General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Terrys Pharmacy, 4 Castle Hill Parade, The Avenue, London, W13 8JP

**Pharmacy reference:** 9010522

**Type of pharmacy:** Community

**Date of inspection:** 29/02/2024

## Pharmacy context

This is an independently owned community pharmacy. The pharmacy is on a parade of local shops and businesses in Ealing, West London. It provides a range of services including dispensing prescriptions. And it has a selection of over-the-counter medicines and other pharmacy related products for sale. It provides a selection of other services, including a winter flu vaccination service, a travel vaccination service. And the new NHS Pharmacy First service. It also supplies medicines in multi-compartment compliance pack to some people.

## 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 does not have sufficiently robust procedures for managing its medicines in the way it should. And it does not always store them in the appropriate packaging. |
| **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. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future. The pharmacy has insurance to cover its services. And its team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy has written procedures in place to help ensure that its team members work safely. The pharmacy adequately completes all the records it needs to by law. But it is not thorough enough in ensuring that all its records are up to date and accurate.

### Inspector's evidence

The responsible pharmacist (RP) was the regular RP. He described how he highlighted and discussed dispensing 'near misses' and errors at the time with the team member involved. This helped them to learn from their mistakes and prevent them from happening again. But the team did not record all its mistakes. And it could not find the records when the inspector requested them. Team members agreed that if they were to keep the record book close to hand, they would be more likely to use it each time. And they agreed that having more information about the type of mistakes they were making would help staff to develop good dispensing practice. But the RP was present in the pharmacy full time. And so, he recognised when similar mistakes were being repeated. And when this happened, he reviewed them again with the team, to raise awareness and reduce the risk of a reoccurrence. He was aware of the risk of confusing look-alike sound-alike medicines (LASAs). And in response to several near miss mistakes with LASAs the team had separated several of these products from each other by having other products in between. It had done this with similarly packaged medicines. And similarly named medicines such as tramadol and trazadone. So, it was clear that the team discussed what had gone wrong. And it acted in response to its mistakes. But by not regularly recording what had happened, it did not have a record of what its team members had learned or what they would do differently next time. The RP described how he reviewed near miss records approximately every month. The inspector discussed this with the RP, and they agreed that having an up to date and accurate set of records would help him to monitor learning and improvement more effectively. And it would help support team members to identify the steps in their procedures which could have prevented the mistake from happening.

The pharmacy had a set of standard operating procedures (SOPs) to follow. Established team members had read the existing SOPs relevant to their roles. Trainee pharmacists had worked at the pharmacy for approximately seven months. And had read the SOPs when they first started. They agreed that they may benefit by reading some of the SOPs most relevant to their training again, especially after something had gone wrong. The trainee technician had worked at the pharmacy for several years. And was an established member of the team. And she consulted the RP when she needed his advice and expertise. Team members asked appropriate questions before handing people's prescription medicines to them. Or selling a pharmacy medicine. They did this to ensure that people got the right advice about their medicines. They were observed to attend to their allocated tasks, prioritising the most urgent prescriptions and using the pharmacy's patient medication record system (PMR) competently. The RP had placed his RP notice on display where people could see it. The notice showed his name and registration number as required by law.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy also had a complaints procedure to follow. And the team could provide people with details of where they should register a complaint if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. The RP commented that in the past people were unhappy that they were asked to speak their name and address or date of birth when collecting their medicines. And so, the pharmacy had placed notepaper and a pen on the counter so that people could write this down instead. And hand it directly to a team member. They could also write down details of any medicines they were expecting. This meant that they were sharing their private information with staff members only. The RP also described how the team had removed a central gondola from the shop floor to provide more space. It had done this after recognising that people felt the shop floor to be cramped. And they did not like standing too close to one another. The pharmacy kept people's preferred brands of medicines in stock when it could. So that they did not have to wait while the team ordered them. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy's private prescription records were complete and up to date. And in general, its CD registers were in order. The pharmacy had not received any patient-returned CD medicines for destruction. And so, it did not have a record book for the purpose. The RP agreed that he would introduce a record book to ensure that if the pharmacy did receive any it could record them properly. The pharmacy maintained running balances of its CDs. And the quantity of a random sample of stock checked by the inspector corresponded to the running balance in the register. The pharmacy's emergency supply records were generally in order. But the RP recognised that several of the records needed a clearer reason for supply. The pharmacy's RP records were also generally in order, but it had some omissions where RPs had forgotten to record the time at which their responsibilities ended for the day. The RP understood that the pharmacy should ensure that all its essential records are accurate and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed general training on confidentiality. The pharmacy discarded its paper waste into separate waste containers. And it shredded the waste regularly. Team members kept people's personal information, including their prescription details, out of public view. The RP and trainee pharmacists had completed appropriate safeguarding training. Other team members had been briefed. And they knew to report any concerns to the RP. The team could access details for the relevant safeguarding authorities online. But they had not had any concerns to report.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough suitably trained and skilled team members for the tasks it carries out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

