General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Alpha Chemist Ltd, 480 Church Road, NORTHOLT, Middlesex, UB5 5AU

Pharmacy reference: 1035051

Type of pharmacy: Community

Date of inspection: 15/01/2020

Pharmacy context

This is an independent, family run community pharmacy. It is on a busy main road running through a residential area of Northolt. As well as the NHS Essential Services, the pharmacy supplies methadone to substance misuse clients. It also provides Medicines Use Reviews (MURs), New Medicines Service (NMS), a delivery service and supplies medicines in multi-compartment compliance packs for people living in the local community. The pharmacy also has a prescription delivery service for the housebound.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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	1.4	Good practice	The pharmacy is good at using feedback from people to improve the quality of its services.
2. Staff	Standards met	2.1	Good practice	The pharmacy team has a high level of training and skills. Which means that there are more people qualified to deliver its professionaly led services.
		2.5	Good practice	Staff are able to raise concerns and make suggestions, which means that the pharmacy can continually improve the quality of its services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.3	Good practice	The pharmacy team is good at giving advice to people about their medicines. This means that people have the information they need to take their medicines safely and effectively.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. Its team members understand their roles and responsibilities. They listen to people's concerns and keep people's information safe. Team members discuss any mistakes they make, and they share information on what could go wrong to help reduce the chance of making mistakes in future.

Inspector's evidence

Staff worked under the supervision of the responsible pharmacist (RP), whose sign was displayed for the public to see. They worked in accordance with an up-to-date set of standard operating procedures (SOPs). And staff had read SOPs relevant to their roles. The pharmacy had procedures for managing risks in the dispensing process, but staff said that mistakes were relatively rare. All incidents, including near misses, were discussed at the time and recorded. The team also had regular meetings to review and discuss any mistakes and ways of preventing a reoccurrence. This was small close-knit team and it was clear that discussions about the tasks in hand were integral to the day to day running of the pharmacy. The superintendent (SI) reviewed all near misses each month in order to identify what had led to the mistake or what could be done differently in future. But the advice to 'not rush' when dispensing and to be 'more careful' when checking drug form, had been repeated on three consecutive months. So, it seemed that more specific guidance was required, to help the team to further reflect on what had gone wrong. And to help them identify any mistakes before transferring the dispensed item to the RP for an accuracy check.

But it was clear that team discussions about incidents had made staff aware of the risk of certain types of error. Staff were required to take extra care when selecting 'look alike sound alike' drugs (LASAs). The SI had discussed LASAs with the team, and several had been separated to help reduce the chance of the wrong one being selected. This included amlodipine and amitriptyline and azithromycin 500mg and azathioprine 50mg. Many LASAs had been separated with different products in between. Three different strengths of doxazosin had been separated by placing different strengths of diazepam between them. The dispenser described a previous near miss between the 60-tablet pack of Eliquis 2.5mg and the 20-tablet pack. The packs were the same size and had the same livery. Although the two pack sizes were place together, they had been marked in pen with the number 20 or 60 as appropriate.

The pharmacy team had a positive approach to customer feedback. The team had received a customer concern regarding the time taken to find her prescription. The concern prompted a review of the prescription retrieval system. The new system had proved more efficient and staff found that prescriptions were now easier to find. The pharmacy had a documented complaints procedure. Customer concerns were generally dealt with at the time by the RP or SI. Staff said that complaints were rare but if they were to get a complaint it would be recorded. Details of the local NHS complaints advocacy and PALs were available on line. The pharmacy had professional indemnity and public liability arrangements so, they could provide insurance protection for staff and customers. Insurance arrangements were in place until 31 March 2020 when they would be renewed for the following year.

All the necessary records were kept and were generally in order including records for private prescriptions, emergency supplies, unlicensed 'Specials' and the RP. Controlled Drug (CD) registers were also in order. The pharmacy had a system for recording the receipt and destruction of patient returned

CDs. These records are necessary as they provide an audit trail and give an account of all the non- stock Controlled Drugs (CDs) which pharmacists have under their control.

