General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cross Chemist, 5 Royal Parade, Ealing, LONDON, W5 1ET

Pharmacy reference: 1041431

Type of pharmacy: Community

Date of inspection: 21/11/2019

Pharmacy context

This is an independently owned community pharmacy. It is on a parade of shops on a busy intersection of west London commuter routes. As well as the NHS Essential Services, the pharmacy supplies methadone to substance misuse clients. It also provides Medicines Use Reviews (MURs), New Medicines Service (NMS) and a delivery service. The pharmacy supplies medicines in multi-compartment compliance aids for people living in the local community. The pharmacy provides seasonal flu vaccinations and a travel vaccination and malaria prophylaxis 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

In general, the pharmacy's working practices are safe and effective. Its team members listen to people's concerns and try to keep people's information safe. They discuss any mistakes they make and share information to help reduce the chance of making mistakes in future. But team members do not do enough in the way that they gather information and use it to learn and improve.

Inspector's evidence

Staff worked in accordance with a set of standard operating procedures (SOPs). They worked under the supervision of the responsible pharmacist (RP) whose sign was displayed for the public to see. Staff had read the SOPs relevant to their roles. The pharmacy had a procedure for managing risks in the dispensing process. According to procedure, all incidents, including near misses were to be recorded and discussed, although only six near misses had been recorded in the last three months. And, there was no formal process of review. The records available did not provide details of what had led to the mistake or what would be done differently in future. Without accurate records of what had gone wrong it may be difficult for the pharmacists and staff to conduct a thorough review of their mistakes so that they could continue to learn from them. This could be particularly relevant for dispensing staff who had yet to begin any formal training.

But, although team members had not been recording all their mistakes, they said that mistakes were relatively rare. They also said that all incidents, including near misses, were discussed at the time. Discussions included finding ways of preventing a reoccurrence. Staff were required to take extra care when selecting 'look alike sound alike' drugs (LASAs). The RP had discussed LASAs with staff to help reduce the chance of selecting the wrong one including allopurinol 100mg and 300mg and similar looking packs of Teva branded of bumetanide 1mg and spironolactone 25mg. Staff described taking extra care when dispensing any of these products.

The pharmacy team had a positive approach to customer feedback. The results of a recent survey had prompted staff to discuss smoking cessation, diet and exercise when appropriate with their customers. One of the medicines counter assistants (MCAs) described how they ordered the same brands of medicines for certain people to help them to take their medicines properly. Customer preferences included the Bristol brand of bisoprolol 5mg and Pfizer Lipitor 10mg and 20mg. These products were kept in a separate basket to ensure they were kept for those who needed them and not supplied to anyone else. The pharmacy had a documented complaints procedure. Customer concerns were generally dealt with at the time by the responsible pharmacist (RP) and superintendent (SI). Staff said that complaints were rare but if they were to get a complaint it would be recorded. Details of the local NHS complaints advocacy and PALs were available on line. 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 12 October 2020 when they would be renewed for the following year.

All the necessary records were kept and were generally in order including records for private prescriptions, unlicensed 'Specials', emergency supplies and the responsible pharmacist record. Controlled Drug (CD) registers were also in order. The pharmacy had a system for recording the receipt and destruction of patient returned CDs. But there was a quantity of Shortec 10mg capsules which had

not yet been entered in the record. These records are necessary as they provide an audit trail and give an account of all the non-stock Controlled Drugs (CDs) which pharmacists have under their control.

Staff had received confidentiality training and signed a confidentiality agreement. Completed prescriptions were stored in the dispensary in a way that patient details couldn't be viewed from customer areas. And discarded patient labels and prescription tokens were shredded on a regular basis. But the pharmacy's delivery records had multiple patients per page, so individual people's details could potentially be viewed by other people signing for their deliveries. The pharmacists had both completed level 2 CPPE training for safeguarding children and vulnerable adults. Support staff knew to raise concerns with pharmacists. 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 one another which will help the pharmacy maintain the quality of its services. But the pharmacy does not do enough to make sure its team members are formally trained for all of their tasks.

Inspector's evidence

The pharmacy had a regular responsible pharmacist (RP), who worked five days per week, and regular locums on Saturday. The rest of the team included four part-time MCAs. On the day of the inspection the RP was supported by two MCAs. The MCAs were observed dispensing prescriptions although they had not yet been registered on a recognised dispensing training course. The RP called the NPA to register one of the MCAs on a course during the inspection. Team members were observed to work well together. They assisted each other when required. The daily workload of prescriptions was in hand and customers were attended to promptly.

Staff received regular training through the on-line training programme; training matters. Records showed that training over recent months included information on hay fever, sore throats and mouth care. They had also had additional interactive training on winter conditions through pharma plus. Staff described being able to raise concerns. They described having regular, informal discussions during which they could make suggestions and raise concerns. The MCA described how they had raised a concern that they were only able to order stock from the dispensary computer. After this a new computer terminal had been installed on the counter. This had improved work flow by allowing the team to order stock and make enquiries without interrupting the dispensing process. The pharmacist felt able to make his own professional decisions in the interest of patients. He would offer a service such as an MUR, NMS or Flu vaccination when he felt it beneficial for someone.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a safe, secure environment for people to receive healthcare services. But the pharmacy's storage arrangements meant that it did not look as tidy and organised as it could. And its décor needs to be refreshed.

