General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bush Pharmacy, 334 Uxbridge Road, Shepherds Bush, LONDON, W12 7LL

Pharmacy reference: 1041512

Type of pharmacy: Community

Date of inspection: 04/07/2022

Pharmacy context

The pharmacy is located on a busy local high street next door to a GP surgery and in close proximity to several other surgeries. It serves a mixed local population. The pharmacy provides a range of services, including the New Medicine Service and flu vaccinations. It also supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications.

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 adequately identifies and manages the risks associated with its services to help provide them safely. It largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And it protects people's personal information. People who use the pharmacy can provide feedback about its services. When a dispensing mistake occurs, team members generally react appropriately. But they do not always make a record of dispensing mistakes. So, they might be missing opportunities to learn and make the services safer.

Inspector's evidence

The pharmacy had not made many changes to its services as a result of the COVID-19 pandemic. The responsible pharmacist (RP) said that it had been difficult at the start of the pandemic, and there had been a period of heavy dispensing as doctors were prescribing three to six months' worth of medication for people. But the team had managed their workload well throughout. The pharmacy had made a number of changes to help reduce the likelihood of cross infection. For example, a one-way system had been introduced and the number of people allowed in at the same time was restricted. At one point team members were only serving people from the door as they could not manage the flow of people inside the pharmacy. This was only for a short period of time. A delivery service had been provided during the pandemic but this had since stopped. The RP said that the pharmacy worked closely with other local pharmacies and supported each other. PPE was available for the team.

The RP said that a new set of standard operating procedures (SOPs) were introduced in December 2021 and were due to be reviewed in 2023. These were held electronically but were not annotated with date of implementation or review. Team members had signed record sheets to confirm they had read and understood the SOPs. A business continuity plan had been introduced to help ensure team members knew what steps to take in an emergency.

Near misses (where a dispensing mistake was identified before the medicine had reached a person) were highlighted with the team member involved at the time of the incident. A near miss log was displayed on the dispensary wall but only four near misses had been documented since January 2022. The RP said that team members did not document all near misses and that he would encourage them to do so in the future. The inspector discussed the benefits of recording and reviewing the near miss records, for example, to help the pharmacy to identify patterns and minimise the chance of mistakes. The RP described some changes that had been made to minimise near misses, for example, warning stickers had been placed on the shelves to highlight some medicines such as finasteride and folic acid. There was a process in place to record and report dispensing errors (where a dispensing mistake had reached a person). There had not been any dispensing errors for some time.

Team members understood their roles and responsibilities and were aware of the tasks they could and could not carry out in the absence of the RP. The correct RP notice was displayed. Samples of the RP record were not always maintained in line with requirements as the time the RP ceased responsibility was not always recorded. This may make it harder to identify who was RP at a particular time. Other records required for the safe provision of pharmacy services were generally completed in line with legal requirements, including those for private prescriptions and emergency supplies. Several controlled drug (CD) registers were inspected, and these were filled in correctly. The physical stock of a CD was checked

and matched the recorded balance. The pharmacy had current professional indemnity and public liability insurance.

People were able to give feedback or raise concerns online or verbally. The pharmacy had received several positive reviews online. Information on how people could make a complaint was available within the practice leaflet which was displayed in the retail area.

Team members had completed training on the General Data Protection Regulation (GDPR) and had read the pharmacy's information governance policy. Confidential waste was shredded on site. All patient records were held electronically and computers were password protected.

The RP and pharmacy technician had completed the Centre for Pharmacy Postgraduate Education training on safeguarding vulnerable people. All support staff had also completed some training on the subject. The team were aware of the Ask for ANI campaign and had displayed posters in the pharmacy to inform people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to adequately manage its workload. Members of the pharmacy team are provided with some in-house training relevant to their roles and responsibilities. And they have opportunities to give feedback to help improve the pharmacy's services.

Inspector's evidence

There was the RP, a pharmacy technician, two trainee technicians and a medicine counter assistant (MCA) working during the inspection. All members of the team had either completed training or were enrolled onto a suitable course. They worked well together and communicated effectively with each other and with people who used the pharmacy. Team members said there was sufficient cover for the services provided.

The MCA had been working at the pharmacy for over 30 years. She asked relevant questions before selling pharmacy-only medicines and was aware of medicines which were liable to abuse. She described referring to the RP at times, for example, before selling medicines for young children. She said she knew the customers well and could identify any unusual requests.

Trainee members of the team mainly completed their course modules at home but said they were provided with some study time during working hours when possible. The RP had recently enrolled all team members onto a third-party training platform where they could access online modules. They described keeping up to date by reading leaflets and booklets, for example, on eye infections, baby feeds and dermatitis. Training records were not maintained but the RP retained some certificates.

Team members said they felt comfortable discussing any issues with the RP or making any suggestions. The RP had recently introduced lunch break rotations after receiving some feedback from team members. Performance reviews were conducted informally every year and the RP said that he provided feedback to team members on a regular basis. Targets were not set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the services offered and they are kept secure. There is a room where people can have private conversations with a team member.