Staff had been briefed on the importance of confidentiality and had read and signed a confidentiality agreement. Completed prescriptions were stored in the dispensary in a way that patient details couldn't be viewed from customer areas. And discarded patient labels and prescription tokens were shredded on a regular basis. The pharmacists present had both completed level 2 CPPE training for safeguarding children and vulnerable adults. Support staff had been briefed and knew to raise safeguarding concerns with pharmacists. The pharmacy team had not had any specific safeguarding concerns to report. Contact details for the relevant safeguarding authorities were available online and staff had a SOP to follow.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has a good level of highly trained and skilled individuals. It manages the workload safely and effectively. And team members work well together. They are able to raise concerns and make suggestions to improve the quality of its services.

Inspector's evidence

The pharmacy regularly had two to three pharmacists working at any one time. It had three regular full-time RPs, including the SI and his wife, as well as a full-time locum and a part-time locum. Having two to three pharmacists on duty allowed pharmacists to spend time counselling patients and provide additional services such as flu vaccinations without impacting the dispensing service. The rest of the team included one full-time dispenser, a full-time trainee dispenser and two part-time medicines counter assistant (MCAs). A recent new join, working his probationary period, was employed as a trainee MCA six hours per week. On the day of the inspection the RP was the regular locum. She was supported by the SI, a trainee dispenser and two MCAs. Team members were observed to work well together. They assisted each other when required. The daily workload of prescriptions was in hand and customers were attended to promptly.

The RP described being able to raise concerns. This was a family business and regular discussions were integral to the day to day running of the pharmacy. Staff would have informal discussions during which they could make suggestions and raise concerns. The dispenser described the team's idea to highlight prescriptions for gabapentin and pregabalin for patients using multi-compartment compliance pack. They did this to ensure that prescriptions for the drugs, which were CDs, could be obtained and dispensed within the prescription's 28-day period of validity. They found that by highlighting the prescriptions staff were aware of the need to look out for them or chase them up as necessary. They did this to ensure that the compliance packs could be dispensed in full and on time for people. Staff had also suggested separating fast moving lines from less commonly prescribed lines. They found that this had helped with dispensing efficiency. The RP felt able to make her own professional decisions in the interest of patients. She would offer an MUR or NMS when he felt it beneficial for someone. She was also targeted with managing the daily workload and to provide a good service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises were tidy, organised and clean. They provide a safe, secure environment for people to receive healthcare services.

Inspector's evidence

The pharmacy's premises were in a built- up area of north west London. They were on a busy main road, with housing behind the pharmacy and opposite. They had a bright modern appearance with a double front, full height windows and a glass door to provide natural light. The shop floor was to the front with the dispensary behind. The shop floor was clear of obstructions and wide enough for wheelchair users. There was a small seating area for waiting customers. Items stocked included a range of baby care, healthcare, beauty and personal care items.

The pharmacy had a consultation room which the pharmacist used for private conversations and services such as MURs. There was a door to the room from the dispensary for staff and another from the shop floor for customers. The dispensary was relatively spacious. It had a nine to ten metre U-shaped run of dispensing bench with a sink. And an additional island in the middle where multi-compartment aid dispensing took place. The area of dispensing work surface overlooking the shop was where staff dispensed and checked 'walk- 'in prescriptions. Work surfaces were well used but there was a clear work flow. And overall, the dispensary was clean, tidy and organised. To the rear of the premises the pharmacy had a staff area, toilet and a storage room with a fire door to the outside. Staff areas were clean. In general, the pharmacy was tidy and organised and had a professional appearance. Shelves, worksurfaces, floors and sinks were clean.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes them available to everyone. It manages its medicines safely and effectively and gives people the advice they need to help them take their medicines properly. The pharmacy is good at helping people to benefit from their medicines. The pharmacy's team members check stocks of medicines regularly to make sure they are in date and fit for purpose.

