General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Parmay Pharmacy, Unit 4, 160 North End Road, West Kensington, LONDON, W14 9PR

Pharmacy reference: 1096041

Type of pharmacy: Community

Date of inspection: 19/07/2021

Pharmacy context

This pharmacy is one of six branches of a small group of pharmacies. It is located within a parade of shops, on a busy road in West London. The pharmacy dispenses medication to people residing locally. It supplies medication in multi-compartment compliance packs to people who need help managing their medication. The pharmacy also offers a delivery service and the Covid-19 vaccine Service. This inspection was undertaken during the Covid-19 pandemic. Conditions on registration are in place on this pharmacy that prevent some services being provided. These conditions remain in force at the time of this inspection.

Overall inspection outcome

✔ **Standards 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 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 manages the risks associated with its services. People who use the pharmacy can provide feedback and raise concerns and the pharmacy team has received training to help protect the welfare of vulnerable people. Team members generally respond appropriately when mistakes happen during the dispensing process.

Inspector's evidence

The pharmacy had made several changes in response to the Covid-19 pandemic. Screens were fitted at the medicine counters and signage was displayed to help remind people of the restrictions. The pharmacy was limiting the number of people in to maintain social distancing measure and a delivery service was available for people who were shielding. Personal protective equipment (PPE) and hand sanitizers were available for the team and members of the public. A staff risk assessment had been carried out.

There were two large folders containing standard operating procedures (SOPs). The SOPs had been updated in April 2021 but were not signed by team members to confirm they had been read and understood. The responsible pharmacist (RP) was not sure if an SOP covering the sale of medicines existed and whether it had been updated to take into consideration the enforcement action imposed on the pharmacy. The RP said she would check this with the superintendent pharmacist (SI).

Dispensing mistakes which were identified before the medicine was handed to a person (near misses) were seen to be routinely documented. The pharmacist said that these were discussed during team meetings held at the end of the month. A Royal Pharmaceutical Society near miss improvement tool was used to document any trends identified and action to be taken by the team. The RP said that some medicines had been separated to minimise picking errors, for example, pravastatin and pantoprazole. One action point record in the improvement tool in September 2020 was ‘store stock tidily’ but stock was seen to be stored in a disorganised manner on some shelves. Different medicines and strengths were mixed, for example ropinirole tablets were placed over risperidone tablets. This could increase the likelihood of picking errors. The RP said that stock would be tidied.

Dispensing mistakes which reached people (dispensing errors) were recorded and reported on the National Reporting System. A copy of the incident form was printed out and retained at the pharmacy for reference. The RP discussed a dispensing mistake where a person was supplied with three weeks of their multi-compartment compliance packs instead of one week. The doctor had been informed of the dispensing mistake and the pharmacy had updated the person’s bag labels and their online record to highlight the weekly collections. The person was now asked to sign a record to confirm they had collected their weekly packs.

The correct RP notice was displayed. Samples of the electronic RP record were seen to be well maintained. Other records required for the safe provision of pharmacy services were generally completed in line with legal requirements, including those for emergency supplies, private prescriptions and unlicensed medicines. A sample of controlled drug (CD) registers was inspected, and these were filled in correctly. The physical stock of two CDs were 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. A complaints procedure and record book were in place.

Members of the team said they had completed some training on protecting people's confidentiality and had read the relevant SOPs. There were two large folders containing data security and protection procedures, but these were not filled in or signed by members of the team to confirm they had been read. Confidential waste was collected in a separate bag, but some labels were found in the normal waste bin. These were removed and placed in the correct bag during the inspection. Computers were password protected and smartcards were used to access the pharmacy's electronic records. Medicines awaiting collection were stored behind cabinets inside the dispensary and other confidential information was not visible to members of the public.

Members of the team had completed online training on safeguarding vulnerable people. The trainee dispensers described signs of abuse and said that they would refer safeguarding concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

Team members work well together, and they manage the pharmacy's workload well. They feel comfortable about raising concerns. They do the right training for their roles. And they complete some ongoing training to help keep their knowledge up to date.

Inspector's evidence

During the inspection there was a regular pharmacist, two trainee dispensers, one trainee medicine counter assistant (MCA) and a trainee pharmacist. All trainee members of staff were enrolled onto courses relevant to their roles. The trainee pharmacist had started on the day of the inspection but had a two-week induction prior to that. The team was seen to be working well together and managing the workload well, and in an organised manner.

A contingency plan was in place and this had been submitted to the NHS in response to the pandemic. The RP said that local surgeries would be informed, and people would be signposted to other local pharmacies if the pharmacy had to shut in an emergency. Members of staff from another branch could also be drafted in to help.

