

# Registered pharmacy inspection report

**Pharmacy Name:** Kings Pharmacy, 50 Greenford Road, GREENFORD, Middlesex, UB6 9AT

**Pharmacy reference:** 1087323

**Type of pharmacy:** Community

**Date of inspection:** 12/03/2020

## Pharmacy context

An independent, family run community pharmacy. The pharmacy is located on a parade of shops in a residential area of Greenford. As well as NHS essential services, the pharmacy also provides seasonal flu vaccinations, 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. And a substance misuse service.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	2.5	Good practice	The members of the pharmacy team work effectively to support one another. They are confident in their roles. And are involved in making improvements to the safety and quality of services provided.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	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

The pharmacy had a close-knit team which 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 rare. All incidents, including near misses, were discussed at the time and recorded. The team also had regular informal meetings to review and discuss any mistakes and ways of preventing a reoccurrence. This was a small, established team and it was clear that discussions were integral to the day to day running of the pharmacy. One of the two regular pharmacists reviewed all near misses each month using the CPQS recording system. And while there was not much detail on the near miss record about what had led to the mistake or what could be done differently in future. The CPQS form identified several areas which had been discussed. 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 amitriptyline and amlodipine and ramipril tablets and capsules. Different strengths of other medicines had been separated with other products in between. Near misses due to mistakes with LASAs had reduced as staff became more aware of the risks. Records showed that discussions were had within the team to raise awareness of the different forms of drugs such as salbutamol and salbutamol easi-breathe inhalers. The dispenser had been coached to dispense directly from the prescription rather than labels, to ensure that a labelling mistake did not lead to a dispensing mistake.

The pharmacy team had a positive approach to customer feedback. And tried to keep specific brands of medicines for people who needed them to help with compliance. Preferences included the Bristol brand of amlodipine tablets and the Metabet and Actavis brands of metformin tablets. Notes were added to individual patient medication records (PMRs) to ensure they were dispensed for those who needed them. A previous 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 had a large sign on the door to promote it to people. Customer concerns were generally dealt with at the time by one of the regular RPs. Formal complaints would be referred to the RP who was also the Superintendent (SI). Staff said that complaints were rare and could not recall having had one. But if they were to get a complaint it would be recorded. Staff could find details for the local NHS complaints advocacy and PALS on line if anyone requested them. The pharmacy had professional indemnity and public liability arrangements in place until the end of June 2020. So, they could provide insurance protection for staff and customers. Insurance arrangements were renewed annually.

All the necessary records were kept and were generally in order including Controlled Drug (CD) registers. And records for private prescriptions, emergency supplies, unlicensed 'Specials' and the RP. 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 been trained to protect confidentiality and had also had information governance training. Completed prescriptions were stored on shelving in the dispensary out of view of patients and the public. Discarded patient labels and prescription tokens were shredded regularly. Both pharmacists had completed level 2 CPPE training for safeguarding children and vulnerable adults. Both dispensers had been briefed and knew to raise safeguarding concerns with either of the 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 are involved in making improvements to the safety and quality of services provided. They work well together in a supportive environment.

### Inspector's evidence

The pharmacy was run by a husband and wife team who were also the two regular RPs. The RPs had the support of locums to cover days off and holidays. On the day of the inspection the pharmacy was run by both regular RPs and one of the part-time dispensers. Staff were observed to work well together. They assisted each other when required and discussed matters regularly and openly. Staff had noticed an increase in prescription volume with people concerned about obtaining their medicines as a result of fears around the rise in the number of cases of coronavirus (Covid-19). But the daily workload of prescriptions was in hand and customers were attended to promptly. The RP described how both pharmacists often stayed behind in the evening to complete any outstanding workload. He explained that both RPs spent time reassuring people about medicines supplies. They were encouraging people to order their prescriptions with enough time for the team to obtain them, order the drugs and dispense them.

Staff were able to discuss matters as they worked and were able to keep up to date with any current issues. Staff were provided with training information to keep their knowledge up to date. Recent training had included managing sore throats and lower gastro-intestinal tract (GIT) health. Staff were aware of current problems around the availability of hand sanitiser and antibacterial hand soap, as a result of a significant increase in demand in recent days. They were aware of the government's guidance advising people to keep their distance from one another and wash their hands regularly during the current coronavirus outbreak. The dispenser said they were trying to ensure that they did not sell a disproportionate amount of hand wash to any one person.

