General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Conway Chemist, 8 Station Parade, West Acton, LONDON, W3 0DS

Pharmacy reference: 1041402

Type of pharmacy: Community

Date of inspection: 17/10/2019

Pharmacy context

An independently run community pharmacy. The pharmacy is in a residential area of West Acton, next to other locally run shops and businesses and near an underground tube station. As well as the NHS Essential Services, the pharmacy provides Medicines Use Reviews (MURs), New Medicines Service (NMS)and a delivery service for the elderly and housebound. The pharmacy also provides medicines in multi-compartment compliance packs for people living in the local community.

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 safe and effective. The pharmacy's team members listen to people's concerns and keep people's information safe. They discuss any mistakes they make and share information on what could go wrong to help reduce the chance of making mistakes in future.

Inspector's evidence

Team members worked under the supervision of the RP whose sign was displayed for the public to see. And there was a set of standard operating procedures (SOPs) for staff to follow. Team members had read and signed the SOPs relevant to their roles. The pharmacy had procedures for managing risks in the dispensing process and team members said that mistakes were relatively rare. All incidents, including near misses, were discussed at the time. Although there was no formal process of review the pharmacist would review near misses periodically. The team also had regular discussions about how to prevent the same mistakes from happening again and how to improve the safety and effectiveness of dispensing overall. The pharmacist described how they had made each other aware of similarly named and similarly packaged items. Look-alike-sound-alike drugs (LASAs) such as olanzapine and omeprazole had been separated to help prevent a mistake. Other LASAs had been discussed to raise awareness of the risks of selecting the wrong one. The pharmacist described how all dispensed products were double checked either by himself or the dispenser, depending on who had dispensed it.

The pharmacy had a documented complaints procedure. A SOP for the full procedure was available for reference. Where possible, customer concerns were dealt with at the time by the regular pharmacist. Formal complaints were recorded and referred to the owner or her representatives. But, staff said complaints were rare. Details of the local NHS advocacy service and PALs could be provided on request. But, the pharmacy team generally had a positive approach to customer feedback. A previous survey demonstrated a high level of customer satisfaction. The team described how they ordered the same brands of medicines for certain people to help meet their needs. Customer preferences included the Teva brand of atorvastatin 40mg and diazepam 2mg. Notes were added to patients' patient medication records (PMRs) as a reminder for staff. The pharmacy had professional indemnity and public liability arrangements so, they could provide insurance protection for staff and customers. Insurance arrangements were in place until 30 July 2020 when they would be renewed for the following year.

All the necessary records were kept and were in order including emergency supplies, the responsible pharmacist (RP) and unlicensed 'Specials' were also in order. Records for private prescriptions were generally in order although several did not provide the prescription date. Controlled Drug (CD) registers were generally in order although the MST 10mg tablets register had been amended part-way through to include Morphgesic 10mg tablets and all generic forms of the drug, whilst there was also an open register for Filnarine 10mg tablets, a named generic. This could lead to an incorrect entry and the existence of two registers for generic forms of morphine sulphate 10mg MR tablets. The pharmacy kept records for CDs, returned by people, for destruction.

Staff had undergone information governance and GDPR training. They had also read and signed a confidentiality agreement. Completed prescriptions were stored with patient details facing away from the counter and customer areas so that they could not be seen by other people using the pharmacy. Discarded labels and tokens were shredded. The pharmacist on duty had completed level 2 CPPE

training for safeguarding children and vulnerable adults. Remaining staff had been briefed and were aware of their responsibilities. The pharmacy team had not had any specific safeguarding concerns to report. Contact details for the relevant safeguarding authorities were available online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload safely and effectively and team members work well together. They are comfortable about providing feedback to employers and are involved in improving the pharmacy’s services

Inspector's evidence

The pharmacy had a regular responsible pharmacist (RP) who managed services with the support of two part- time trainee dispensers and two part-time medicines counter assistants (MCA)s. On the day of the inspection the RP was supported by one of the trainee dispensers and an MCA who began work part-way through the inspection. This was small close- knit team and it was clear that discussions about the tasks in hand were integral to the day to day running of the pharmacy. Team members were observed to work well together. They assisted each other when required and discussed matters openly. The daily workload of prescriptions was in hand and customers were attended to promptly.

The RP described being able to raise concerns. He said he had regular informal discussions with the owner’s representatives. Team members had informal discussions during which they could make suggestions and raise concerns. The RP described how he had requested a new carpet at the door as the old one was worn. He was concerned about the risk of trips and falls and so the carpet was replaced. The RP felt able to make his own professional decisions in the interest of patients. He would offer an MUR or NMS when he felt it beneficial for someone. He was mainly targeted with managing the daily workload and to provide a good service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, tidy and organised. They provide a safe, secure and professional environment for people to receive healthcare services.