The MCA was observed referring to the pharmacist before selling an antifungal cream to a person who had already tried another treatment. The MCA described her main responsibilities, which included receiving, checking and sorting deliveries, serving customers and selling over-the-counter medicines. The MCA said that some changes had been implemented with regards to receiving stock from wholesalers, to help reduce discrepancies. The MCA now ticked quantities on the invoices to confirm the items had been received or highlighted missing items. She completed a 'missing items' form if an item was not received and sent this to the wholesaler. Invoices were sent to head office at the end of every month.

All members of staff said they were aware of the restrictions placed on the purchase, sale and supply of certain medicines. They described signposting people to other pharmacies if they needed these particular medicines.

Trainee members of the team completed their course modules in their own time. They were provided with ongoing training material to read at work, for example, they had recently read about the possible switch of two oral contraceptives from prescription-only to pharmacy (POM to P) status. The pharmacist also updated the team with any changes and shared other useful information, for example, Covid-19 updates. One trainee dispenser said she received thorough 'hands on' training from previous colleagues who were very experienced. The RP said she was up to date with continuing professional development and regularly completed training from the Centre for Pharmacy Postgraduate Education. She also read the Pharmaceutical Journal and bulletins from the Pharmaceutical Services Negotiating Committee to keep up to date.

Performance reviews were previously conducted by the manager, but he had recently left. Members of the team said that the RP provided regular feedback. Team members reported that they felt comfortable to approach the RP or SI with any issues regarding service provision. Targets were not set for the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the services offered and are fitted to a high standard. They are kept secure and people can have a conversation with a team member in a private area.

Inspector's evidence

This was a spacious, clean and bright pharmacy. A full refit had recently been completed and fittings were to a high standard. The dispensary was spacious and there was ample work and storage space. Workbenches were kept clean and tidy. A small room located behind the dispensary was solely used to assemble and store multi-compartment compliance packs. A staff room was available, and this was fitted with a small kitchenette and had a table, chairs and lockers for members of the team. A consultation room was available in the pharmacy area. This was clean and organised and had a desk, lockable cabinets and a sink. The room allowed a conversation at a normal volume to take place inside and not be overheard, and a blind was fitted at the window for privacy.

The pharmacy premises had been split in half using barriers. The pharmacy, medicines counter and retail area took up one half and an aesthetic clinic took up the other half. There were separate entrances for both areas. The aesthetic clinic had a small waiting area with a reception desk and two large clinic rooms. This area was currently used for the Covid-19 vaccine service. Both consultation rooms had worktops, cabinets and sinks fitted. One had a therapy bed, and another had a wipeable sofa and chair.

Plastic screens had been fitted at the counters in response to the Covid-19 pandemic. Members of the team cleaned the pharmacy at least twice a day to help prevent cross-infection, in addition to the cleaner who came once a week. The ambient temperature and lighting were adequate for the provision of pharmacy services. Air conditioning was available to help regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

People can access the pharmacy's services. The pharmacy has systems in place for making sure that its services are well organised, particularly the multi-compartment compliance pack service. People taking higher-risk medicines are generally provided with the advice they need to take their medicines safely. The pharmacy orders its medicines from reputable sources and largely stores them properly.

Inspector's evidence

There were two entrances at the front of the pharmacy premises, one was used for routine pharmacy services and another for the Covid-19 vaccine service. Large posters were displayed to direct people to the correct entrance. Access was step free and via double doors at both entrances. A third exit was located at the side of the premises and this was used as an exit route for people accessing the vaccine service. Members of the team said they actively promoted services, such as the New Medicine and Covid-19 vaccine services. Some members of the team were multilingual and were observed translating for people. Large-font labels were available for people with poor eyesight and a delivery service was available for housebound people.

The aesthetics service was not currently provided at the pharmacy. This would be run by a dentist who was in the process of registering with the Care Quality Commission.

Dispensing audit trails to identify who dispensed and checked medicines were seen to be completed. There was ample workspace and baskets were used to separate prescriptions and prevent transfer between people.

Medicines were delivered to peoples' homes by the delivery driver. A delivery log was maintained. People were not asked to sign to confirm receipt of their medicines to help reduce the risk of cross-infection during the pandemic. A calling card was posted to people and medicines were returned to the pharmacy if the person was not at home.

Medicines awaiting collection were stored in cabinets inside the dispensary. Dispensed medicines awaiting collection and requiring cold storage were stored in one fridge, those awaiting delivery were stored in another fridge and stock was kept in a third fridge.