Inspector's evidence

The pharmacy's premises were close to a busy thoroughfare with housing close by. The premises had a traditional appearance with a large window and a double glass door. Only one side of the door could be used as a chiller containing drinks had been placed in front of the door on the other side. Light from the windows and door was partly obscured by the fridge and a cash machine, a display stand and a promotional TV monitor. The pharmacy had not been upgraded or redecorated for many years. This made it look less clean than it was. Overall, the shop floor area was clear of obstructions. 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 folded down to allow people access. Overall the dispensary was small. There was a small dispensary behind the chemist counter with a doorway leading directly outside to the rear. The dispensary had a five to six metre, L- shaped run of bench space and shelves and drawers for storing medicines. There was an additional, narrower, run of bench space which was approximately one to two metres in length, to the side. The consultation room was small with a small desk and a folding door. The pharmacy had high shelving for storing files folders and excess stock. But had no additional storage facilities.

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 work benches were slightly cluttered. The paintwork in the dispensary and customer areas was marked in places and was in need of refreshing. 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. The pharmacy generally manages its medicines safely and effectively and gives people the advice they need to help them take their medicines properly. The pharmacy's team members check stocks of medicines regularly to make sure they are in date and fit for purpose. But the pharmacy does not make its services available to everyone. And it does not store all of its medicines appropriately, once they have been removed them from their original packs. This means that it may be more difficult for them to identify those medicines if there was a problem.

Inspector's evidence

The pharmacy's services were advertised at the front window and there was a small range of information leaflets available for customer selection. The pharmacy entrance had a step up from outside, which meant it wasn't suitable for wheelchair users. The consultation room was located behind the counter and also would not have been suitable for wheelchair access. The pharmacy offered a prescription ordering service for those who had difficulty managing their own prescriptions. It also offered a delivery service for people who needed it. Surgeries would call or fax the pharmacy, to let them know when there was a prescription ready for collection. The pharmacy had a set of SOPs in place. A sample of SOPs was checked and, in general, staff appeared to be following them. They were carrying out regular CD stock balance stock audits, as per the SOP. And the quantity of stock checked (morphine sulphate ampoules 10mg/ml) was found to match the running balance total in the CD register.

Multi-compartment compliance aids were provided for people who needed them. Patient information leaflets (PILs) were offered to patients with new medicines and regularly with repeat medicines thereafter. The medication in compliance aids was given a description, including colour and shape, to help people to identify the medicines from the descriptions. The labelling directions on compliance aids gave the required BNF advisory information to help people take their medicines properly. The pharmacist understood the risks for people on sodium valproate who were in the at-risk group and said that he would provide counselling. He also had valproate warning cards, booklets and the MHRA pack containing guidance for pharmacists. Packs of sodium valproate in stock bore updated warning labels. The pharmacy also had extra warning labels for supplies made in plain white cartons. The pharmacy did not currently have any patients in the at-risk group taking the drug.

The pharmacy had up to date PGDs and service specifications for both the private and NHS flu vaccination services. People were briefed on what to expect when receiving a vaccination and asked to complete a consent form. Records were kept of the consultation for each vaccination, including details of the product administered. The pharmacy had procedures in place for managing an anaphylactic response to the vaccination. The pharmacy had the equipment and software for scanning products in accordance with the European Falsified Medicines Directive (FMD) and were scanning all packs with a unique barcode.

Medicines and Medical equipment were obtained from: Alliance Healthcare, AAH, DE Group, Colorama, Sigma, OTC direct and Chemi lines. Unlicensed 'specials' were obtained through Colorama or Sigma. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. The

pharmacy had an open bottle of methadone 1mg/ml which had not been marked with the date on which it was opened. Although the pharmacy dispensed the contents of a full bottle every week, and therefore well within the expiry date of an opened bottle, the labelling on all medicines should accurately reflect the medicine's expiry date. The pharmacy had a quantity of loose gliclazide tablets, in a plain dispensing bottle, in amongst its dispensing stock. The bottle had been labelled with the drug name, strength, form and expiry date only and hence was not packaged with any of the manufacturer's information such as the product licence number, batch number or a PIL. This meant that they could be missed if subject to a safety alert or recall.

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. General stock was regularly date checked and records kept. Short dated stock, with an expiry of date six months or less was highlighted with a red dot and listed under the month of expiry. medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. But the staff did not have a list of hazardous waste to refer to, which would help ensure that they were disposing all medicines appropriately. Drug recalls and safety alerts were generally responded to promptly. The recent recall for paracetamol tablets and this week's recall for ranitidine oral solution had been acted upon and none of the affected stock found. The pharmacist described how he had returned two bottles of ranitidine oral solution following the October recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

In general, the pharmacy, has the right equipment and facilities for the services it provides. Its facilities and equipment are clean and used in a way that keeps people's information safe.

Inspector's evidence

In general, the pharmacy had the measures, tablet and capsule counting equipment it needed. But liquid measures were made of plastic and not of the appropriate BS standard. Tablet and capsule counting equipment was clean. Precautions were taken to help prevent cross contamination by using a separate measure for methadone. 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 used the NPA advice line service and had access to a range of reputable online information sources such as NHS, NICE websites.

There were three computer terminals available for use in the dispensary. Two computers had a PMR facility, the other was for general management and administrative tasks. Computers were password protected and were out of view of patients and the public. The pharmacist was using his own smart card when working on PMRs. 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 for safe disposal.

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.