General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Churchills Pharmacy, 202 Chiswick High Road, LONDON, W4 1PD

Pharmacy reference: 1041411

Type of pharmacy: Community

Date of inspection: 05/01/2024

Pharmacy context

This is an independently owned community pharmacy. The pharmacy is on a parade of local shops and businesses in the west London suburb of Chiswick. It provides a range of services including dispensing prescriptions. And it has a selection of over-the-counter medicines and other pharmacy related products for sale. It provides a range of other services, including a winter flu vaccination service, a blood pressure 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 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 responsible pharmacist (RP) was the regular responsible pharmacist (RP). He was also the superintendent and owner. The RP described how he generally highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistake from happening again. The team did not regularly record its mistakes. And it did not have a formal process for regularly reviewing them. But the RP was present in the pharmacy full time. And he recognised when similar mistakes were being repeated. And when this happened, he reviewed them with the team, to raise awareness and reduce the risk of a reoccurrence. The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs). And in response to several near miss mistakes with LASAs it had separated several of these products to different areas of the dispensary. It had done this to reduce the risk of selecting the wrong one. But the team recognised that preventing such mistakes required on going monitoring and intervention. And while it was clear that the team discussed what had gone wrong. And it acted in response to its mistakes, it did not record what its team members had learned or how they would improve. And they did not always identify the steps they could introduce to their own procedures to prevent future mistakes. The RP, and inspector discussed this and agreed that it was important to ensure that all near miss mistakes should lead staff to reflect on their own dispensing procedures. And improve them. And by recording them it would also help the RP to monitor learning and improvement more effectively.

The pharmacy had a set of standard operating procedures (SOPs) for its team members to follow. The RP agreed that the SOPs were due for a review. Team members had read them. And they appeared to understand and follow them. The medicines counter assistant (MCA) consulted the RP when she needed his advice and expertise. And she asked appropriate questions before handing peoples prescription medicines to them. Or selling a pharmacy medicine. She did this to ensure that people got the right treatment and advice about their medicines. The dispensing assistant (DA) was observed to attend to her allocated tasks, prioritising the most urgent prescriptions and using the pharmacy's patient medication record system (PMR) competently. The RP had placed his RP notice on display where people could see it. The notice showed his name and registration number as required by law.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy also had a complaints procedure to follow. And the team knew how to provide people with details of where they should register a complaint if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. The RP commented that, at times, people were unhappy that their medicines were not available. These issues were often out of the pharmacy's control, as the problem often arose with medicines which were unavailable from the manufacturer. Or only available at a significant cost to

the pharmacy. But, to help the situation, the team worked closely with local surgeries to ensure that people did not go without essential medicines. It chased prescriptions up when there was a delay. And it arranged for alternatives when it received a prescription for an item it could not supply. It also tried to keep people's preferred brands of medicines in stock so that they did not have to wait while the team ordered them. 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 RP record, its private prescription records and its controlled drug (CD) registers. It kept a record of its CD running balances. And a random sample of stock checked during the inspection matched the total recorded in the register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. But it had not had any for some time. The inspector and RP discussed this and agreed that it was important to ensure that team members understood the importance of ensuring that the pharmacy had records for all patient returned CDs. The pharmacy's emergency supply records were generally in order although it had some gaps where team members had forgotten to record the reason for making the supply. But it was clear that the team understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They discarded confidential paper waste into separate waste bins as they worked. And all confidential waste was collected regularly for shredding by a licensed waste contractor. The team also kept people's personal information, including their prescription details, out of public view. Team members had completed appropriate safeguarding training. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. But it had not had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained and skilled team members for the tasks it carries out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

On the day of the inspection the RP worked with an additional part-time pharmacist, a DA and an MCA. The pharmacy employed three part-time trainee MCAs who generally worked on Saturdays only. While the trainee MCAs had received in house training, they had not yet begun any formal training on a recognised MCA training programme. The RP agreed that all team members should have the right skills for their roles, and that the three trainees would be enrolled on an appropriate training course as soon as possible. Team members attended promptly to people at the counter. They were efficient and calm. And they supported one another, assisting each other when required. The team had the daily workload of prescriptions in hand. And while in the process of catching up after the busy Christmas period, it tried hard to keep on top of its other tasks. The part-time pharmacist and RP assisted the MCA when needed. And together they dealt with queries promptly.