Inspector's evidence

The pharmacy's services were advertised at the front window and there was a small range of information leaflets available for customer selection. There was a small lip at the pharmacy entrance, but it was low enough for wheelchair users to cross. The shop floor was wide enough for wheelchair users to move around and the consultation area could also be accessed by someone using a wheelchair. The pharmacy offered a prescription collection service although the need was rare. It also a prescription ordering service for those who had difficulty managing their own prescriptions.

There was a set of SOPs in place which were under review. In general, staff appeared to be following the SOPs. They carried out a full CD stock audit on a regular basis as per the SOP. And the quantity of stock checked (oxycodone 20mg capsules) matched the running balance total in the CD register. Multi-compartment compliance aids were provided for people who needed them. Product information leaflets (PILs) were offered to patients with new medicines and regularly with repeat medicines. The medication in compliance aids was given a description, including colour and shape, to help people identify the medicines. And the labelling directions on compliance aids gave the required BNF advisory information to help people take their medicines properly. The pharmacy had conducted national NHS audits for sodium valproate, Lithium and NSAIDs. Pharmacists, understood the risks to people in the at-risk group taking sodium valproate. But at the time of the inspection the pharmacy had no at-risk patents on the drug. Packs of sodium valproate in stock bore the updated warning label. The pharmacist had warning cards and leaflets for any new patients and extra warning labels for supplies made in plain white cartons. Lithium patients had been counselled and issued with an advice booklet to help them identify symptoms of toxicity and manage their condition. The pharmacy's audit on NSAIDS had identified that all patients taking an NSAID had also been prescribed with a PPI. The pharmacy ordered the same brands of medicines for certain people to help with compliance. It also supplied the same brands of anti-epileptic medicines for individual patients where possible, which was often necessary to help control their condition. Notes were added to individual patient medication records (PMRs) to ensure they were dispensed for those who needed them.

The pharmacy had up-to-date PGDs and service specifications for both the private and NHS flu vaccination services. People were briefed on what to expect when receiving a vaccination and asked to complete a consent form. Records were kept of the consultation for each vaccination, including details of the product administered. The pharmacy had procedures in place for managing an anaphylactic response to the vaccination. The pharmacy had the equipment and software for scanning products in accordance with the European Falsified Medicines Directive (FMD) and were scanning packs with a unique barcode. Medicines and Medical equipment were obtained from: AAH, Alliance Healthcare, Colorama and Sigma. Unlicensed 'specials' were obtained from Avicenna. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. An open bottle of

methadone SF 1mg/ml had been marked with the date on which it was opened, to indicate that it would expire 28 days from that date. All expired CDs were clearly marked as such to ensure they could not become confused with current stock.

A CD cabinet and a fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read and recorded daily. General stock was regularly date checked and records kept. Stock which had reached its expiry date was removed from storage and put in the Doop bin for collection by a licensed waste contractor. And staff had a list of hazardous waste to refer to, which would help ensure that they were disposing all waste medicines appropriately. Drug recalls and safety alerts were generally responded to promptly. The RP described responding to the December recall for ranitidine tablets. The pharmacy had not had any of the affected stock. But he could recall returning faulty batches of Emerade injections when they were recalled last year. Recalls were recorded electronically.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities for the services it provides. In general, it uses its facilities and equipment to keep people's information safe.

Inspector's evidence

The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures and tablet triangles were of the appropriate BS standard and clean. And amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris. CD denaturing kits were used for the safe disposal of CDs. The pharmacy team had access to reputable and up-to-date information sources such as the BNF, the BNF for children and the drug tariff. Pharmacists also used the NPA advice line service. The also had access to the BNF app and had access to a range of reputable online information sources such as EMC, NHS and NICE.

There were three computer terminals available for use in the dispensary. All computers had a PMR facility, were password protected and were out of view of patients and the public. Pharmacists were using their own smart cards when working on PMRs. Staff used their own smart cards to maintain an accurate audit trail and to ensure that access to patient records was appropriate and secure. Patient sensitive documentation was stored out of public view in the pharmacy. And the pharmacy had a shredder for confidential paper waste.

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.