General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Church Pharmacy Limited, 83 Uxbridge Road, Hanwell, LONDON, W7 3ST

Pharmacy reference: 1041460

Type of pharmacy: Community

Date of inspection: 19/12/2019

Pharmacy context

This is an independent, family run pharmacy. It is on a busy main road on the outskirts of Ealing town centre. As well as 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 for those who need it. And it supplies medicines in multi-compartment compliance aids for people living in the local community. The pharmacy also provides a travel vaccination and malaria prophylaxis service and a seasonal flu 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

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. All incidents, including near misses were to be recorded and discussed, but near misses had not been recorded in the last three months. The records made prior to this had prompted a review of procedures for handing out prescriptions. They had also prompted a more thorough check of patient name and drug quantity. The team said that they discussed all incidents at the time. And held monthly reviews to identify what had led to the mistake or what would be done differently in future. But, as incidents had not all been recorded the information available for review was incomplete. Without accurate records of what had gone wrong each time, 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.

But, although team members had not been recording all their mistakes, they said that mistakes were always discussed with the pharmacist. And discussions included finding ways of preventing a reoccurrence. Staff were required to take extra care when selecting similar drugs such as atorvastatin and simvastatin and different strengths of various drugs such as losartan. Different strengths of commonly prescribed drugs were separated with products in between to help reduce the chance of selecting the wrong one. Staff described taking extra care when dispensing any of these products.

The pharmacy team had a positive approach to customer feedback. The RP described how they ordered the same brands of medicines for certain people to help them to take their medicines properly. Customer preferences included the Teva brand of atenolol 100mg and the Milpharm brand of bisoprolol 10mg. Notes were made on individual patient medication records (PMRs) to ensure they were dispensed for those who needed them. The pharmacy had a documented complaints procedure. Customer concerns were generally dealt with at the time by the RP or superintendent. Staff said that complaints were rare but if they were to get a formal complaint it would be recorded. Details of the local NHS complaints advocacy and PALs were available online. The pharmacy had professional indemnity and public liability arrangements in place, so they could provide insurance protection for staff and customers. Insurance arrangements were in place until 31 July 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 and emergency supplies. CD registers were also in order. The pharmacy did not have any records for the receipt and destruction of patient returned CDs but said this was because they hadn't had any. A system for recording patient returned CDs provides an audit trail and gives an account of all the non-stock Controlled Drugs (CDs) which pharmacists have under their control. Records for unlicensed 'Specials' were generally in order although there were several which did not have labelling

or prescriber's details. Several records for the RP did not show the times at which the RPs responsibilities had ceased for the day.

Staff had been briefed on the importance of confidentiality. They had also been briefed on information governance in general and GDPR. 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. The pharmacy's delivery records did not reveal one person's details to another. The pharmacists had both completed level 2 CPPE training for safeguarding children and vulnerable adults. Support staff knew to raise safeguarding 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 which helps the pharmacy to improve the quality of its services.

Inspector's evidence

The pharmacy had two regular RPs (brothers) who managed services between them. Each RP worked three full days per week. One of the RPs was also the superintendent (SI). The rest of the team included a full-time dispenser, a part-time dispenser, a full-time, trainee medicines counter assistant (MCA) and a part-time, trainee MCA. On the day of the inspection the RP was supported by both dispensers, and both MCAs. 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.

This was a family business and regular discussions were integral to the day to day running of the pharmacy. Staff would have informal discussions during which they could make suggestions and raise concerns. The dispenser described how she had offered opinion and helped organise the general workflow, with regard to multi-compartment compliance aids. She did this by preparing some compliance aids on a weekly basis so that changes could be accommodated more easily. The pharmacist was both the SI and a director of the business and 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 also tried to manage the daily workload and to provide a good service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises were tidy, organised and clean. They 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.

Inspector's evidence

The pharmacy's premises were on a busy main road, adjacent to a residential area. They had a modern appearance with a double front, full height windows and a glass door to provide natural light. However, windows were partly obscured by display stands and posters. The shop floor was clear of obstructions and was 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 narrow area of shop floor to the side of the counter and dispensary. Customers could stand here while waiting for their prescriptions. And could talk to the pharmacist in relative privacy. The consultation room was located here, to the rear of the pharmacy. The pharmacist used the consultation room for private conversations and services such as MURs. The consultation room had a sharps bin on the floor and a filing cabinet containing patient sensitive documents. The door to the room was kept closed although not locked, but it was unlikely that a member of the public could enter the room unnoticed as it was in direct view of staff working at the dispensary's main dispensing and checking bench. The dispensary was compact. It had a three to four metre L-shaped run of dispensing bench to the front and side and a further two to three metre run of bench space to the side and rear. The longest run of bench space was where most of the dispensing took place. The rear area of dispensing bench had a hatch which was originally designed for handing out prescriptions and patient counselling. But staff found that patients would often lean over the hatch area whilst staff were dispensing other prescriptions. This proved to be distracting. And posed a risk to the confidentiality of other patients. Staff had therefore placed boxes in front of the hatch area to stop people leaning over. This area of dispensing bench was now used for multi-compartment aid dispensing. Work surfaces were well used but there was a clear work flow.

