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: 12/09/2024

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 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 has suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy suitably identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take appropriate action to prevent mistakes in the future.

Inspector's evidence

The responsible pharmacist (RP) was the regular responsible pharmacist (RP). And he often worked alongside the superintendent (SI). The RP and SI described how they generally highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistakes from happening again. The team had reviewed its processes since the previous inspection. And it now recorded its near miss mistakes. And it could locate the records easily. Pharmacists reviewed the team's mistakes as they happened. And they checked for any trends. The RP recognised when similar mistakes had been repeated. And when this happened, he reviewed them with the team, to raise awareness and reduce the risk of a reoccurrence. The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs). And in response to near miss mistakes with LASAs it had separated several of these products to different areas of the dispensary. And it had highlighted the shelf edge with an alert label. It had done this with products such as quetiapine and quinine, and escitalopram and enalapril, to reduce the risk of selecting the wrong one. It was clear that the team acted in response to its mistakes. And it discussed what had gone wrong. The RP, SI and inspector discussed the detail of what the team recorded on its near miss records. And they agreed that records should show what its team members had learned and how they would improve further. They discussed how this would help support team members to identify the steps in their procedures which could have prevented the mistake from happening in the first place.

The pharmacy had a set of standard operating procedures (SOPs) for its team members to follow. The SOPs were up to date. And team members had read them. And they appeared to understand and follow them. The trainee pharmacists consulted the RP or SI when they needed their advice and expertise. And they asked appropriate questions before handing peoples prescription medicines to them. Or selling a pharmacy medicine. They did this to ensure that people got the right advice about their medicines. The dispensing assistant (DA) and trainee technicians 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 did not receive many complaints. But it had a complaints procedure to follow. And the team knew how to 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 described how the team had responded to a situation where surgery staff had referred someone to the pharmacy for the pharmacy first service. But the pharmacy had to refer them back again as they were not eligible for treatment

under the service. The RP felt that the person concerned had not had a good experience as they had to go back and forwards between the surgery and pharmacy before getting treatment. As a result, the RP met with surgery staff to explain the service to them to ensure that referrals were appropriate. The surgery had also provided the pharmacy with a direct number on which team members could call surgery staff to advise that they would be referring someone back so that they could be given an appointment without further delay or inconvenience. The team also worked closely with local surgeries to ensure that people did not go without essential medicines. It chased prescriptions up when there was a delay. And it arranged for alternatives when it received a prescription for an item it could not supply. It also tried to keep people's preferred brands of medicines in stock 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 kept its records in the way it was meant to, including its RP record, its records for emergency supplies. And its controlled drug (CD) registers. It kept a record of its CD running balances. And a random sample of stock checked during the inspection matched the total recorded in the register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. The register was complete and up to date. The pharmacy's private prescription records were generally in order. But some records did not show the prescriber's details as required by law. The team understood the importance of ensuring that all the pharmacy's essential records were in order.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They discarded confidential paper waste into separate waste bins as they worked. And they shredded the waste regularly. The team also kept people's personal information, including their prescription details, out of public view. Team members had completed appropriate safeguarding training. And they knew to report any concerns to the pharmacist. The team had a direct working relationship with the local safeguarding lead. And it could discuss any issues with them. But it 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 the SI, two trainee pharmacists, two trainee technicians and a DA. Trainee pharmacists worked part time at the pharmacy and part-time at the local surgery. And 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 SI was tutor to the other trainee. All 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. The team was up to date with the prescription workload, and most of its other tasks.

Team members had regular one-to-one meetings with the RP to support their training and development. And they described feeling supported in their work. They also had regular meetings each week in which they could discuss issues. And when they could also give and take feedback. They also discussed issues as they worked. They could also raise concerns with the RP or the SI if they needed to. 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. 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 met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. The pharmacy team gets its medicines and medical devices from appropriate sources. And in general, team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy generally ensures that all its medicines are stored correctly and safely.

Inspector's evidence

The pharmacy had information on its windows promoting its services. Its doorway had a small ramp up to the entrance, which provided step-free entry. Its customer area was free of unnecessary obstacles, making it suitable for people with mobility issues. The pharmacy could also order people's repeat prescriptions if required. And it had a delivery service. But the pharmacy tried to prioritise the service for people who were housebound. And had no other way of getting their medicines. The team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. It also supplied medicines against private prescriptions, some of which came from private online prescribing services.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. And it updated people's records. The DA processed the prescriptions for the compliance packs. Compliance packs had been labelled with a description of each medicine, including colour and shape, to help people to identify them. And it supplied patient information leaflets (PILs) with each month's supply. It also included the required British National Formulary (BNF) advisory information on compliance pack labels. And so, people had all the necessary information to help them to take their medicines properly. Pharmacists 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, none of whom were in the at-risk group. The RP understood that he must counsel people 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 knew to provide warning cards and information leaflets with each supply. And he was aware of the requirement to supply valproate medicines in their original packs.

The pharmacy offered the 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 GP. The pharmacy had received requests directly from people. And from its local GP surgeries. Its most common requests were from people seeking treatment for infected insect bite. And for sinusitis. Pharmacists had the appropriate protocols to follow. And they kept the necessary records for each supply. It was clear that they understood the limitations of the service and when to refer people to an alternative health professional. And it had worked closely with its local surgery to ensure that the referrals the surgery made were appropriate for people. The pharmacy also provided a Hypertension Case Finding Service. The RP described how the service had highlighted high blood pressure readings in patients which had led to investigations revealing underlying health issues.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And the team stored its medicines, appropriately. Stock on the shelves was tidy and organised. And the team knew that all medicines should be stored in the manufacturer's original packaging where possible. The pharmacy checked the expiry dates of its stock, regularly. And when the team identified any short-dated items it highlighted them. And it removed them from stock. It only dispensed them with the patient's agreement where they could use them before the expiry date. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had read and acted on a recall received that day. But it had not had any stock affected by it or any other 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, the basement 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.