General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Allchin Pharmacy, 28 England's Lane, LONDON, NW3 4UE

Pharmacy reference: 1040571

Type of pharmacy: Community

Date of inspection: 26/02/2020

Pharmacy context

The pharmacy is located on the high street in a busy mixed commercial and residential area of north west London. 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 collection and delivery and seasonal flu vaccination. The pharmacy has healthy living status.

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's working practices are safe and effective. The pharmacy team satisfactorily manages the risks associated with the provision of its services. The pharmacy has up-to-date written procedures which tell staff how to complete tasks safely. It keeps the records it needs to show medicines are supplied safely and legally. The pharmacy team members make sure that people have the information they need so that they can use their medicines safely. They understand their role in protecting the welfare of vulnerable people and keeping people's information secure.

Inspector's evidence

Near misses were recorded and reviewed. A patient safety review (PSR) was compiled regularly detailing actions to improve patient safety such as separating 'lookalike soundalike' (LASA) medicines. Staff had completed training to reduce LASA errors. Amlodipine 5mg and 10mg tablets were separated by alendronate tablets placed between both strengths. Fast moving medicines were stored together which separated some LASA medicines automatically. Inhalers had been moved to a new location so inhalers which were similar in appearance or name were separated. Alert stickers highlighted medicines with several strengths. Staff had re-trained in the relevant standard operating procedures (SOPs). Reviewing near misses had shown most incidents were due to distraction so the pharmacy team tried to reduce noise and interruptions during the dispensing process. Incidents and learnings were discussed with staff and an intervention was recorded on the patient medication record (PMR) if appropriate. As a result, there had been a reduction in near misses.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. The clinical and final accuracy check of prescriptions was completed by the pharmacist. Interactions between medicines for the same person were shown to the pharmacist as part of the clinical check. The dispensing audit trail on the dispensing labels was completed identifying staff involved in dispensing and checking prescriptions. There was a procedure for dealing with outstanding medication. The original prescription was retained and an owing slip was issued to the patient. For 'manufacturer cannot supply' items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance aids were prepared for a number of patients both domiciliary and in two care homes. The pharmacy managed prescription re-ordering on behalf of patients. New prescriptions were checked against the previous prescription, discharge summary or backing sheet for changes. Queries were clarified with the patient or their doctor. There was an audit trail of responses to queries including notes on the PMR if needed. There was a folder to retain patient information such as backing sheets. The backing sheet was reprinted when there were changes in medication. The pharmacy liaised with the doctor's surgery or the hospital when new patients were identified who would manage administration of medicines better if supplied in a compliance aid.

Backing sheets included a description identifying individual medicines and the pharmacist gave an assurance that patient information leaflets (PILs) would be routinely supplied with each set of compliance aids. High-risk medicines such as sodium valproate and alendronate were generally not supplied in a compliance aid. If controlled drugs (CDs) were supplied in the compliance aid the date on the prescription was managed to ensure supply within the 28-day validity period. Levothyroxine tablets

were supplied in the compliance aid and special instructions highlighted to ensure being taken correctly.

The care homes re-ordered prescriptions on behalf of their patients via a medication administration record (MAR) sheet. The care home ordered medicines, noted any changes such as dose and also recorded any medicines not required to be included in the compliance aid. Prescriptions were checked against the MAR sheet. Each medicine was supplied in a separate compliance aid in a rack according to the administration time. Each rack had a dispensing label with the patient and medication details including dose.

Standard operating procedures (SOPs) were newly reviewed and included procedures for complaints, CD and responsible pharmacist. Staff were due to re-train in updated SOPs. There were staff training records to show staff were up to date with training for the previous SOPs. A staff member who served at the medicines counter was observed following the sales protocol when asked for a medicine. The same staff member explained that she would not give out a prescription or sell a pharmacy only medicine if the pharmacist was not on the premises.

