General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Thomas; H.V., 81 Mill Lane, West Hampstead, LONDON, NW6 1NB

Pharmacy reference: 1040620

Type of pharmacy: Community

Date of inspection: 19/02/2020

Pharmacy context

The pharmacy is located on a high street in a 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, substance misuse, travel medicines and vaccinations, minor ailments and seasonal flu vaccination.

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 manages the risks associated with the provision of its services appropriately. The pharmacy has written procedures which tell staff how to complete tasks safely. It keeps the records it needs up to date 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 and information was collated to produce an annual patient safety review (PSR) detailing the steps taken to improve patient safety. 'Lookalike and soundalike' (LASA) medicines had been separated to minimise picking errors. Three strengths of atenolol were on separate shelves. Propranolol and procyclidine tablets were separated and olanzapine and montelukast were separated due to similar names or packaging. Referring to the PSR, learning points included ensuring split packs were clearly marked to reduce quantity errors, checking patient identity before handing out prescriptions to patients with similar names and reading the discharge summary following a hospital stay to check changes in medication had been actioned via a new prescription. The PSR was discussed during staff meetings.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. The dispenser labelled and assembled the prescription. Labels were generated and medicines were picked from reading the prescription. The pharmacist performed the clinical and final check of all prescriptions prior to completing the dispensing audit trail to identify who dispensed and checked medicines. The pharmacist checked interactions between medicines for the same patient. Bagged prescriptions awaiting collection were placed in the retrieval system. 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 on a rolling basis according to a matrix. There was a separate bench area to prepare compliance aids. The pharmacy managed prescription re-ordering on behalf of patients and checked new prescriptions against the previous prescription and backing sheet for changes. There was an audit trail of any query regarding changes in medication and what prescription items were requested. A folder of information which included discharge summaries following a stay in hospital was maintained. The pharmacy liaised with the doctor's surgery when new patients were identified who would manage administration of medicines better if supplied in a compliance aid. If appropriate, a risk assessment was completed to establish suitability of the patient to have medicines supplied in a compliance aid.

Checking sheets included a description identifying individual tablets and capsules. Patient information leaflets (PILs) were routinely supplied with each set of compliance aids. High-risk medicines such as sodium valproate were generally supplied separately from the compliance aid. If alendronate was supplied in a compliance aid, the carer and patient were aware of any special instructions. Controlled drugs (CDs) were generally not included in a compliance aid and managed to ensure supply within the

28-day validity of the prescription. Levothyroxine tablets were supplied separately if the patient could manage special instructions ensuring medicines were taken correctly.

There was a folder of standard operating procedures (SOPs) including CD and complaints procedures. SOPs were due for review. There were staff training records. The staff member at the medicines counter said she would not give out a prescription or sell a pharmacy only medicine if the pharmacist were not on the premises. Patients could provide feedback on the pharmacy via the annual community pharmacy patient questionnaire. There was a practice leaflet on display. To protect patients receiving services, there was professional indemnity insurance in place provided by NPA expiring 31 May 2020. The responsible pharmacist notice was on display and the responsible pharmacist log was completed.

Records for supplies of private prescription and 'specials' medicines were complete. A sample of patient group directions (PGDs) which were seen were in date. The CD and methadone registers were mostly complete. Methadone was audited weekly. A random check of the stock of MST tablets reconciled with the recorded balance. Invoice number and name but not always address of the supplier were recorded for receipt of CDs. Footnotes correcting entries were not always signed and dated. A record was maintained of patient-returned CD destruction.

The pharmacist and staff had undertaken General Data Protection Regulation (GDPR) training. Ensuring a privacy notice was displayed was discussed. Staff were using their own NHS cards and were aware of the confidentiality procedure. Confidential waste paper was collected for shredding. The Data Security and Protection (DSP) toolkit was due to be completed. The pharmacy computer was password protected and backed up regularly. The pharmacist had completed Centre for Pharmacy Postgraduate Education (CPPE) level 2 safeguarding training. Staff had completed safeguarding and dementia friends training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together and manage the workload safely. They are well trained and understand their roles and responsibilities. Team members are comfortable about suggesting ways to improve the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time regular pharmacist, the superintendent pharmacist (SI) who covered the regular pharmacist's days off, one part-time dispenser also accredited as a medicines counter assistant (MCA), one full-time MCA and a newly recruited staff member to work Saturdays. Both weekday staff delivered medicines outside the pharmacy.

