General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dillons Pharmacy, 17 Church Road, Acton, LONDON, W3 8PU

Pharmacy reference: 1041390

Type of pharmacy: Community

Date of inspection: 11/05/2023

Pharmacy context

The pharmacy provides a range of services from its premises including dispensing prescriptions for people at home and for the residents of residential and care homes. The pharmacy has a small selection of over-the-counter medicines and other pharmacy related products for sale from its premises. And it provides a range of other services including a winter flu vaccination service and a travel vaccination service.

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 has suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And, in general, it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy adequately identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The team had a system for recording its 'near miss' mistakes and errors. But it did not always record them. And the records it did keep did not contain much detail. But the responsible pharmacist (RP) described how she highlighted and discussed near misses and errors with team members as soon as she discovered them. She did this to ensure that they had learned from their mistakes. And to reduce the chance of them making the same mistake again. The inspector and RP discussed the importance of recording what staff had learned from their mistakes and any actions arising from them. They discussed how this would provide more detailed information for review. And it would help the team to continually improve their dispensing procedures. They agreed that near miss mistakes should prompt staff to identify what they could do differently to help them avoid making a similar mistake again. But although the team had not kept full records of its near misses it had taken steps to manage risk and keep mistakes to a minimum. The pharmacist described how the team took extra care with medicines which look alike and sound alike (LASA) such as ropinirole and risperidone. And she had placed warning 'LASA' labels on the shelves in front of these products to reduce the chance of picking the wrong one. The team had also separated similarly packaged items such as prednisolone and prednisolone GR to different sections of the dispensary, also to reduce the chance of the wrong item being selected. The RP described how she kept the team up to date on new products and services. And she also coached them on what to do when someone asked to buy a medicine which had previously been prescription only. But had changed its category to an over-the-counter medicine. She highlighted areas of risk. And she provided general business information. And she helped the team to identify its priorities each day.

The pharmacy had put measures in place to keep people safe from the transfer of infections. It had a regular cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. It also had a cleaner who cleaned the premises throughout, every one to two weeks. It had hand sanitiser for team members and other people to use. And it had a screen up at its small medicines counter. The pharmacy had a set of standard operating procedures (SOPs) to follow. The SOPs were shortly due for review. Staff had read the SOPs. And they had signed them to show that they understood them and would follow them. The pharmacy had two trainee dispensers. And the RP described how she coached them and oversaw their dispensing activities to ensure that they were following the SOPs. She described how team members in training, consulted her before selling a pharmacy medicine to someone. The RP had placed her RP notice on display where people could see it. The notice showed her name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services directly to the pharmacy's team members. They could also give feedback to the head office team. It was clear that the pharmacy had

many regular customers. And that the RP knew them well. And so, when people expected their medicines to be ready, the RP explained the prescription process to them. The RP was overheard telling people that it often took a week or more for prescriptions to come back from the local surgery. And so, she advised them to allow enough time between ordering their prescriptions and collecting their medicines. She did this to explain that with current workload pressures, it took additional time for the surgery to generate people's prescriptions. And once surgeries had generated prescriptions it took time for the pharmacy to be able to access them. And to sort out any problems and get their medicines ready safely and on time. Other people had been concerned when the pharmacy did not have their medicines in stock. Or when there were manufacturers' delays. The RP took time to explain the situation to people. But to prevent them from going without their medicines, team members contacted the appropriate GP surgery to request alternatives where appropriate. The pharmacy also tried to keep people's preferred make of medicine in stock so that they were always available for them. The pharmacy had a complaints procedure. And team members could provide people with details of where they should register a complaint if they needed to. But the RP usually dealt with people's concerns at the time. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy generally kept its records in the way it was meant to, including its controlled drugs (CD) register and its RP records. The pharmacy maintained and audited its CD running balances. And the quantities of random samples checked during the inspection matched the total recorded in the CD register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. And this was complete and up to date. The pharmacy also kept records of it private prescriptions. And records of its emergency supplies. But several entries in its private prescription records did not show the prescriber's full details. And the pharmacy did not keep records of its emergency supplies, other than on people's medication records. The RP and inspector agreed that all the pharmacy's essential records should be kept as required by law.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. The pharmacy had arrangements to make sure its confidential waste was collected and then sent to a centralised point for secure destruction. And they generally kept people's personal information, including their prescription details, out of public view. The RP had completed appropriate safeguarding training to level 2. And remaining team members had been briefed. And they had read the pharmacy's safeguarding policy document which was on display. The team could access details for the relevant safeguarding authorities online. But it had not yet had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has an appropriate range of skills and experience to support its services. And the pharmacist manages the workload safely and effectively. Team members support one another satisfactorily. And they keep their knowledge up to date. Team members receive sufficient feedback to help them carry out their tasks properly. But the pharmacy does not have enough staff to manage all its workload efficiently.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. The RP worked at the pharmacy full time, with Saturday morning shifts covered either by regular locums or one of the pharmacy's directors. During the inspection, the RP was on duty alone due to staff illness. Which she had been notified of that morning. So, at short notice the RP had arranged for another team member to come in to work to support her. But they had not arrived by the time expected. On a typical day, the team consisted of the RP, a trainee dispensing assistant (DA) and, or a medicines counter assistant (MCA). But the regular trainee MCA was on maternity leave and her hours had not been replaced. So, the team was managing without her until her return. This would be in approximately four months' time. The team had two trainee DA's. who had qualified as pharmacy technicians overseas. Both trainees had recently completed their probationary period. And the RP planned to put them on a recognised training course at the earliest opportunity. The team generally kept the daily workload of prescriptions in hand. But due to her being on her own, while managing the pharmacy and the inspection, the RP had fallen slightly behind with the day's prescriptions. But she worked hard to keep on top of her dispensing tasks. And at the same time, she dealt with a continuous stream of people requesting prescriptions or advice. And she dealt with them compassionately, promptly and efficiently, whether in person or on the phone. She indicated that that team members generally worked closely with one another. They assisted each other when required and discussed issues. And they supported one another to complete their tasks. The RP encouraged all the trainees to seek her help when they needed it.