Patient feedback was obtained via the community pharmacy patient questionnaire and the practice leaflet and complaints procedure were displayed. To protect patients receiving services, there was valid professional indemnity insurance in place provided by the National Pharmacy Association (NPA). The responsible pharmacist notice was on display and the responsible pharmacist log was completed.

The CD and methadone registers were complete and the balance of CDs was audited regularly although not always in line with the SOP. A random check of the actual stock of Morphogesic 10mg tablets reconciled with the recorded balance in the CD register. The supplier name but not always address were recorded for receipt of CDs. Footnotes correcting entries were generally signed and dated. Patient-returned CDs were recorded in the destruction register for patient-returned CDs. Records for supply of medicines for private prescriptions, emergency and unlicensed ‘specials’ were mostly complete although there were some missing prescriber details. The patient group directions (PGDs) for flu and meningitis ACWY were in date.

The pharmacist and staff had undertaken General Data Protection Regulation (GDPR) training. Staff had signed confidentiality agreements and were using their own NHS cards. Confidential waste paper was collected for shredding. The pharmacy computer was password protected, backed up regularly and the screen was locked when not in use. The pharmacist had completed Centre for Pharmacy Postgraduate Education (CPPE) level 2 safeguarding training. Staff had completed safeguarding and dementia friends training. There was a community pharmacy checklist for staff reference.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified team members to provide its services safely and manage the workload. The pharmacy team members are comfortable about suggesting ways to improve the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time pharmacist, one part-time pharmacist, one full-time pre-registration pharmacist (enrolled on Propharmace pre-registration training course), one full-time dispenser training as a pharmacy technician, one part-time dispenser accredited with Buttercups, one full-time and two part-time medicines counter assistants (MCAs) two accredited and one enrolled on training, one trainee MCA to cover Saturdays and one newly recruited student not yet enrolled on training.

The regular pharmacist was the pre-registration tutor. The pre-registration pharmacist attended study days and training topics included BNF chapters, calculation and first aid. The pre-registration pharmacist could study during quiet periods in the pharmacy. The pre-registration pharmacist completed CPPE training courses such as cardiac arrythmias and epilepsy, There were regular appraisals every 13 weeks to monitor progress in pre-registration training.

Staff could undertake training on the Alphega tablet on topics such as customer services and improved their product knowledge by reading industry publications. In line with the Pharmacy Quality Scheme (PQS) training had been completed in risk management (RM), sepsis, safeguarding and reducing LASA medicine errors. Recognising sepsis symptoms and referral to A&E or the doctor had been risk assessed. Staff performance was monitored through an annual documented appraisal via the Alphega tablet. There were informal team meetings to discuss near miss and other issues. Staff were able to provide feedback and had suggested rationalising dispensary space by re-locating the inhalers, antibiotics and creams. There was a whistleblowing policy. Staff said targets and incentives were not set in a way that affected patient safety and wellbeing.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and suitable for the services provided. The pharmacy prevents people accessing the premises when it is closed and keeps medicines and information safe.

Inspector's evidence

The pharmacy was located on a corner site in a Victorian style building with large windows. The pharmacy premises were re-fitted before the previous visit and presented a bright, clean and professional image. Lavatory facilities were clean and handwashing equipment was provided. The consultation room was locked when not in use and protected patient privacy. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes it easy for people to access its healthcare services. It gets its medicines from reputable suppliers and makes sure they are stored securely at the correct temperature. The pharmacy team members know what to do if any medicines need to be returned to the suppliers. They highlight prescriptions for high-risk medicines and provide people with the information they need to take their medicines safely. And they give advice to people about where they can get other support.

