General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Collins Chemist, 285B Edgware Road, London, W2 1HP

Pharmacy reference: 9012257

Type of pharmacy: Community

Date of inspection: 25/06/2024

Pharmacy context

This community pharmacy is located on a busy main road in Paddington, West London. The pharmacy relocated from another premises nearby in January 2024. The pharmacy sells over the counter medicines, and a wide range of health and wellbeing products. A large portion of the pharmacy's workload involves dispensing of NHS prescriptions. It also offers some other NHS services including the Pharmacy First Service, COVID-19 and flu vaccinations. And it provides private services such as travel vaccinations and ear wax removal.

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

Overall, the pharmacy manages the risks associated with the services it provides. It keeps the records it needs to by law, and it suitably protects people's personal information. Team members understand their responsibilities in safeguarding children and vulnerable people. And the pharmacy has written procedures to make sure the team members know what is expected of them. But the pharmacy's procedures are not effectively utilised to make sure its team members always work in a safe and effective manner. And the pharmacy team members do not always record and review their mistakes, so they may miss additional opportunities to learn and improve.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) based on industry templates. These were available as electronic versions and the dispenser demonstrated how she accessed them. The SOPs covered the pharmacy's main activities and working processes. Most of the team members had signed and dated signature sheets to show they had read and agreed the SOPs. However, the SOP templates had not been formally adopted or dated to show when they had been implemented. This meant SOPs might not always reflect the pharmacy's current working practices.

Team members could explain their roles and they worked under the supervision of the pharmacist. A responsible pharmacist (RP) notice was displayed near to the medicines counter. This did not identify the pharmacist on duty at the time, but this was rectified when it was pointed out. The pharmacy's professional indemnity insurance was provided by a recognised insurer.

Dispensing labels were initialled by the pharmacist responsible for the supply. But team members involved in the assembly process did not always sign to indicate their involvement. They explained how they discussed any mistakes or incidents to identify any contributing factors. The dispenser explained how she had recently highlighted some look-alike-sound-alike medicines to the rest of the team. The pharmacist described how he would handle a dispensing incident to make sure it was suitably resolved, and how he would inform the superintendent pharmacist. Team members were unsure how to record near miss errors and incidents but agreed to discuss this with the superintendent so they could do this if needed. The incomplete dispensing audit trail and lack of error recording could mean the pharmacy team members may miss further opportunities to learn and improve.

The pharmacy used a recognised patient medication record (PMR) system to record prescription supplies. Patient group direction (PGD) consultations and services were recorded appropriately. The team maintained all of the records required by law, including RP logs, controlled drugs (CD) registers, private prescriptions, emergency supply records, and specials records. Records were generally in order, but there were a few record keeping anomalies. For example, RP records did not always identify the time the pharmacist ceased their duties which could cause confusion if a query arose. CD registers did not record the details of the person delivering the medicine on behalf of the pharmacy as the person collecting the medicine. CD running balances were maintained and some balance checks were completed. A couple of CD balances checked were found to match the quantity in stock. But not all register CD register balances were regularly audited which could lead to delays in identifying discrepancies. Specials records had occasional details missing.

Team members understood the principles of data protection and the medicines counter assistant (MCA) confirmed that she completed training on this. There was a data protection and information governance folder with procedures and guidance. Dispensary staff had individual NHS smartcards. The pharmacist's card was not working, and he was using the regular pharmacist's card to access some information. He was aware this was not appropriate and agreed to follow up his request to have his own card issue resolved. Confidential paper waste was separated and shredded. Confidential material was stored out of public view. The pharmacist was level 2 safeguarding accredited. Team members said they would report any concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide the services that it offers. Team members working on the medicines counter and in the dispensary complete the essential training for their roles. Other team members working in the retail business do not complete any pharmacy training. This limits the roles they undertake and means they cannot provide occasional support for the pharmacy services if needed.

Inspector's evidence

The staff present included the RP who was a regular locum, a dispenser, and a medicines counter assistant (MCA). The dispenser and MCA were employed full-time. Another team member nominated as the pharmacy manager was working in the retail area. He was responsible for the beauty business. He said that he did not usually undertake any pharmacy activity, although he had completed the weekly prescription deliveries that morning as the superintendent, who usually worked as the RP, was absent. There was another part-time team member, but she wasn't present during the inspection. The pharmacist was unsure of her role.

The pharmacy was busy and there was a steady stream of people presenting to buy medicines and collect their dispensed prescriptions. The team worked well together to manage the workload. Team members felt they could discuss issues or concerns with the superintendent. And the dispenser knew how to report concerns to other authorities if she felt the need to.

Pharmacists were accredited to the provide other services including supplies of medicines under patient group directions (PGDs). The superintendent was responsible for the travel vaccination service. The dispenser and MCA both confirmed they had completed relevant accredited training. The dispenser produced her dispensing assistant certificate. She was enrolled on an NVQ3 course and was in the process of completing it. Team members explained that they sometimes completed eLearning modules to help to keep their knowledge up to date, and they had access to other training materials such as pharmaceutical publications. No targets were set for the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare services. The pharmacy team has access to consultation rooms for services such as vaccinations, and if people want to have a conversation in private.

Inspector's evidence

The pharmacy was situated in a brand-new purpose-built unit. It had a spacious retail area with an elevated open plan dispensary at the back of the unit. Two consultation rooms were accessible from the retail area. Public facing areas were fitted to a high standard and professional in appearance. The pharmacy was well-lit, clean, and professional in appearance. Air conditioning controlled the room temperature.

