General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bliss Pharmacy, 107-109 Gloucester Road, LONDON, SW7 4SS

Pharmacy reference: 1093221

Type of pharmacy: Community

Date of inspection: 08/05/2019

Pharmacy context

The pharmacy is located on a busy high street in an affluent area in West London. And it serves a large number of tourists, mainly from the Arab Gulf states. The pharmacy does not have an NHS contract and only dispenses private prescriptions. It also sells over-the-counter medicines and provides blood pressure measuring and blood glucose testing services.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	4.3	Standard not met	The pharmacy cannot show that it keeps medicines that need cold storage at the right temperatures. This could mean that these medicines are not safe to use.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally manages its risks well to make sure people are kept safe. The pharmacy largely keeps records it needs to by law. And it generally protects people's personal information. But team members do not always record mistakes. This may mean that they are less able to spot patterns in mistakes and they may not always understand how to prevent similar mistakes in the future.

Inspector's evidence

A double check was obtained the majority of the time; the dispenser assembled the medicines and placed them in baskets which were put aside to be checked by the pharmacist. The superintendent pharmacist (SI) said he took a short mental break when checking prescriptions that he had dispensed and conducted an additional check when bagging the medicines up.

Short dated medicines were marked with a coloured sticker to reduce the risk of supplying date expired medicines. However, there was limited storage space and medicines were not always stored in an organised manner.

The SI said that the dispensary was regularly de-cluttered as there was limited space. Uncollected medicines which were older than six to eight6-8 weeks were removed from the retrieval system to create more space.

Near misses were not routinely documented; only one near-miss had been recorded since the last inspection in 2016. The SI said that near misses were discussed with members of the pharmacy team. Some changes had been made to reduce errors, for example, newly switched generics were kept with the branded medicines following a near miss where rizatriptan was selected instead of rosuvastatin. Members of the team said they had highlighted the similarities between amlodipine and amiloride tablets.

The SI said that dispensing incidents would be recorded on a specific form which was available at the pharmacy. The SI could not recall any dispensing incidents at the pharmacy. In date standard operating procedures (SOPs) were in place but not all current members of staff had signed the relevant ones to confirm they had read and understood them.

In date indemnity and public liability insurance was in place. The correct responsible pharmacist (RP) sign was displayed and was visible to people. The RP log was generally complete but the time the pharmacist ceased responsibility was not recorded on a number of occasions.

The private prescription register was held electronically. Samples of the register were not always fully complete; some prescriber details were either missing or incorrect. This may make it harder for the pharmacy to show what had happened if there was a query. One prescription which was dated February 2018 and another undated prescription had both been dispensed in May 2019. Some private prescriptions were missing patient addresses and there was no evidence that the pharmacy team had tried to obtain confirmation from prescribers. Emergency supplies were not provided at the pharmacy; medicines were independently prescribed by the pharmacists. 'Specials' records were filled out in line

with MHRA requirements.

Controlled drugs (CDs) were stored securely. Regular balance audits were generally conducted monthly for regularly dispensed CDs, but other CDs were normally just checked once a year. A random stock check of a CD agreed with the recorded balance. Expired stock was kept in a labelled plastic bag, separated from in-date stock.

Members of the team said that customer feedback forms were normally available, but the pharmacy had run out of these at the time of inspection. The SI said he regularly received feedback from foreign embassies whose citizens used the pharmacy. The pharmacy team were now aiming to provide products with longer expiry dates after receiving feedback from an embassy that their citizens' medicines were short-dated and may not be sufficient for the course prescribed.

A frosted glass divider had been fitted at the dispensary bench to minimise the risk of sharing patient-sensitive information. Computers were password protected and confidential waste was shredded at the pharmacy. Medicines awaiting collection were stored inside the dispensary, away from people’s view. Some members of the team said they had received a verbal briefing on protecting patient confidentiality. There was no evidence that all members of the team had completed formal training on data protection and the General Data Protection Regulation. This could mean that they may not know how to protect people’s information properly.

The dispensary manager (also a trainee technician) and pharmacist said they had completed formal training on safeguarding vulnerable people (though this was some time ago for the SI). The dispenser and assistant had not received any training; the dispenser had previously attempted to complete a module through the Centre of Pharmacy Postgraduate Education (CPPE). This could mean that they may not know how to deal with safeguarding issues properly. The SI said he would raise concerns to the social services but contact the NPA for advice beforehand. He queried whether he should raise concerns if a child involved was from abroad (the pharmacy served a large number of tourists); he was advised to refresh his knowledge on safeguarding.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services it provides, and they work in an open environment where they can make suggestions. But they do not always get time set aside to complete ongoing training. This may mean that they could find it harder to keep their skills and knowledge up to date.

Inspector's evidence

At the time of inspection there was the SI, a dispenser, a trainee technician (also the dispensary manager), two assistants, an operations assistant, a beauty sales advisor and a beauty therapist. One of the assistants had been working in the dispensary for approximately two months. The dispensary manager was looking to enrol the assistant onto a dispensing course following a probation period and had discussed this with him.

Annual and emergency leave was covered internally. There was a structured rota in place; members of the team were either planned in for the 9am to 5pm or the 2pm to 10pm shifts. There was at least one pharmacist and one dispenser at any one time in the dispensary.

The dispensary manager described her responsibilities. These included helping with dispensing, managing queues, maintaining stock levels, managing accounts, supervising the ordering of over the counter and retail products, dealing with complaints and liaising with embassy doctors. The operations assistant dealt with online orders of beauty products and was not involved in dispensary tasks.