The dispenser described having regular informal discussions with both the regular RPs. And she was also able to raise concerns or make suggestions as to how services could be improved. She described how she had taken over the running of the multi-compartment pack dispensing service. She did this by making sure prescriptions were ordered with enough time to have the packs dispensed for people when they needed them. She also chased the surgeries for any outstanding prescriptions and was quick to follow up changes to prescriptions following patient discharge from hospital. She also described how she would always query any changes to prescriptions to ensure they were intended by the prescriber. As this was their own business, both pharmacists felt able to make their own professional decisions in the interest of patients. And would offer an MUR, an NMS consultation or flu vaccination when they felt it beneficial for someone. The team was self-motivated to manage the daily workload and provide a good, efficient service.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises have a dated appearance. But they are clean, organised and professional looking. They provide a safe, secure environment for people to receive healthcare services.

### Inspector's evidence

The pharmacy had a traditional appearance. It had a spacious shop floor with a smaller dispensary and consultation room to the back. It had a double front with full height windows and a glass door to provide natural light. And its customer areas were clear of obstructions. And had a small seating area for waiting customers. The pharmacy's aisles were wide enough for wheelchair users. Items stocked included a range of baby care, healthcare, beauty and personal care items. The dispensary was on a slightly raised plinth behind the counter. It had a six to seven metre L-shaped run of dispensing bench (approximately) which was generally used for dispensing and accuracy checking. It also had a smaller run of dispensing bench opposite which was usually used for dispensing multi-compartment compliance packs. The front facing area of dispensing bench was where staff dispensed and checked most 'walk-in' prescriptions. Overall, the dispensary was clean, tidy and organised. Access to the dispensary was restricted to authorised individuals only, and at the discretion of the pharmacist.

The pharmacy's premises were dated, although clean, tidy and adequately maintained. Work surfaces and floors were generally uncluttered, and shelves and sinks were clean. There was a consultation room adjacent to the dispensary. The door to the room was generally left open to promote it to people. The room contained cupboards on the wall above its desk. While the cupboards were used to store files containing confidential patient information, staff felt it was unlikely that anyone would be able to enter the room unnoticed as it was so close to the dispensary and counter.

## 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 generally 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

The pharmacy advertised a sample of its services at the front window. And, there was a small range of information leaflets available for customer selection inside. 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 room 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. Staff knew customers by name, and it was clear that there were many regular customers who relied on the pharmacy to organise their medication and repeat prescriptions for them. The pharmacists would often deliver people's medication to them.

The pharmacy had an up-to-date set of SOPs in place. In general, staff appeared to be following the SOPs. They provided an audit trail of the dispensing process as per the dispensing SOP. And carried out a full CD stock audit on a regular basis as per the SOP. 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. And the labelling directions on compliance packs gave the required BNF advisory information to help people take their medicines properly. But while the pharmacy generally provided patient information leaflets (PILs) with new medicines, it didn't supply them with repeat medicines. And it did not provide a description, including colour and shape, which would help people identify each of the medicines in the packs. This information would help people to take their medicines in the way intended and maximise the benefit from them. The pharmacy had conducted national NHS audits for sodium valproate, lithium and non-steroidal anti-inflammatory drugs (NSAIDs). The pharmacists understood the risks to people in the at-risk group taking sodium valproate. But at the time of the inspection the pharmacy did not have any at-risk patients on the drug. Packs of sodium valproate in stock bore the updated warning label. Lithium patients had been counselled to help them identify symptoms of toxicity and manage their condition. The pharmacy's audit on NSAIDs had identified all patients taking an NSAID to ensure that they had also been prescribed with a proton pump inhibitor (PPI) drug.

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, Sigma and Colorama. Unlicensed 'specials' were obtained from Thame laboratories. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. 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 responded to in a timely manner.



## 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 a CD cabinet for storing CDs in accordance with safe custody regulations. And CD Denaturing kits were available for the safe disposal of CDs. The pharmacy had the measures, tablet and capsule counting equipment it needed. And its measures were of the appropriate BS standard. It also had a separate counting triangle for cytotoxic tablets, all of which was clean. Methadone measures were marked with a label to make sure they weren't used for any other liquids. And amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris. 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 two computer terminals available for use. One in the dispensary and one in the consultation room. Both computers had a PMR facility, were password protected and were generally out of view of patients and the public. Staff were using their own smart cards when working on PMRs. Staff usually 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 disposing of 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.