The pharmacy was administering the Covid-19 vaccine over three and a half days every week. The RP said that approximately two vaccines were administered every five minutes, equating to 180 vaccines each day the service was provided. The vaccine was provided under the National Protocol. The RP and another regular pharmacist conducted the clinical checks, administered the vaccine and entered information onto the system. A locum pharmacist was booked in to cover the dispensary on the days the vaccine service was running. One person was employed to cover the reception, another managed the queues and a third person, who was normally a volunteer from St Johns Ambulance, carried out the post-vaccine observation. There were two large leather chairs and two foldable chairs in the small waiting area, all placed close to each other. Several foldable chairs were lined up in a narrow corridor leading to one of the clinic rooms. The RP said that two observation areas were created with these chairs, one in the corridor and another just outside the exit, near the corridor. Although there were two observation areas, there was normally only one person carrying out the observations. The RP was

advised to review this arrangement as it may increase the likelihood of the observer missing a person experiencing an anaphylactic reaction. The corridor was also narrow, and this meant that people accessing the clinic rooms would walk closely past those waiting in the observation area. The RP had completed online and practical training in order to provide the service, including the vaccine-specific and first-aid training. Other members of the team had completed training on the online systems. PPE and emergency kits were available in the clinic rooms.

A Covid-19 testing service was also available at the pharmacy. People carried out the tests inside the consultation room, under the supervision of the pharmacist. The testing kits were then sent to a laboratory using a courier service. The pharmacy had not completed accreditation with the National Accreditation Body for the United Kingdom (UKAS) as the superintendent pharmacist had been told that the pharmacy did not need it. The RP was advised to contact UKAS directly and confirm this.

The multicompartment compliance pack service was well organised. The service was managed by three trainee dispensers and packs were assembled in a separate room, to help minimise distractions. There were clear audit trails of when prescriptions were due, requested, received and processed. Any changes or missing items were followed up with the prescriber. A log was also filled in to inform the pharmacist of any changes. The log included details of the change, the member of staff at the pharmacy who had confirmed this change and details of who they had spoken to. People who were hospitalised were listed on a white board, so it was clear for all members of the team. Their packs were stored on a top shelf and disposed of after 8-12 weeks. Packs were assembled against prescriptions and backing sheets. Cut-outs of the medicine packs used were placed with the assembled packs for the pharmacist to conduct a final check. Some medicines, such as cytotoxics, were not placed in the packs. These were labelled with their batch number and expiry date if they were removed from their original pack. Backing sheets included descriptions of the medicines to help people or their carers identify the medicine. Patient information leaflets were not routinely supplied, which may mean people did not have up to date information about their medicines. The trainee dispensers said they would start supplying these routinely. Assembled packs were stored on shelves labelled with their collection or delivery day. This helped ensure they were supplied on the correct day.

The RP said that prescriptions for higher-risk medicines, such as sodium valproate, were highlighted with a ‘see pharmacist’ sticker. Members of the team knew to refer to the pharmacist if this sticker was attached to a prescription. The RP said that she provided advice to people in the at-risk group but on questioning, she said that child-bearing age was 18-50 years old. This may mean that some people in the at-risk group could be missed and not provided with the appropriate counselling and advice. The RP said she would re-read the guidance. Methotrexate was kept in a separate basket, with a separate tablet counting triangle. Only one strength was stocked at the pharmacy, to help minimise the risk of dispensing errors. The pharmacy did not have the steroid emergency cards, but the RP was aware of them and said she would order some.

Medicines were obtained from licensed wholesalers. Stock was date checked every six months and date-checking records were maintained. One medicine which had been deblistered and stored in an amber medicine bottle was not labelled with the batch number or expiry date. The medicine was disposed of during the inspection. A pack of gabapentin capsules was seen to contain two different batches, one batch expiring approximately a year before the other batch. The pack was removed from the shelf. The temperatures for the fridges in the dispensary were monitored daily and records indicated that they were maintained within the recommended range. The RP said that the temperatures for the fridge used to store the Covid-19 vaccine were only checked on the days the service was running (3.5 days per week) and were not recorded. The fridge temperature was within the recommended range at the time of inspection. The RP provided assurances that the temperature would be checked and recorded daily. Waste medicines were stored in appropriate containers, but these

containers were kept in the staff toilet. The RP was advised to review this arrangement to help reduce the risk of product diversion. The RP said that drug alerts and recalls were actioned, but records of any action taken were not maintained. She was aware of the recent alerts, and said she would maintain records of action taken in response to alerts in the future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had glass measures but some required cleaning. There were tablet counting triangles, including a separate triangle for cytotoxic medicines. This helped avoid cross-contamination. The fridges were clean and suitable for the storage of medicines. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Members of the team had access to the internet and several up-to-date reference sources. A blood pressure monitor was in use, but the RP did not know how old it was. She said she would the monitor would either be calibrated or replaced if required.

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.