The assistant working in the dispensary said he used the WWHAM questioning technique when selling Pharmacy-only medicines (P-medicines) and described using his professional judgement to refer or refuse some sales. He was aware of the legal restrictions on the sale of pseudoephedrine-containing products and the reasons behind this. He said he would not sell P-medicines or dispense prescriptions but that he would hand out dispensed and checked medicines in the absence of the RP.

There was little evidence of structured training for the pharmacy team; the SI said that staff were kept updated of any changes verbally. Some members of the team completed training modules, for example from CPPE, in their own time. Training records were not maintained at the pharmacy.

Appraisals were conducted once a year. Members of the team were happy to raise concerns to the SI or director. The dispensary manager had requested for the frosted glass divider which was fitted at the front counter to be lifted slightly to reduce the risk of sharing patient sensitive information. This was taken on board by the director and maintenance had been contacted to arrange for the work to be carried out.

Daily meetings were held to discuss targets, issues, concerns and workload. The SI had discussed telephone calls that the pharmacy had received from someone, checking if the pharmacy had a medicine which may be abused. As a result, the team decided to remove this medicine from the shelf and store it away from people’s view. Members of the team said they communicated effectively together and shared information on a telephone messaging application to ensure all members of the

team were kept up to date. Daily sales targets were set for the team, but they felt these targets were reasonable and did not affect their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally suitable for the pharmacy's services.

Inspector's evidence

The dispensary, which was located to the rear of the shop, was relatively small and comprised one long workbench and storage shelves. There was limited work and storage space; medicines were not always stored in an organised manner (some vitamins were mixed together in large baskets) and bags of medicines awaiting collection were kept on the dispensary floor.

The pharmacy was clean and bright. The room temperature was suitable for the provision of pharmacy services. There was no sink fitted in the dispensary, but members of the team said they used the sink inside the consultation room, which was located next to the dispensary. The room was clean and tidy. A storage room was located in the basement; excess stock was stored in this room. The premises were secure.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always give additional information to people taking higher-risk medicines. This could mean that they may not have all the information they need to take their medicines safely. The pharmacy generally manages medicines to make sure that they are safe for people to use. But it cannot show that it is routinely storing fridge medicines safely. People with a range of needs can access the pharmacy's services. The pharmacy generally provides its services safely.

Inspector's evidence

Access into the pharmacy was via a small step; members of the team described helping blind people and those with wheelchairs into and around the premises. Members of the team spoke a variety of languages including Arabic, French, Bengali, Hindi, Kurdish and Albanian and said they translated for customers when possible.

Pharmacy services were advertised on the pharmacy's website and on a screen in the pharmacy. Team members signposted people to other service providers if a service was not available at the pharmacy.

Dispensing audit trails were not maintained to help identify members of the team involved in dispensing and checking prescriptions. This could make it harder for the pharmacy to identify who did which task if there was a query.

Owing slips were generated for part-dispensed prescriptions and provided to people. The dispensary manager said that the pharmacy contacted prescribers for an alternative product if there were long-term stock supply issues with a medicine.

Both regular pharmacists were independent prescribers. The SI said he mainly prescribed medicines within his fields of competence which were diabetes and pain management. However, a number of prescriptions from a sample checked, were for antibiotics. People were asked to complete a patient questionnaire, detailing their symptoms, medical history and allergies, but some forms were not fully complete. This could mean that the pharmacy is not always able to show that the medicines were prescribed safely. The SI described referring people to other healthcare providers, for example, a person taking blood thinners and a medicine with a narrow therapeutic index was referred to a local hospital after presenting with high fever and described having night sweats.

The pharmacy did not routinely record monitoring parameters for people on higher risk medicines; the SI explained that people taking these medicines were normally closely monitored by their prescribers. He said that he provided advice on side effects and signs of toxicity but could not describe dietary advice to provide people taking lithium. Members of the team had read the valproate guidance but did not have the information cards available to hand or the warning stickers needed when dispensing part packs to women in the at-risk group. The SI thought that the at-risk group for women was 18 to 39

years. He said he would order additional supplies of the information cards and warning stickers.

Stock was received from licensed wholesalers. The SI said that expiry date checks were conducted on sections of the dispensary every one or two weeks, but records of these checks were not always maintained. Short-dated medicines were seen to be marked with a coloured sticker. Some loose blisters were found on the shelves and several packs of medicines expiring in May 2019 were found still on the shelves. Although they had not yet expired. Some medicines and vitamins were mixed together in baskets which may result in an increased chance of picking errors.

The maximum temperature for one fridge was showing as 23 degrees Celsius at the time of the inspection. The thermometer was reset, and the temperature then showed as 8.4 degrees Celsius after a short period of time. Team members could not show the inspector how they checked the temperatures using the thermometers fitted on the fridges. The electronic fridge temperature logs showed that the temperatures for all three fridges were kept within the required range. But as the team members could not show how the temperature was monitored, it was not clear if these were accurate.

Team members said that drug alerts and recalls were received from the MHRA or wholesalers, but the pharmacy had not received some recent alerts, for example, those for prednisolone tablets and chloramphenicol eye drops. Audit trails of action taken in response to these alerts were not maintained. The SI said he would sign on to the MHRA's email subscription service to receive drug alerts and recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

There were two clean glass measures available. Clean counting triangles were also available, including a separate one for cytotoxic medicine. The fridges were clean, but it was not clear if the temperatures inside were maintained within the recommended range. Members of the team had access to the internet and several reference sources.

The SI said that the blood pressure monitor was two and a half years old and the blood glucose monitor was six months old. Internal checks were not conducted for the blood glucose monitor. This could make it harder for the pharmacy to show that it could give accurate readings. The SI said he would look into what checks should be done on the device.

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.