Team members did not have formal meetings or appraisals about their work performance. But they discussed issues as they worked. They described feeling supported in their work. And they could make suggestions about how to improve the general workflow. They could also raise concerns with the RP if they needed to. This was a family run independent pharmacy. And pharmacists felt they could make day-to-day professional decisions in the interest of patients.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an environment which is adequate for people to receive its services. And they are sufficiently clean, tidy and secure.

Inspector's evidence

The pharmacy was on a long parade of shops and businesses serving the local community. It had a small retail area with seating for waiting customers. It also had a consultation room which was close to the counter and dispensary. The consultation room had see-through glass windows. But the windows had blinds which could be pulled down to provide privacy for people. And so, it provided a place for people to receive pharmacy services or have a private conversation with one of the pharmacists. The pharmacy had a short pharmacy counter which was open on one side. The opening provided access to the dispensary and the area behind the counter for staff and authorised visitors. The opening at the counter also connected the retail space to the back shop area. With a prescription storage area and a staff area. This provided easy access for staff retrieving prescriptions for people. It had a medicines counter which supported a transparent screen to help reduce the risk of spreading viral infections. It kept its pharmacy medicines behind the counter.

The pharmacy had a compact dispensary. But it had enough space for team members to dispense the pharmacy's multi-compartment compliance packs. The dispensary had dispensing benches on three sides which were used for the pharmacy's dispensing activities. And it had storage facilities above and below the benches. One of the dispensary's workstations faced the retail space and the back of the medicines counter, so that team members could see people waiting. The pharmacy had a cleaning routine. And it generally kept its worksurfaces tidy and organised. It cleaned its work surfaces and equipment regularly. Team members cleaned floors periodically and they tried to keep them tidy. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

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. The pharmacy team gets its medicines and medical devices from appropriate sources. And in general, team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy generally ensures that all its medicines are stored correctly and safely.

Inspector's evidence

The pharmacy had information on its windows promoting its services. And it had a doorway which provided step-free entry. Its customer area was generally free of unnecessary obstacles, making it suitable for people with mobility issues. The pharmacy could also order people's repeat prescriptions if required. And it had a delivery service. But the pharmacy tried to prioritise the service for people who had no other way of getting their medicines. The team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. It also supplied medicines against private prescriptions, some of which came from private online prescribing services.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. And for people living 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 DA processed the prescriptions for the compliance packs. Compliance packs had been labelled with a description of each medicine, including colour and shape, to help people to identify them. While the pharmacy supplied patient information leaflets (PILs) with new medicines it did not supply them with regular repeat medicines. And so, people may not have all the necessary information to help them to take their medicines properly. The inspector and the team agreed that it was important to ensure that people had all the information they needed about their medicines. Pharmacists gave people advice on a range of matters. And they 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, some of whom were in the at-risk group. The RP understood that he must counsel people when supplying the medicine to ensure that they were aware of the risks associated with it. And to ensure they were on a pregnancy prevention programme as appropriate. The RP also knew to provide warning cards and information leaflets with each supply. And he was aware of recent changes in the law about supplying valproate medicines in their original packs. The pharmacy offered a private phlebotomy service. So that people could have a blood test to detect a range of health issues. And the service was delivered by the part-time pharmacist. People were often referred to the pharmacy by their GPs for this service. The pharmacist kept appropriate records of each consultation. And samples taken were sent off to a private laboratory for timely analysis. The service was proving popular with local people.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And in general, the team stored its medicines, appropriately. And stock on the shelves was tidy and organised. But some medicines had been placed back on shelves as loose strips. And not in the manufacturer's original pack. This meant that they were not stored in packs containing all the required manufacturer's information. And while this did not present a high risk of error, it may mean that the

strips could be missed if subject to a recall or an expiry date check. The RP agreed that the team should review its understanding of the procedures to follow when putting medicines back into stock after dispensing. Historically the pharmacy checked the expiry dates of its stock, regularly. But it had been unable to do so recently because of work pressures. But team members described checking expiry dates when they dispensed each item. When the team identified any short-dated items it highlighted them. And it removed them from stock. It only dispensed them with the patient's agreement where they could use them before the expiry date. 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. But the RP agreed that team members should review their understanding of how to take accurate fridge temperature readings. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources. The pharmacy had several computer terminals which had been placed in the consultation room and in the dispensary. Computers had password protection. Team members had their own smart cards. But occasionally they shared each other's. The inspector and team members discussed the importance of using their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in the dispensary out of people's view.

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.