General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 333 Greenford Avenue, Hanwell, LONDON, W7 1JH

Pharmacy reference: 1041455

Type of pharmacy: Community

Date of inspection: 20/02/2020

Pharmacy context

This is a community pharmacy belonging to Well, a large independent pharmacy business. The pharmacy is on a busy main road running through a residential area of Greenford. As well as the NHS Essential Services, the pharmacy provides Medicines Use Reviews (MURs), New Medicines Service (NMS) 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	N/A	N/A	N/A
2. Staff	Standards met	2.5	Good practice	Team members work effectively together in a supportive environment. And they are involved in making improvements to the safety and quality of services.
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. Its team members understand their responsibilities in helping to protect vulnerable people. They listen to people's concerns and keep their information safe. They discuss any mistakes they make and share information 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 electronically. 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 were integral to the day to day running of the pharmacy. The regular pharmacist reviewed all near misses each month in order to identify what had led to the mistake or what could be done differently in future. Staff were required to take extra care when selecting 'look-alike, sound-alike' drugs (LASAs), and several had been separated to help reduce the chance of the wrong one being selected. This included amlodipine, amitriptyline and azithromycin, ramipril tablets and capsules and quetiapine and quinine. Warning labels had been placed in front of stock as an additional reminder. Near misses due to mistakes with LASAs had reduced significantly from previous months as staff became more aware of the risks. The most common near misses over the last two months had been related to the quantity or form of drug dispensed. Records showed that discussions were had with staff at the time to raise awareness of the different forms of drugs and to check quantities, particularly when dispensing multi-compartment compliance packs. Advice to read the prescription carefully had been repeated from time to time. So, it seemed that more specific guidance may help the team to further reflect on what had gone wrong. And help it identify any mistakes before transferring the dispensed item to the RP for an accuracy check.

The pharmacy team had a positive approach to customer feedback. Last year's patient questionnaire showed a very small number of respondents would like a more private area for confidential conversations. So, staff said they offered the use of the consultation room to patients regularly. The room also had a large sign on the door to make it more obvious to people. The team described how they had become aware of one or two incidents where different prescriptions (electronic) for the same patient had been received separately on the system. This meant that, on occasion, not all the items for the same patient were handed out together. So, staff now used the scanner to see how many prescriptions were in the system for each patient. The pharmacy had a documented complaints procedure. Customer concerns were generally dealt with at the time by the RP and formal complaints referred to the Superintendent (SI). Staff said that complaints were rare but if they were to get a complaint it would be recorded. Details of the complaints procedure and invitation for feedback was provided in the pharmacy practice leaflet which was on display. And staff could find details for local NHS complaints advocacy and PALS 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 30 June 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, and the RP. Controlled Drug (CD) registers were also in order. Records for unlicensed 'Specials' were generally in order although a small number did not contain patient, label and prescriber details. The pharmacy had a system for recording the receipt and destruction of patient returned CDs. These records were necessary to provide an audit trail and give an account of all the non- stock Controlled Drugs (CDs) which pharmacists had under their control.

Staff had completed training on preserving confidentiality. They had an SOP to follow which they had read and signed. 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 discarded into a basket while working and transferred to a confidential waste bag for collection by a licensed waste contractor. The pharmacist present had 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. But had referred vulnerable patients to their GPs when they had become forgetful about taking their medicines. 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 has enough staff to manage its workload safely. Team members can make suggestions and get involved in making improvements to the safety and quality of services provided. They work effectively together in a supportive environment.

Inspector's evidence

The pharmacy was run by a regular RP with support of relief pharmacist managers to cover days off and holidays. The rest of the team included a full-time dispenser, a part-time dispenser, and a pharmacy graduate who also worked part-time. On the day of the inspection the pharmacy was run by a relief manager and a dispenser. A second dispenser arrived part way through the inspection. Staff were observed to work well together. They assisted each other when required and discussed matters openly. The daily workload of prescriptions was in hand and customers were attended to promptly.

Staff were able to discuss matters as they worked and were able to keep up to date with any current issues. And they were consulted regarding topics for inclusion on healthy living promotions. Staff were provided with an online training tool to keep their knowledge up to date. Recent training had included sepsis awareness, the safe delivery of dispensed medication and essential training on protecting patient confidentiality.

The dispenser described having regular performance reviews. And she was also able to raise concerns or make suggestions as to how services could be improved. She described how she had suggested that every prescription for multi-compartment compliance packs should be checked against the medicines administration record (MAR) sheet each time. This would help make sure that staff could spot any changes and query them with the surgery. She had also suggested introducing a system whereby compliance packs for patients who had gone into hospital were removed from the retrieval system and set aside until the team had received notification of any changes or received a patient discharge notice.

The RP described being able to raise concerns. She felt able to make her own professional decisions in the interest of patients. She would offer an MUR, an NMS consultation or flu vaccination when she felt it beneficial for someone. And she would ask people to come back if providing the service at that time would put the dispensing service under unnecessary pressure. She was also targeted with managing the daily workload and providing a good service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally clean, organised and professional looking. They provide a safe, secure environment for people to receive healthcare services. The pharmacy uses its facilities in a way which protects people's privacy, dignity and confidentiality.

Inspector's evidence

The pharmacy's premises were in a residential but built- up area of north west London. They were on a busy main road, on a parade of local shops and businesses. The pharmacy was bright and well lit. It had a double front with 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 was accessible from the shop floor and next to the counter. The pharmacist used the room for private conversations and services such as MURs. The dispensary was behind the counter. The dispensary had an eight metre L-shaped run of dispensing bench with a sink. The area of dispensing work surface overlooking the shop was where staff dispensed and checked 'walk- in' prescriptions. The side area was used for dispensing multi-compartment compliance packs but only when clear of other prescriptions. So, this was generally done at quieter times. 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 generally clean although showing signs of wear and tear in places.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally delivers its services in a safe and effective manner. And, people can easily access them. The pharmacy generally sources, stores and manages medicines safely. And it carries out checks to make sure its medicines are fit for purpose. Staff try to make sure they give people the advice and information they need to help them use their medicines safely and properly.

Inspector's evidence

A selection of the pharmacy's services were advertised at the premises. And, there was a small range of information leaflets available for customer selection. The pharmacy had step-free access at its entrance, suitable 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 had a prescription ordering service for those who had difficulty managing their own prescriptions.

There was a set of SOPs in place which were available electronically. 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 matched the running balance total in the CD register. Multi-compartment compliance packs were provided for people who needed them. Patient information leaflets (PILs) were offered to patients with new medicines and regularly with repeat medicines. The medication in compliance packs was given a description, including colour and shape, to help people identify the medicines. And the labelling directions 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 non-steroidal anti-inflammatory drugs (NSAIDs). The pharmacist 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 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 proton pump inhibitor (PPI) drug. 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 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 HSE, Alliance Healthcare and AAH. Unlicensed 'specials' were obtained from IPS. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. But there was a bottle of Loratadine 5mg/5ml oral solution on the shelf which had been opened six months earlier. And had therefore passed the one month, post opening, expiry date. But as it had been marked with the date of opening staff said that they would check this before dispensing. All expired CDs and patient returned CDs had been destroyed appropriately.

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. But staff did not have 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. Records showed that the RP had responded to the recent recall for Beconase nasal spray. The pharmacy had not had any of the affected batch.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. In general, the pharmacy uses its facilities and equipment to keep people's private 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 generally 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. They 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. Two in the dispensary and one in the consultation room. All computers had a PMR facility, were password protected and were out of view of patients and the public. Staff 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 confidential paper waste was collected for safe disposal.

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.