### Inspector's evidence

The RP worked at the pharmacy five days a week. The pharmacy had a second pharmacist who worked one day a week to cover the RP's day off. On the day of the inspection the RP worked with two trainee pharmacists, the trainee technician and a dispensing assistant (DA). The DA worked solely on dispensing multi-compartment compliance packs in an area reserved for this purpose in the basement. The RP worked closely with the trainee pharmacists. And he was a tutor to one of them. The tutor to the second trainee did not work full-time at the pharmacy. The inspector discussed this with the RP and the second trainee, and they agreed that they would review the number of hours of supervision the trainee had with their tutor. And consider changing the trainee's tutor to the RP with whom she worked most days. Trainees had protected study time and they added to this by also studying at home. Team members attended promptly to people at the counter. They were efficient and calm. And they supported one another, assisting each other when required. And together they dealt with queries promptly. But while the team was up to date with the prescription workload, it had fallen behind with some of its other tasks.

Team members did not have formal meetings or appraisals about their work performance. But they discussed issues as they worked. They described feeling supported in their work. And they could make suggestions about how to improve the general workflow. They could also raise concerns with the RP if they needed to. Trainee pharmacists described how they had discussed how to manage the pharmacy's emails so that it was easier for the team to find emails according to their subject or purpose. And they had organised the pharmacy's emails by organising them into different folders. This meant that they could find and act on messages from the surgeries more quickly. And they could see and act on any drug recalls from the MHRA more easily. This was an independently run pharmacy. And the RP felt he could make day-to-day professional decisions in the interest of patients.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy's premises provide an environment which is adequate for people to receive its services. And they are sufficiently clean, tidy and secure.

### Inspector's evidence

The pharmacy was on a parade of shops and businesses serving the local community. It had a small retail area with seating for waiting customers. It also had a consultation room which was close to the counter and dispensary. The consultation room provided a place for people to receive pharmacy services or have a private conversation with the pharmacist. The door to the room was generally kept closed. But the computer in the consultation room had been left on after being used earlier in the day. The computer had a patient medication record (PMR) system. And patient sensitive information had been left open on the computer screen. While the risk of anyone entering the room unaccompanied was low, the RP agreed with the inspector that the PMR should be closed when not in use. The pharmacy had a short pharmacy counter which was open on one side. The opening provided access to the dispensary and the prescription storage area. This provided easy access for staff retrieving prescriptions for people. It had a medicines counter. And it kept its pharmacy medicines behind the counter.

The pharmacy had a compact dispensary. But it had enough space for team members to dispense the pharmacy's daily prescriptions. The dispensary had dispensing benches on three sides which were used for the pharmacy's dispensing activities. And it had storage facilities above and below the benches. One of the dispensary's workstations faced the retail space and the back of the medicines counter, so that team members could see people waiting. The pharmacy had a basement with a staff area, stock storage and an area for dispensing multi-compartment compliance packs. Staff accessed the basement from stairs just off the dispensary. The pharmacy had a cleaning routine. And it generally kept its worksurfaces tidy and organised. It cleaned its work surfaces and equipment regularly. Team members also cleaned floors regularly and they kept them tidy. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

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

### Summary findings

The pharmacy does not ensure that it keeps all its medicines for dispensing in appropriate packaging. It also does not ensure that it stores them properly. And it does not make all the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy makes its services accessible for people. And it gets its medicines and medical devices from appropriate sources.

