General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newcare Pharma Limited, 16-18 Station Parade, Willesden Green, LONDON, NW2 4NH

Pharmacy reference: 1040566

Type of pharmacy: Community

Date of inspection: 04/10/2022

Pharmacy context

The pharmacy is close to Willesden Green Underground Station in northwest London. The area is mixed residential and commercial. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include prescription delivery, supervised consumption, needle exchange, seasonal flu vaccination, community pharmacy consultation service, sale of health food and homeopathic remedies, new medicines and discharge medicines services.
,

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	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's working practices are safe and effective. It has satisfactory procedures in place to identify and manage risks and make sure its team members work safely. But these are due for review and may not reflect current best practice. The pharmacy team members do not always record mistakes they make so they may be missing opportunities to learn and prevent the same mistakes happening again. The pharmacy generally keeps the records it needs to by law. Members of the pharmacy team protect people's private information, and they are appropriately trained in how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. But they did not routinely record them or the lessons they learnt from them. So, they could be missing opportunities to spot patterns or trends with the mistakes they made. The responsible pharmacist (RP) explained that medicines involved in incidents, or were similar in some way, such as esomeprazole tablets and capsules, were generally separated from each other in the dispensary to reduce the chance of mistakes in picking medicines for prescriptions. The pharmacy team stored the most frequently dispensed medicines together which also helped to reduce mistakes. The RP completed a dispensing incident reporting form on the pharmacy computer system if needed.

Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were clinically, and final checked by the RP. The pharmacy team checked interactions between medicines prescribed for the same person with the RP or the prescriber. Any interventions were recorded on the patient medication record (PMR). Team members highlighted prescriptions for medicines that the RP needed to discuss with the patient, so they had all the information they needed to take their medicines safely.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these were due to be reviewed. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. They knew what they could and could not do, what they were responsible for and when they might seek help. A team member explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints procedure. And customers were asked to complete a community pharmacy patient questionnaire to get people's feedback and suggestions on how it could do things better.

The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. The pharmacy team members had self-tested for COVID-19 twice weekly. The pharmacy had fitted

screens at the medicines counter and team members had access to fluid resistant face masks to help reduce the risks associated with the virus. They used anti-bacterial spray to clean pharmacy surfaces and applied hand sanitising gel when they needed to. The pharmacy team assessed the risks associated with providing services. Documenting their findings and remedial actions was discussed. They completed audits in line with the pharmacy quality scheme (PQS), such as people's asthma inhaler technique and people of child-bearing potential taking valproates. And they kept records of their findings.

The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and displayed a notice that told people who the RP was. Ensuring the RP signed out at the end of the session was highlighted. The pharmacy had a controlled drug (CD) register. And the stock levels recorded in the CD register were checked on a regular monthly basis in line with the SOP. A random check of the actual stock of two CDs matched the recorded amount in the CD registers. The team kept a record of unwanted CDs returned to the pharmacy by people. The pharmacy kept records of its supplies of unlicensed medicinal products, the emergency supplies it made and the private prescriptions it supplied electronically. The RP had signed and dated the patient group direction (PGD) for the flu service. Records of administration of the flu vaccination were entered onto Sonar and the person's doctor's surgery was informed. Records were generally in order.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Its team tried to make sure people's personal information could not be seen by other people and was disposed of securely. And one of the pharmacy team described how the pharmacy protected people's private information. The pharmacy team had undertaken training in safeguarding procedures. And the RP was signposted to the NHS safeguarding App so members of the pharmacy team would have the current contact information to raise concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work well together to manage their workload and deliver services safely. The pharmacy supports them in completing appropriate training and they understand their roles and responsibilities. They are comfortable about providing feedback on how the pharmacy could improve its services.

Inspector's evidence

At the time of the visit, the pharmacy team consisted of the full-time RP, a regular locum pharmacist who covered Saturdays, one full-time and one part-time registered pharmacy technician, two full-time dispensing assistants (DA), one full-time medicines counter assistant (MCA), one full-time delivery driver and two other full-time staff and one part-time cleaner. The owner demonstrated the business continuity plans to deal with the pharmacy's changing needs as they arose. One of the team said that they had generally been able to manage to cover staff absence.

The team members could download topics to study when the pharmacy was quiet, and they included those required for the pharmacy quality scheme (PQS) or new over-the-counter (OTC) products to sell. Members of the team who sold health food and homeopathic remedies had undertaken training with Nelson's and Weleda. The pharmacy technicians had their own training requirements to fulfil. The RP had completed and filed the certificates including remote training skills, inhaler technique, risk management, sepsis, and health inequalities. The flu training had been online and certificates showed competence in first aid and immunisation techniques. They worked well together, served people quickly, and processed their prescriptions safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. A member of the team explained questions to ask people when making recommendations for OTC medicines. And knew when to refer requests to a pharmacist.

