generally worked well together. So, people were served promptly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for babies or young children, people who were pregnant or breastfeeding, people who were old and people with long-term health conditions to the pharmacist on duty.

The RP confirmed that each pharmacy team member had completed or was undertaking accredited training relevant to their role. Members of the pharmacy team discussed their performance and development needs with their manager when they could. They shared learning and were kept up to date during one-to-one discussions or informal meetings. They were encouraged to ask questions and familiarise themselves with new products. They were also asked to complete training to make sure their knowledge was up to date. And they could train in their own time or while they were at work when the pharmacy wasn't busy. The pharmacy didn't set targets for its team. And it didn't incentivise its services. Members of the pharmacy team felt able to make decisions to keep people safe. And they didn't feel under pressure to do the things they were expected to do. Team members 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. And their feedback led to compliance packs being made up in the mornings when the pharmacy wasn't so busy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate and secure environment to deliver it services from. And people can receive services in private when they need to. But its team don’t always have the space they need to work in when it’s busy.

Inspector's evidence

The public area of the pharmacy was air-conditioned, bright, clean, and adequately and professionally presented. But the main area used to make up people’s prescriptions was small. And its worksurfaces and available storage space were limited. This meant that items were sometimes stored on the floor. The pharmacy did have a larger dispensary at the back of the premises. But this wasn’t being used as it needed to be decluttered and tidied. The RP gave assurances that the area would be cleared and cleaned following the inspection. So, it could be used to store medicines and make up people’s compliance packs. Some parts of the ceiling in the non-public facing area of the pharmacy had been damaged due to a leak from a neighbouring property. But the ceiling was due to be repaired or replaced once the leak had been fixed and the surrounding area had dried out. Members of the pharmacy team were responsible for keeping the premises clean and tidy. The pharmacy had a consulting room for the services it offered. And this could be used if people needed to speak to a team member in private. People’s conversations in the consulting room couldn’t be overheard outside of it. The consulting room was locked when it wasn’t being used. So, its contents were kept secure. The pharmacy had the sinks it needed for the services it provided. And it had a supply of hot and cold water.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access. Its working practices are safe and effective. Its team members are helpful. And they make sure that people have the information they need. So, they can use their medicines safely. The pharmacy gets its medicines from reputable sources. And it generally stores them appropriately and securely. Members of the pharmacy team mostly dispose of people's unwanted medicines properly. And they carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy had an automated door. Its entrance was level with the outside pavement. And it had wide aisles. These things made access to the pharmacy, and its services, easier for people who used wheelchairs or mobility scooters. The pharmacy had some notices that told people about its products and the services it delivered. And it had a small seating area for people to use if they wanted to wait in the pharmacy. Members of the pharmacy team were helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. And it kept an audit trail for each delivery to show when a person's prescription was delivered. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked whether a medicine was suitable to be re-packaged. And it generally assessed each request for the service to make sure compliance packs were appropriate for the patient. The pharmacy provided a brief description of each medicine contained within the compliance packs as well as patient information leaflets. And an audit trail of the people who had assembled and checked each compliance pack was routinely kept. The pharmacy team marked some 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. Team members knew that women or girls able to have children mustn't take valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed valproate needed to be counselled on its contraindications. And they had access to the valproate educational materials they needed.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices tidily within the dispensary within their original manufacturer's packaging. But some loose and unlabelled medicines found during the inspection were quickly removed and disposed of. The pharmacy team checked the expiry dates of medicines at regular intervals. It needed to record when it had done these checks. And it marked products which were soon to expire to reduce the chances of it giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy team recorded the destruction of the CDs that people returned to it. And out-of-date CDs were kept separate from in-date stock. But these have been allowed to build up. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But the pharmacy didn't have an appropriate bin for the disposal of hazardous waste medicines. The pharmacy had a process for dealing

with alerts and recalls about medicines and medical devices. And its team members described the actions they took and demonstrated what records they made when they received a drug alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a few glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And the RP could contact the Pharmacists' Defence Association to ask for information and guidance. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. Its team regularly checked and recorded the temperature of this refrigerator. And a new maximum and minimum thermometer had recently been ordered to replace the existing thermometer. The pharmacy restricted access to its computers and patient medication record 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 their NHS smartcards were stored securely when they weren't working.

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.