### Inspector's evidence

The pharmacy had a small ramp providing step free access. And its customer area was free of clutter and unnecessary obstacles. It had a delivery service for people who found it difficult to visit the pharmacy. And it could also order people's repeat prescriptions for them if necessary. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. And prevent error. The pharmacy dispensed multi-compartment compliance packs to approximately 100 people in care homes and in the community. The pharmacy had a file for each compliance pack patient. Each person's file had details of the medicines they were taking. And team members kept them up to date by adding any changes that had been made by the doctor or hospital. Compliance packs were usually assembled by the DA and then checked by the RP. The pharmacy labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. But the system used for labelling the packs had not been set up to print the required British National Formulary (BNF) advisory warnings. And while the pharmacy generally supplied patient information leaflets (PILs) with new medicines. it did not supply them with regular repeat items. The inspector discussed this with the DA and the RP and it was agreed that the pharmacy would add the required advisory warnings to compliance pack labelling. And leaflets would be supplied at the beginning of each cycle. To ensure that people had additional information about their medicine. And to help them to take their medicines properly.

The RP gave people advice on a range of matters. And they would give appropriate advice to anyone taking higher-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, one of whom was in the at-risk group. The RP counselled them when supplying the medicine to ensure that they were aware of the risks associated with it. And to ensure they were on a pregnancy prevention programme as appropriate. The RP also provided warning cards and information leaflets with each supply. And he was aware of recent changes in the law about supplying valproate medicines in their original packs.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines appropriately and in their original containers. But the inspector found packs of medicines which contained mixed batches of different brands of the same medicine. And one pack contained two different strengths of the same medicine. Several strips in these packs had different expiry dates. This meant that the information on the outside of the packs did not accurately describe what was inside them. And this increased the risk of mistakes. This could happen if some of the contents had been recalled. And expiry dates on individual strips could be missed during the usual checks. The inspector discussed this with the RP. It was agreed that team members should review their understanding of the correct procedures to follow when dispensing a split-pack of

medicines. And when putting medicines back into stock after dispensing. The pharmacy offered the recently introduced NHS Pharmacy First service. This allowed people to access medicines for seven common conditions after an appropriate consultation with the pharmacist. And without having to see a prescriber. The pharmacy had received referrals from its local GP surgeries for the service. And it had also had requests directly from people. The pharmacist had the appropriate protocols to follow. And he kept the necessary records for each supply. He described the popularity of the service. And it was clear that he understood its limitations and when to refer people to an alternative health professional. It was also clear that trainee pharmacists understood the principles of anti-microbial resistance and how to follow the protocols around treating infections under the service.

The pharmacy generally checked the expiry dates of its medicines and devices. but it had not done so in recent months. And it didn't keep records to show what had been checked, when they had been checked and who had checked them. And the system was not robust enough to identify which medicines were short dated. This posed a risk that medicines due to expire soon were not taken off the shelf. The pharmacy team members explained that when they found a short-dated item they highlighted them so that they could be easily identified during the dispensing process. But, during the inspection, a random stock check found several medicines which had expired. This was discussed with the team. And team members agreed that they should conduct a full date check of all stocks as soon as possible. And keep a full audit trail. But team members described how they checked expiry dates when they dispensed, and accuracy checked every medicine to ensure that the medicines they supplied were in date. The team put its out-of-date and patient-returned medicines into dedicated waste containers.

The team generally stored its CD items appropriately. And it had two fridges for storing its fridge items. But when asked team members were not able to read fridge temperatures properly. And so, the records it kept were not accurate. The inspector discussed this with the team who agreed that all dispensing team members should be re-trained on how to read the maximum and minimum temperatures on the fridge thermometer. And on how to reset it every time a reading is taken. The team understood that keeping accurate records of fridge temperatures would ensure that they could monitor fridge temperatures properly and provide assurance that the medicines within it were being stored appropriately. The pharmacy responded promptly to drug recalls and safety alerts. And it kept records of these. The team had not had any stock affected by recent recalls.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. The team uses its facilities and equipment to keep people's private information safe.

### Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources. The pharmacy had several computer terminals which had been placed in the consultation room and in the dispensary. Computers had password protection. Team members had their own smart cards. But occasionally they shared each other's. The inspector and team members discussed the importance of using their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in the dispensary out of people's view.

## 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. |