The RP described the pharmacy as having a small, close-knit team who worked regularly together and could raise concerns and discuss issues when they arose. The RP kept team members up to date by providing information about new services and new medicines. And they tried to complete training when they could. Team members did not have formal reviews about their work performance but reportedly discussed issues as they worked. And they had one-to-one meetings with the RP if there was anything specific to discuss. The RP felt that, in general, she could make day-to-day professional decisions in the interest of patients. But increasingly she felt pressure from local surgeries to provide emergency supplies, when they could not produce prescriptions in good time for people. But while this added further pressure to her already heavy workload, she felt able to make decisions about the appropriateness of making such supplies, case by case.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. They are tidy and organised and sufficiently clean and secure. The pharmacy provides an adequate and secure environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy's premises had a small retail area and a small dispensary. And it had a consultation room. The team followed a cleaning routine to ensure that contact surfaces were clean. And so, the pharmacy was clean and tidy. The dispensary had a single run of dispensing bench in the main dispensary and a separate run of dispensing bench in a narrow, smaller room behind, which was used for dispensing and checking multi-compartment compliance packs. It had an additional room to the rear of the dispensary which was currently used for general storage and occasional staff rest breaks. And it also had a general staff area. The pharmacy had two rooms upstairs which were used for office and administration work. And for training. Overall, the pharmacy was clean and tidy. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

The pharmacy had a consulting room for the face-to-face 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 could not be overheard outside of it. And its contents were kept secure. The pharmacy had a sink for staff and dispensing purposes. The sink had a supply of hot and cold water. And it was cleaned thoroughly after use. Members of the pharmacy team were responsible for keeping the premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. And in general, it ensures that it supplies its medicines with the information that people need to take their medicines properly. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. But it does not ensure that all the medicines on its shelves are packaged and labelled correctly.

Inspector's evidence

The pharmacy had a gradual but small step-up at its entrance. This was due to it being on a slight hill. The RP described how the team assisted people who may have difficulty with the entrance. But people rarely needed it. The pharmacy's customer area was free of unnecessary obstacles. And it had a delivery service. The pharmacy prioritised the service for people who had no other way of getting their medicines. It also ordered people's repeat prescriptions when asked. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them and for a small number of people in care environments. The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. And it updated people's records. The team labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And its labelling directions gave the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. So that people could find the information they needed if they wanted to. The pharmacist gave people advice on a range of matters. And she would give appropriate advice to anyone taking higher-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP described how she would counsel at-risk people when supplying the medicine to ensure that they were on a pregnancy prevention programme. The RP also knew to supply the appropriate patient cards and information leaflets each time. The RP also provided a blood pressure measuring service. And a travel vaccination service. She provided these services under the appropriate, protocols and kept records. People sought the blood pressure service themselves or on the advice of their GPs. The RP described how she had referred several people back to their GPs after finding that their blood pressure readings were higher than they should be.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. It generally stored its medicines appropriately and in their original containers. But the inspector found packs of medicines with two distinct brands of the medicine inside. And some of the strips had different expiry dates, or no expiry date at all where they had been cut from the original strip. And so, the additional strips could be missed during expiry date checks. And those added from a different brand or different batch could be missed if they were part of a medicines recall. The pack also indicated that it contained 28 tablets when it contained 50. And so, it did not give a clear and appropriate description of the contents. The inspector discussed this with the RP, and they agreed that

team members in training should review their understanding of the correct procedures to follow when putting medicines back into stock after dispensing.

The pharmacy stored its medicines stock in a tidy and organised manner. It date-checked its stock regularly. And it kept records to show what had been checked and when. The team identified and highlighted any short-dated items. And it removed them from stock at the appropriate date. It only dispensed them with the patient's agreement where they could use them before they had expired. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls. But in December last year it had returned two capsules from a recalled batch of Macrobid PR 100mg capsules.

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 the appropriate equipment for counting tablets and capsules. And it had the appropriate measures for measuring liquids. And the equipment it used was cleaned after use. Team members had access to a range of up-to-date reference sources. The pharmacy had several computer terminals which had been placed at individual work- stations around the pharmacy. Computers were password protected. And team members knew to use their own smart cards to ensure that they could maintain an accurate audit trail. And to ensure that access to patient records was appropriate and secure.

The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of this refrigerator. People's personal data was kept securely. The pharmacy restricted access to its computers and patient medication record systems. 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. The RP calibrated the blood pressure measuring machine regularly to ensure it gave accurate readings.

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.