Inspector's evidence

The pharmacy’s premises had a traditional appearance with double front, full-height windows and a glass door providing natural light. The pharmacy had step free access from outside. The pharmacy had been partly modernised, but it had retained its traditional appearance with some original wooden shelving and drawer units along one wall. Overall, the shop floor area was bright and clean. It was clear of obstructions and wide enough for wheelchair users. There was a small seating area for waiting customers. Items stocked included a range of baby care, healthcare, beauty and personal care items.

The pharmacy had a consultation room which the pharmacist used for private conversations and services such as MURs. The door to the room was situated behind the chemist counter part of which could be raised to allow people access. Overall the dispensary was relatively spacious. There was a small dispensary behind the chemist counter with a doorway leading into two further rooms and staff facilities to the rear. The majority of dispensing took place in the small dispensary to the front, which had a three to four metre L- shaped run of bench space and shelves and drawers for storing medicines. The room just behind had a three to four metre run of bench space and a desk. This room was used for dispensing multi-compartment compliance packs and for general administrative tasks as well as for storing files folders and bulky items of stock. Rooms to the back were used by staff and for general storage.

The dispensary was generally clean, tidy and organised but there was a lack of storage space with some bulky items stored on the floor and slightly cluttered work benches. The floor in back shop areas was worn in places and looked like it needed to be replaced. In general, the pharmacy was tidy and organised and had a professional appearance. Shelves, worksurfaces, floors and sinks were generally clean.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes them available to everyone. The pharmacy generally manages its medicines safely and effectively. The pharmacy's team members check stocks of medicines regularly to make sure they are in date and fit for purpose. But, it does not store all of its medicines appropriately, once they have been removed them from their original packs. While team members generally give people the advice they need, they do not always give people enough information to help them take their medicines properly.

Inspector's evidence

A selection of the pharmacy's services was advertised at the front window. The pharmacy also had a small range of information leaflets for customer selection. The consultation room was suitable for wheelchair access which meant that wheelchair users could access services requiring a private consultation, such as a MUR. There was a set of SOPs in place and in general, staff appeared to be following them. But, there were some examples of SOPs not being followed; CD stock was audited periodically rather than weekly as per the CD SOP and patient returned CDs were not always recorded on receipt. However, the quantity of stock checked (MST 60mg tablets) matched the running balance total in the CD register.

Multi-compartment compliance packs were provided for people who needed them. Patient information leaflets (PILs) were offered to patients with new medicines but not on a regular basis thereafter. While labels on compliance packs had the required BNF advisory information, to help people take their medicines properly, the packs were supplied without a description of colour and shape, so it would have been difficult for people to identify which medicine was which. The pharmacy had procedures for targeting and counselling all patients in the at-risk group taking sodium valproate. Staff couldn't locate warning cards, and the MHRA guidance sheet but the RP said he had read the safety alert information issued by the MHRA and offered counselling as appropriate. Packs of sodium valproate in stock bore the updated warning label.

Medicines and Medical equipment were obtained from: AAH, Alliance Healthcare, Sigma and Colorama. Unlicensed 'specials' were obtained from Thame Laboratories. All suppliers held the appropriate licences. In general, stock was stored in a tidy, organised fashion. But, there were several dispensing bottles of loose tablets or capsules which had been de-blistered from their original packs. The bottles contained only a brief description of the contents and did not show the product form, PL number, batch number or expiry date. And, there was no indication that the label description and contents had been checked by a pharmacist. Products stored in this way could be missed when checking product recalls or expiry dates, and if any mistakes had been made when bottling the products, they may lay undetected. A CD cabinet and a fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read and recorded daily. Stock was regularly date checked and records kept. Short dated stock was highlighted. The pharmacy team was scanning products in accordance with the European Falsified Medicines Directive (FMD).

Waste medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. But staff did not have a list of hazardous waste to refer to or a separate container, so they could ensure that they were disposing of all medicines appropriately. Drug recalls and safety alerts

were generally responded to and records were kept. The RP had received a recall that morning for Rifadin 150mg capsules and had not found any of the affected stock. None of the recalled batches had been identified in the recent recalls for ranitidine tablets, Dovobet gel, Incruse inhalers and aripiprazole 1mg/ml.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities for the services it provides. It uses its facilities and equipment to keep people's information safe.

Inspector's evidence

The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures and tablet triangles were of the appropriate BS standard and clean. Precautions were taken to help prevent cross contamination by using a separate triangle for counting loose cytotoxic tablets. And amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris. CD denaturing kits were used for the safe disposal of CDs. There were up to date information sources available in the form of a BNF, a BNF for children and the drug tariff. Pharmacists also had access to a range of reputable online information sources such as NHS, NICE and EMC websites.

There were two computer terminals available for use in the dispensary. Both computers had a PMR facility, were password protected and were out of view of patients and the public. It was noted that the RP was using his own smart card when working on PMRs. The dispenser used the other computer and her own smart card. Staff used their own smart cards to maintain an accurate audit trail and to ensure that access to patient records was appropriate and secure. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was shredded.

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.