General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Barons Pharmacy, 3 Margravine Gardens, LONDON, W6 8RL

Pharmacy reference: 1041445

Type of pharmacy: Community

Date of inspection: 12/09/2023

Pharmacy context

The pharmacy is near a busy underground station in a largely residential area. It provides NHS dispensing services, the New Medicine Service and flu vaccinations (seasonal). It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medicines in multi-compartment compliance packs to some people who live in their own homes and need this support. And it receives most of its prescriptions electronically. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

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 identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. The pharmacy protects vulnerable people. And people can provide feedback about the pharmacy's services.

Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs). And team members had signed to show that they had read, understood, and agreed to follow them. The pharmacist said that he highlighted near misses (where a dispensing mistake was identified before the medicine had reached a person) with the team member involved at the time of the incident. And the team members were then responsible for identifying and rectifying their own mistakes. Some near misses had been recorded but the pharmacist said that this was not consistent. He said that he would remind team members to record them so that they could be reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacist said that there had not been any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. He would record them on a designated form, undertake a root cause analysis and inform the superintendent pharmacist (SP).

There was clear workspace in the dispensary and an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. Team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. The pharmacist took a mental break between dispensing and checking medicines.

Team members' roles and responsibilities were specified in the SOPs. The pharmacist said that the pharmacy would open if he had not turned up in the morning. He said that team members knew which tasks they should and shouldn't undertake if there was no responsible pharmacist (RP) signed in. And he said that they would not sell any pharmacy-only medicines or hand out dispensed items if he was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The private prescription records were mostly completed correctly. But the prescribers' address was not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly.

The pharmacist used his own smartcard to access the NHS electronic services during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens.

The complaints procedure was available for team members to follow if needed. The pharmacist said that there had not been any recent complaints and he would refer any to the SP.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education level 3 training about protecting vulnerable people. He described potential signs that might indicate a safeguarding concern and said that he would refer any concerns to the relevant authority. And he gave an example of action he had taken in response to a safeguarding concern. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can take professional decisions to ensure people taking medicines are safe and they can raise any concerns.

Inspector's evidence

There was one pharmacist working during the inspection and he usually worked with a trained dispenser. The pharmacy was up to date with its dispensing and the workload was well managed. The pharmacist appeared confident when speaking with people. He routinely counselled patients on how to take their medicines and ensured that they understood before they left the pharmacy. He asked people questions to establish whether an over-the-counter medicine was suitable for the person it was intended for. He was aware of the restrictions on sales of pseudoephedrine-containing products and knew the reason why. He would refer people to their GP if they regularly requested to purchase medicines which could be abused or may require additional care.

The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. Recent training had been completed for the for the Pharmacy Quality Scheme and included sepsis and safeguarding. The pharmacist was of the continuing professional development requirement for professional revalidation. He had recently completed training about inhaler techniques and over-the-counter medicines misuse. He had also learned about a specific medicine so that he could better understand a patient’s symptoms. The pharmacist said that he had completed declarations of competence and consultation skills for the flu vaccination service.

The pharmacist explained that team members discussed issues and prioritised tasks each morning. And he could make professional decisions. He said that team members had informal ongoing performance reviews. And he had a good working relationship with the SP which meant he could make suggestions. The SP provided cover when the pharmacist was on leave. Targets were not set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access and a bell sounded when the front door was opened. It was bright, clean, and tidy throughout and this presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There was a small bench in the shop area for people to use while waiting. It was positioned away from the counter and dispensary to help minimise the risk of conversations being overheard. The consultation room was accessible to wheelchair users and was to the rear of the pharmacy. It was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. And the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. And people who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

There was a small step up to the pharmacy with a wide entrance. Team members had a clear view of the main entrance from the medicines counter and dispensary. They could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy could produce large-print labels for people who needed them.

Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that prescriptions for higher-risk medicines were usually annotated with blood test results, and he checked these before dispensing the medicines. And a record of blood test results was kept. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription is no longer valid. The pharmacist said CDs and fridge items were checked with people when handed out. The pharmacy supplied valproate medicines to a few people. The pharmacist said that there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacy had additional patient information leaflets, warning cards and warning stickers available for use with split packs. The pharmacist said that they would refer people to their GP if they needed to be on the PPP and weren't on one.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every regularly and this activity was recorded. Short-dated items were clearly marked, and medicines were kept in their original packaging. But there were a few medicines found in with dispensing stock that had expired at the end of August 2023. The pharmacist said that he would ensure that medicines were removed from dispensing stock before they had expired in future.

Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Part-dispensed prescriptions were checked frequently. Prescriptions for alternate medicines were requested from prescribers where needed and there were no part dispensed prescriptions at the pharmacy. The pharmacist said that prescriptions were kept at the pharmacy until the remainder was dispensed and collected. And he said that 'owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. The pharmacist said that items uncollected after around three months were returned to dispensing stock where possible. And the prescriptions for these items were returned to the NHS electronic system or to the prescriber.

People had assessments to show that they needed their medicines in multi-compartment compliance packs to show that they needed them. Prescriptions for people some people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. other people requested them themselves. Prescriptions for 'when required' medicines were not routinely requested. The pharmacist said that people usually let the pharmacy know if they needed them the next time their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. The pharmacist said that the dispenser usually dispensed the packs, and he checked them.

Deliveries were made by a delivery driver twice a week to people who were not able to get to the pharmacy. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. If the person was person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor had been in use for a few months. And it would be replaced in line with the manufacturer’s guidance. The weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.