The dispensary was fitted with around three or four metres of bench space, storage drawers and a sink for the preparation of medicines. Work areas were reasonably clear. The medicines counter could be easily supervised if the pharmacist was working in the dispensary. The consultation room that was in use had a desk, two chairs and storage cupboards for equipment as well as a sink. The room was not locked when not in use although it contained some confidential information and a sharps bin. The pharmacist agreed to liaise with the superintendent to resolve this matter.

Behind the dispensary there was a fire exit and stairs leading to two stock rooms and a staff toilet which had handwashing facilities. The large stock room also served as a staff rest area and one corner had been fitted with a bench as was used for the assembly of multi-compartment compliance packs. The premises was suitably secured when closed.

The pharmacy had a website which appeared to be under development as its functionality was limited. It promoted some of the pharmacy’s services and provided contact details. The website did not provide information about the owner or superintendent pharmacist so people couldn't make additional checks if needed to verify the authenticity of the pharmacy. The website directed people to a third-party website operating an online shop for beauty and wellbeing product.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally well managed and easy for people to access. It gets its medicines from licensed suppliers, and it carries out some checks to ensure medicines are in good condition and suitable to supply. The pharmacy has procedures to help make sure it provides its compliance pack and home delivery services safely. But team members do not always consistently follow these procedures. This could make it harder for the pharmacy to explain what has happened if there was a query or concern.

Inspector's evidence

The pharmacy had step-free access from the pavement and a wide automated door at the entrance. There was a small amount of health promotion material in the retail area.

The team dispensed of mixture of walk-in and repeat electronic prescriptions. Dispensed medicines were appropriately labelled, and patient leaflets were routinely supplied. The team members were aware of the Pregnancy Prevention Programme for people at risk taking valproate containing medicines and the associated dispensing requirements. Interventions were usually recorded on the PMR. Some people received their medicines in weekly compliance packs. The pharmacist said compliance packs were only initiated if the person's doctor requested it, and the pharmacy did not assess the person's suitability. Each person had a record showing how packs should be assembled. But records were limited, and they didn't contain any additional details such as audit trail of changes, care arrangements or interventions. The pharmacist said patient leaflets were supplied each month with packs. Compliance packs were suitably labelled, although labels did not include a description of each medicine they contained. The pharmacist pointed out these should ideally be included and agreed to discuss it with the superintendent. The lack of descriptions could mean people may find hard to identify individual medicines dispensed into compliance packs.

The pharmacy delivered prescription medication to people's home once a week. A note was left for the person if a delivery attempt was unsuccessful. A list of deliveries was kept, and book was available to record deliveries of CDs. But the time of delivery was not recorded, and signatures were not consistently obtained as proof of receipt, including for CDs. This could make it harder to explain what had happened in the event of a query.

The pharmacist was accredited to provide the NHS services including the Pharmacy First service. A folder with the different protocols was available for reference. PGDs were available on the computer. The pharmacy also participated in providing flu and COVID 19 vaccinations. It could also provide the NHS hypertension case finding service and the New Medicine Service if appropriate, but these were not routinely offered.

Private services including travel vaccinations and ear was removal service. Travel vaccinations were administered under (PGDs). The pharmacy was a yellow fever centre. The ear wax removal service was offered in conjunction with a third-party provider who provided training and protocols to follow.

Medicines were sourced from licensed wholesalers and suppliers. The pharmacy had a large stock

holding. Expiry date checks were completed periodically but they were not recorded. A full stock take had completed earlier in the year. A random check of the dispensary shelves found no expired items. Some medicines were de-blistered and placed in containers to facilitate the assembly of compliance packs. Most containers were labelled appropriately and included the medicine batch number and expiry date, but a couple of medicines did not have this information. Similarly, a bottle was found labelled simply as Sytron liquid into which the medicine had been decanted. This medicine also has limited expiry once opened. These items were removed for disposal and the pharmacist agreed to remind team members of the labelling requirements, and regarding liquid medicines with a limited expiry once opened.

Waste medicines were separated in designated bins in the staircase vestibule near the dispensary. There was a booklet to record the receipt and destruction of patient returned CDs. Cold chain medicines were stored in fridges. Drug and device alerts and recalls were received by email and actioned by the pharmacist. But the pharmacist was unsure if the pharmacy kept records so it could show how alerts were managed.

Pharmacy medicines were stored behind the counter. The MCA understood what questions to ask and when to refer to the pharmacist. She was aware of the restrictions when selling codeine containing medicines and what medicines were considered higher risk.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the services it provides. The team members take steps to maintain the equipment so that it is safe to use. But fridges used to store medicines are not always effectively monitored to make sure they are functioning properly.

Inspector's evidence

The pharmacy team had access to the internet and appropriate reference sources. Disposable medicines containers were used. Clean triangles were available for counting tablets and standardised measures were available for dispensing liquids.

Equipment for provision of additional services was available including, an ear micro-suction device, a blood pressure meter and vaccination equipment. The pharmacy's computer systems were password protected. There were PMR terminals in the dispensary and consultation room to facilitate provision of services. All electrical equipment appeared to be in working order.

A standard CD cabinet was in use. CD keys were suitably secured. CD denaturing kits were used to dispose of CDs safely. There were fridges in the dispensary and consultation room for storing cold chain medicines. Both fridge temperatures were in a suitable range as the time of the inspection. Records indicated that the dispensary fridge was checked daily, but the maximum temperatures recorded during the last month had been slightly higher than the expected range. There was no documented explanation and nothing to indicate any action had been taken to resolve this issue. Recent temperature records for the consultation room fridge could not be located. The pharmacist agreed to raise fridge monitoring with the superintendent and make sure these issues were resolved.

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.