Inspector's evidence

The pharmacy was spacious and fittings were well maintained. The retail area was clean and tidy. There was ample work and storage space in the dispensary, and workbenches were clean and well organised. A small room, located behind the dispensary, was used to assemble multi-compartment compliance packs. Both this room and the dispensary were fitted with sinks. Pharmacy-only medicines were kept behind the medicines counter which was fitted with a large screen. Two tables had been placed in front of the medicines counter to help maintain a safe distance between people and team members. The consultation room was accessible to wheelchair users and was located next to the medicines counter. It was suitably equipped and conversations at a normal level of volume in the consultation room could not be heard from the shop area. Stairs beside the dispensary, which previously led to the first floor flat, were now blocked off to prevent unauthorised access to the pharmacy. The flat now had its own street-level entrance. The ambient temperature and lighting were adequate for the provision of pharmacy services. The pharmacy was secured from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. Overall, the pharmacy provides its services safely, particularly the multi-compartment pack service, which is well organised. It orders its medicines from reputable sources and largely stores them properly. But the pharmacy does not always identify people taking higher-risk medicines. This may mean that team members may miss out on oppurtunities to provide people with further information about these medicines.

Inspector's evidence

There was step-free access via an automatic door to the pharmacy. Team members had a clear view of the main entrance and could help people into the premises where needed. Services and opening times were clearly advertised, and a variety of information leaflets was available. Some members of the team were multilingual and translated for people who did not speak English well. The pharmacy's opening hours were now back to normal following a short period when the pharmacy closed one hour early to help the team manage the workload. The RP said that people were still struggling to book appointments with their GP, and this resulted in an increased workload for the pharmacy as people visited more for advice. The pharmacy had introduced the blood pressure checking service as people could not visit their GP for this. The pharmacy also provided disability consultations where people were provided with advice on suitable mobility equipment and daily living aids. The RP described visiting some people in their own homes to help assemble the equipment.

Dispensing audit trails to identify who dispensed and checked medicines were seen to be completed. This helped identify who was involved in these processes. There was ample workspace, and benches were well organised. Baskets were used to separate prescriptions and prevent transfer between people.

Prescriptions were seen to be attached to bags of dispensed medicines. Medicines awaiting collection were stored inside drawers in the dispensary. Prescriptions for higher-risk medicines, such as methotrexate and lithium, were not highlighted in any way. The RP said that he did not routinely check if a person taking these medicines was being monitored by their GP and did not maintain records of any checks. He said he provided additional counselling, for example, on the signs of toxicity with lithium. The pharmacy team were aware of the valproate guidance and said they provided leaflets to people in the at-risk group. Leaflets were seen to be available at the pharmacy. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid.

The multi-compartment compliance pack service was well organised. Packs were assembled in a room behind the dispensary to help minimise distractions. A monthly planner board was displayed on the wall, and people were organised according to date their packs were due. This helped the team plan the service. Prescriptions were ordered at least one week in advance to allow time for the team to follow up any changes or missing prescriptions. The technician printed the tokens and labels out and the trainee technician picked stock and assembled the packs. He wore gloves when assembling the packs. The packs were then checked by the RP before being sealed. The original medicine packs were retained for the RP to check. Prepared packs observed were labelled with product descriptions and mandatory warnings. But patient information leaflets were not always supplied, which could mean that people may

not have up-to-date information about how to take their medicines safely.

CD instalments were prepared two days in advance to help the team manage workload and reduce distractions throughout day. The instalments were dispensed by the technician and checked by the RP with clear audit trails maintained.

Patient Group Directions for the travel vaccine service were in date. The RP had completed the relevant training which included injection techniques and anaphylaxis. Patient questionnaires, consent forms, and records of supplies made were retained at the pharmacy and included details of vaccines supplied, their batch numbers and the expiry dates. The RP also updated the patients' electronic medication records with details of vaccines administered. The pharmacy was also a yellow fever centre and was registered with National Travel Health Network and Centre (NaTHNaC). The RP was aware of his reporting duties and had recently sent the pharmacy's yellow fever report to NaTHNaC.

Expiry date checks were carried out regularly and documented on a log which was displayed in the dispensary. Some tablets had been placed in an amber medicine bottle which was not labelled with the expiry date or batch number. A loose blister of carbidopa/levodopa tablets which had expired in 05/22 was found on the shelf. These were all removed from the shelves for disposal. The fridge temperatures were checked and recorded daily. Drug alerts and recalls were received electronically from the MHRA. The RP explained the action the pharmacy took in response to any alerts or recalls. Waste medicines were kept in appropriate bins and stored securely.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment and facilities it needs to provide its services safely. But it does not always use suitable measuring equipment to measure liquids.

Inspector's evidence

The pharmacy had one plastic measure available. The RP said he would order glass measures and dispose of this. There was one fridge in the dispensary which was clean and well organised. The tablet counting machine had not been calibrated for some time and was covered in tablet residue. The RP said the machine was not used much and added that he would arrange for it to be calibrated and cleaned. A separate counting triangle was available for use with cytotoxic medicines. The RP said that the blood pressure monitor was replaced every 18 months. A liquid measuring device was used to measure methadone. This was serviced annually by the manufacturer. Waste medicine bins were used to dispose of waste medicines. Members of the team had access to the internet and several up-to-date reference sources

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.