All staff had attended continuing professional development training events and study topics included: hay fever update and new inhalers. A company representative had provided training in probiotic supplements.

The pharmacy was working towards healthy living status. Training had been completed in line with the Pharmacy Quality Scheme (PQS) in Community Pharmacist Consultation Service (CPCS), sepsis, safeguarding, 'lookalike soundalike' LASA picking errors and risk management. Sepsis had been risk assessed to ensure staff would recognise symptoms and know when to refer patients to A&E or their doctor. There was a system of annual appraisal to monitor staff performance and there were staff meetings to discuss patient safety issues such as near miss trends. Staff felt able to provide feedback and had suggested re-organising the retrieval system so prescriptions awaiting collection were easier to locate when people came to collect their prescription. There was a whistleblowing policy. Staff said that targets and incentives were not set in a way that affected patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and generally 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 premises had been re-fitted since the previous visit and presented a professional image. The pharmacy premises were clean and tidy. The dispensary was up steps at the back of the pharmacy. Lavatory facilities were clean and handwashing equipment was provided. The consultation room was located towards the front of the pharmacy and was locked when not in use. Patient privacy was protected. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

People with a variety of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and it makes sure they are stored securely at the correct temperature. The pharmacy team members take the right action 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 in the right way. The pharmacy team are helpful and give advice to people about where they can get other support.

Inspector's evidence

There was access to the pharmacy premises via an automatic door and a ramp to assist people with mobility difficulties. Large font labels could be printed to assist visually impaired people. Staff could converse in or understand Swahili, Urdu, Gujarati, Kutchi, French, Maltese and Arabic to assist patients whose first language was not English. Patients were signposted to other local services such as urgent care and walk-in centres. Members of the public could access treatment for minor ailments and emergency supplies via the CPCS. Referrals for CPCS were received from NHS 111 by email and the pharmacist checked Sonar daily for referrals. The current NHS Camden minor ailments service 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 information to give to patients on PPP. The intervention was 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 with CD stickers to ensure supply within the 28-day validity period. Interventions were generally recorded on the PMR.

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 reminded about the weekly dose, when to take folic acid and 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. At the time of the visit, the current audit was to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking non-steroidal anti-inflammatory drugs (NSAID). Other 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 was working towards healthy living status. Health campaigns to raise public awareness included Stoptober, Dry January, winter wellness, flu vaccination, Contact the pharmacist first and NHS 111.

Medicines and medical devices were delivered outside the pharmacy by the MCAs. Delivery items were placed in a delivery box. A delivery sheet was complied with the bag label, a record of any special instructions and a space to record the patient signature if possible. The pharmacist delivered CDs and a patient signature was recorded indicating a safe delivery.

Medicines and medical devices were obtained from Alliance, AAH, Sigma and Colorama. Floor areas were mostly clear, and stock was neatly stored on the dispensary shelves. Stock was date-checked and recorded. 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. Prescriptions containing 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, printed, actioned and a record was maintained.

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, MIMS, Drug Tariff online, EMC and Royal Pharmaceutical Society. The dispensary sink required treatment to remove lime-scale. There were stamped glass measures to measure liquids including a separate marked measure for methadone. The medical fridge was in good working order. Minimum and maximum fridge temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinet was fixed with bolts. The vaccination sharps bin was kept on a high shelf in the locked consultation room. Two in-date adrenaline injection devices were available to treat anaphylaxis and marked ‘Do not dispense’. Staff were using their own NHS cards and were aware of the confidentiality procedure. Confidential waste paper was collected for shredding. The Data Security and Protection (DSP) toolkit was due to be completed. The pharmacy computer was password protected and backed up regularly.

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.