Inspector's evidence

There was wheelchair access to the pharmacy premises. Pharmacy team members could converse in or understand Gujarati, Hindi, Urdu, Albanian, Russian, Ukrainian, French, Farsi, Serbian and Arabic to assist people whose first language was not English. Large font labels could be printed to assist visually impaired people. Patients were signposted to other local services such as the doctor, dentist, local family planning clinic for emergency hormonal contraception, A&E, and Moorfields Eye Hospital. Signposting information was recorded if possible. PGDs available included meningitis ACWY, pneumonia and flu vaccinations. Other medication could be obtained on prescription through Medicspot, the pharmacy online prescribing service using General Medical Council registered doctors. The UK based service was registered with the Care quality Commission. People could complete a consultation in the consultation room via the Medicspot laptop, using available equipment to monitor values such as blood pressure, oxygen levels and temperature. They were directed on how to use the equipment during the consultation. Prescribing was restricted to a maximum supply of medication excluding certain medicine groups. A prescription was electronically transmitted to the pharmacy. Members of the public could access treatment for minor ailments and emergency supplies via the Community Pharmacist Consultation Service (CPCS). The current minor ailments service (NHS Camden) was being phased out due to the introduction of CPCS.

The pharmacist explained the procedure for supply of sodium valproate to people in the at-risk group. Information on the pregnancy prevention programme (PPP) would be explained. There was a folder of information to give to patients on PPP. The intervention was seen to be recorded on the PMR. The pharmacist was aware of the procedure for supplying isotretinoin following a negative pregnancy test result and within seven days of the date on the prescription. Information on the PPP would be explained. The treatment would be initiated by a consultant. The pharmacist said she would contact the prescriber and record the intervention regarding prescriptions for more than 30 days' supply of a CD. CD prescriptions were highlighted to ensure supply within the 28-day validity period.

Prescriptions were highlighted using assorted colour stamps such as 'CD' and 'FRIDGE' to prompt counselling to the patient. The pharmacist said when supplying warfarin, people were asked for their record of INR along with blood test due dates. INR was recorded on the PMR. Advice was given about side effects of bruising and bleeding along with advice about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were asked if they had regular blood tests and reminded about the weekly dose, when to take folic acid and to take care when handling methotrexate tablets. People were advised to seek medical advice if they developed an unexplained fever.

An audit had been conducted to identify people in the at-risk group taking sodium valproate and to

explain the PPP. An audit had been completed to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking non-steroidal anti-inflammatory drugs (NSAID). Recent audits included monitoring dates of last foot checks and retinopathy screening for diabetic people and people taking lithium to ensure they understood signs of toxicity and attended regular blood tests.

The pharmacy had healthy living status. Health campaigns to increase public awareness had been conducted such as sepsis, Stoptober, Dry January, antibiotic resistance, and 'Help us to help you'. There were health related leaflets displayed at the healthy living zone including 'Stay well in winter'. A digital screen facing outside the pharmacy had a rolling display on flu and other subjects.

Medicines and medical devices were delivered outside the pharmacy and patient signatures were recorded in a duplicate delivery book indicating a safe delivery. Medicines and medical devices were obtained from Alliance, AAH, Phoenix, Sigma and Colorama. Floor areas were generally clear, and stock was neatly stored on the dispensary shelves. Stock was date-checked and recorded. There were regular stock takes. No date-expired medicines were found in a random check. Medicines were generally stored in original manufacturer's packaging and the date of opening was marked on liquid medicines. Cold chain items were stored appropriately between two and eight Celsius. Uncollected prescriptions were cleared from retrieval every two months and the patient was contacted. Prescriptions containing high-risk medicines, CDs and fridge items were highlighted. Waste medicines were stored separate from other stock. Falsified medicines directive (FMD) hardware and software was operational at the time of the visit. Drug alerts were received via PharmData, printed, annotated and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Current reference sources included BNF and Apps for yellow card, BNF, safeguarding. There were stamped glass measures to measure liquids including a conical measure for methadone and cylindrical measure for water. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinet was fixed with bolts. Stop smoking equipment was supplied and maintained by NHS Camden. The vaccination sharps bin was closed and on a high shelf. Adrenaline devices to treat anaphylaxis were in date. The pharmacy team members were using their own NHS cards. Confidential waste paper was collected for shredding. The pharmacy computer was password protected, backed up regularly and the screen was locked when not in use.

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.