The RP was signposted to GPhC Knowledge Hub and the GPhC Requirements for the education and training of pharmacy support staff (Oct 2020) for information on accredited training relevant to the team member's roles. They did not have formal appraisals but there were regular team meetings and members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. The team had suggested changes to stock levels in certain items sold by the pharmacy. They knew who they should raise a concern with if they had one. And their feedback had led to changing stock levels to meet demand of people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, bright, secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe and people's private information is protected.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. And steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a large retail area, a medicines counter, a smaller dispensary and storage space. The pharmacy displayed a chaperone policy and signposted people to the consultation room where they could have a private conversation with a team member. The dispensary had limited workspace and storage available. The floor areas were mostly clear. And worksurfaces in the dispensary were clean and clear. The pharmacy had a very clean sink. A cleaner kept the pharmacy’s premises clean. To help minimise risk of infection, there were screens fitted at the medicines counters and hand gel to apply.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. It displays information about the services it offers. People with different needs can easily access them. The pharmacy obtains its medicines from reputable suppliers and stores them securely at the right temperature, so they are safe to use. The pharmacy team members identify people using high-risk medicines and make sure they use their medicines safely. Team members know what to do in response to alerts and product recalls and return any medicines or devices to the suppliers.

Inspector's evidence

There was wheelchair access and large font labels could be printed if necessary. Staff could converse in Spanish, Mandarin and Cantonese or use Google Translate to assist patients whose first language was not English. People were signposted to other local services such as NHS 111, the optician and podiatrist. The pharmacy had a notice that told people when it was open. The pharmacy had seating for people to use if they wanted to wait. And this area was set away from the counter to help people keep apart.

The pharmacy provided a delivery service to people who could not attend its premises in person. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. A CD delivery note was completed for CDs which were delivered. The pharmacy team were sent discharge medicines service (DMS) information by email. The new medicines service (NMS) was followed up by telephone with people after their initial consultation with the pharmacist. The pharmacy received a few referrals via the community pharmacist consultation service (CPCS).

The pharmacy used a disposable system for people who were supplied their medicines in compliance aids. Upon receipt, prescriptions were checked for changes and queries were dealt with prior to preparation. The pharmacy team checked whether a medicine was suitable to be re-packaged. It provided a brief description of each medicine contained within the compliance aids. But it did not always provide patient information leaflets (PILs). So, people did not always have the information they needed to make sure they took their medicines safely. During the visit, the RP gave an assurance that moving forward PILs would be supplied with compliance aids. The pharmacy team prepared compliance aids for a care home. The compliance aids were delivered to the care home and the owner visited the care home to monitor the service.

Members of the pharmacy team knew which of them had prepared a prescription because they initialled the dispensing labels. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added. They were aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed and the pharmacy computer system prompted the pharmacist to provide counselling. For people taking medicines requiring therapeutic monitoring such as warfarin, the RP asked for information about blood test results and counselled patients on factors which may affect how their medicines works. Therapeutic

information was recorded on the person's PMR such INR value for people who took warfarin. If necessary, the pharmacy team could print PILs for medicines they were supplying to people so they had all the information they needed to take their medicines safely.

The pharmacy was providing the flu vaccination service to people in the appropriate clinical risk group. Flu vaccines were stored between two and eight Celsius and administered via PGD. People were vaccinated in the consultation room and given a copy of the relevant PIL and the RP was observed counselling a person after their vaccination. Patient consent was obtained prior to vaccination and a record was made on Sonar ensuring notification was sent to the person's general practice. There were appropriate disposal bins for vaccination service waste and adrenaline injection devices to deal with anaphylaxis. The pharmacy offered a blood pressure checking service and after obtaining patient consent recorded the results and sent them to the patient's doctor if necessary. The pharmacy did provide a supervised consumption service but there were no clients at the time of the visit. Supplies of needles made for needle exchange were recorded anonymously on PharmOutcomes.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. There were some medicines not in their original packaging. So, they may be missed when date-checking stock or after receiving an alert or recall. The pharmacy team checked the expiry dates of medicines regularly a few times a year. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it mostly stored its CDs, which were not exempt from safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy had a plastic screen on its counter. The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy team had access to up-to-date reference sources. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of the refrigerator. The pharmacy collected confidential wastepaper for shredding. The pharmacy restricted access to its computers and PMR system. And only authorised team members could use them when they put in a password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members used their own NHS smartcards.

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.