General storage in the dispensary appeared to be insufficient. Bulky prescriptions were piled up in a box on the floor which meant that their retrieval could be inefficient. However, despite a lack of storage space, the dispensary was generally clean, tidy and organised. To the rear of the premises, the pharmacy had a staff area, toilet and a storage area with a metal door to the outside. Staff areas were clean. Overall, the pharmacy was tidy and organised and had a professional appearance. Shelves, worksurfaces, floors and sinks were clean.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes them available to everyone. It 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 label all of its medicines appropriately, once they have been opened or removed 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 range of information leaflets available for customer selection. But the display of leaflets was untidy and many of the leaflets appeared to have been there for some time. The pharmacy had a step-free entrance. The shop floor had wide clear aisles and the consultation area could be accessed by someone using a wheelchair. The pharmacy offered a prescription collection service although the need was rare. It also had a prescription ordering service for those who had difficulty managing their own prescriptions.

There was a set of SOPs in place. Several SOPs had been reviewed earlier in the year and others were currently under review. In general, staff appeared to be following the SOPs. Although they did not carry out a full CD stock audit every month as per the SOP. A CD stock balance had not been carried out for three months, but the quantity of stock checked (Longtec 10mg capsules) matched the running balance total in the CD register. Multi-compartment compliance aids were provided for people who needed them. There was no SOP for staff to follow but they had been briefed by the pharmacist. Product information leaflets (PILs) were offered to patients with new medicines and provided regularly with repeat medicines. The medication in compliance aids was given a description, including colour and shape, to help people to identify the medicines. And 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 in the at-risk group, who were taking sodium valproate, and said that he would provide counselling. Packs of sodium valproate in stock bore the updated warning label. At time of inspection the pharmacist could not locate the MHRA pack containing warning cards, leaflets and extra warning labels but said he would order more. He was able to locate warning cards which he supplied with other high-risk drugs such as lithium, methotrexate and anticoagulants. The pharmacy had up-to-date PGDs and service specifications for the private, NHS and London wide 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 although product details were missing on some. The pharmacy had procedures in place for managing an anaphylactic response to the vaccination.

The pharmacy had completed the required national audits for sodium valproate, lithium, methotrexate and NSAIDs. And as a result, had counselled patients to ensure that their drug regimens were managed properly. The pharmacy did not yet have the equipment and software for scanning products in accordance with the European Falsified Medicines Directive (FMD) and hence, were not scanning packs with a unique barcode. Medicines and Medical equipment were obtained from: Alliance Healthcare, AAH, Colorama and Sigma. Unlicensed 'specials' were obtained from Sigma and Thame Laboratories

through Colorama. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. But there was a pack containing a loose strip of amlodipine. The pack didn't contain any information to show the drug name, form strength, batch number or expiry date. And the strip itself did not have details of batch number, expiry date or strength. There was also a pack of Sun Pharma codeine phosphate 30mg which contained a loose strip Teva codeine phosphate 30mg. The strip of Teva tablets did not have any other manufacturer's details such as the medicines product licence number or a PIL. A pack of aspirin 75mg tablets was also found to contain mixed batches. There was also an open bottle of sugar free 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 one-to-two weeks, and therefore well within the expiry date of an opened bottle, the labelling on all medicines should accurately reflect the medicines expiry date.

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 no out of date medicines were found. In general, the team kept records of date checking although this had not been done recently. In general, stock which had reached its expiry date was removed from storage and put in the Doop bin for collection and disposal 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, although records could not be located. The RP described responding to the recent recall for ranitidine oral solution and paracetamol 1000mg. The pharmacy had not had any of the affected stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

In general, the pharmacy, has the right equipment and facilities for the services it provides. In general, its facilities and equipment are clean and used in a way that keeps 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 generally clean. But there was a dusty residue on tablet triangles. 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. The pharmacy team had access to reputable and up-to-date information sources such as the BNF, the 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 the PSNC, NHS and NICE websites

There was a computer terminal and a laptop in the dispensary. Both had a PMR facility, were password protected and were out of view of patients and the public. And the laptop could be taken into the consultation room when needed. It was noted that 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 the pharmacy had a shredder for disposing of confidential waste safely.

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.