General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Kilburn Park Pharmacy, Kilburn Park Station, Cambridge Avenue, LONDON, NW6 5AD

**Pharmacy reference:** 1088378

**Type of pharmacy:** Community

**Date of inspection:** 12/12/2019

## Pharmacy context

The pharmacy is located within the premises of Kilburn Park Underground Station with access from the main road at ground level. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. Services are limited due to the size of the pharmacy but include prescription collection and delivery,

## 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

The pharmacy's working practices are generally safe and effective. The pharmacy team makes sure that people have the information they need so that they can use their medicines in the right way. The pharmacy manages risk appropriately and it has written procedures which tell staff how to complete tasks effectively. It keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team keeps people's information secure.

### Inspector's evidence

The pharmacist worked alone so did not record near misses routinely. He explained that one prescription was dispensed and checked at a time. Taking a mental break during the dispensing and checking procedures was discussed. There was limited storage space. Medicines were stored alphabetically on shelving and in dispensary drawers and there were shelf edge labels to mark location of some medicines including allopurinol, amitriptyline and amlodipine. Several packs of the same medicine were held together in rubber bands to separate them from other medicines. The pharmacist said he had increased stock to reduce owing medication over the Christmas period.

Workflow: baskets were not in use to separate prescriptions and medicines during the dispensing process, but one prescription was dispensed, checked and bagged at a time. Labels were generated, and medicines were picked from reading the prescription. The pharmacist checked interactions between medicines for the same patient during the clinical check. The pharmacist performed the final check of all prescriptions prior to partially completing the dispensing audit trail. Initialling both 'dispensed and checked by' boxes on the dispensing label would have provided an assurance to members of the public that patient safety was protected. There was a procedure for dealing with outstanding medication. The original prescription was retained, and an owing slip was issued to the patient if necessary. 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 at another branch of the pharmacy with more space and staff. Electronically prescribing system (NHS) tokens were nominated to the other branch.

The practice leaflet was due to be reprinted. The annual patient questionnaire was conducted. A complaints procedure was on display. The superintendent pharmacist (SI) confirmed that the standard operating procedures (SOPs) were due for review and update. Staff would then retrain in the updated SOPs. The staff member who served at the medicines counter said she would not give out a prescription or sell a P medicine if the pharmacist were not on the premises.

To protect patients receiving services, there was professional indemnity insurance in place provided by the NPA expiring 31 May 2020. The responsible pharmacist notice was on display and the responsible pharmacist log was completed. Records for private prescriptions, emergency and 'specials' supplies were generally complete. The controlled drug (CD) registers were complete and the balance of CDs was audited regularly. A random check of the actual stock of three strengths of MST reconciled with the recorded balances in the CD registers. Footnotes correcting entries were signed and dated. Invoice number and name and address of supplier were recorded for receipt of CDs.

Staff had signed a confidentiality agreement and were aware of procedures regarding General Data

Protection Regulation (GDPR). The Data Security and Protection (DSP) toolkit had been completed by the SI. There was a leaflet about 'How we safeguard information about you' displayed. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS card. The pharmacy computer was password protected and backed up regularly. Staff had undertaken dementia friends training and the pharmacists were accredited at level 2 in safeguarding training via Centre for Pharmacy Postgraduate Education (CPPE).

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough suitably trained staff to deliver its services safely. They work well together and are comfortable about providing feedback to improve the pharmacy's services.

### Inspector's evidence

Staff comprised: one full-time pharmacist, one full-time and one part-time medicines counter assistant (MCA). A staff member from another branch was covering one MCA on annual leave. The delivery person was shared with another branch of the pharmacy. The SI confirmed that training in the delivery procedure had been undertaken along with National Pharmacy Association (NPA) delivery training. Staff were provided with ongoing training via industry publications such as Counter Intelligence Plus and training topics included conditions affecting eyes and ears. In line with the pharmacy quality scheme, the pharmacist had completed training in sepsis and risk management. LASA medicines had been risk assessed and similar packs were identified such as ramipril and amlodipine packs so extra care was taken when putting away stock.

There were annual staff appraisals to monitor performance. There was a whistleblowing policy. Staff were able to provide feedback to improve services. A system of ticketing was in use when filing prescriptions corresponding to bagged medicines awaiting collection. A colour-coded duplicate numbered ticket was attached to the bagged prescription and the prescription which was filed. Staff had suggested using a different colour for each month which would indicate when the retrieval system was due to be cleared of uncollected prescriptions. The pharmacist said targets and incentives were not set for staff.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy’s premises are generally secure and suitable for the provision of its services. The pharmacy prevents people accessing the premises when it is closed to keep medicines and information safe.

### Inspector's evidence

The pharmacy premises were part of the listed underground station building and could not be altered. The pharmacy was accessed by the public from the main road at ground level. There were four tall cylinders in the corner of the retail area to the left of the entrance door. There was one nitrogen and three water cylinders all secured and maintained by London Underground. These were part of the fire extinguisher/sprinkler system for the underground station.

There were two seats for waiting customers in the public area. There was a limited range of over-the-counter goods on sale. The dispensary and work bench space were limited in size. Clearing clutter to free up valuable space was discussed. Lavatory facilities were in the station and not seen but there was a dispensary sink with a water supply. There was no consultation room but the pharmacist said that members of the public requiring a private conversation with the pharmacist could come to the side of the medicines counter towards the dispensary. There was sufficient lighting and ventilation.

## Principle 4 - Services ✔ Standards met

### Summary findings

People with different needs can access the pharmacy's services. The pharmacy gets its medicines from reputable sources to protect people from harm. It makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe to use. The pharmacy team takes the right action if any medicines or devices need to be returned to the suppliers. They make sure that people have all the information they need so that they can use their medicines safely. The pharmacy team members give advice to people about where they can get other support.

### Inspector's evidence

There was not wheelchair access, but staff went to the entrance to assist people with mobility issues. Large font labels could be printed to assist visually impaired people. Staff could converse in Gujarati, Hindi, Swahili and Cantonese to assist people whose first language was not English. Patients were signposted to other local services including the doctor, dentist, walk-in centre and optician.

The pharmacist was aware of the procedure for supplying sodium valproate to people in the at-risk group and information on the pregnancy prevention programme (PPP) to be explained. The intervention would be recorded on the patient medication record (PMR). The pharmacist was aware of the procedure to supply isotretinoin to people in the at-risk group. The treatment had to be initiated by a consultant and would be supplied following a negative pregnancy test result. The patient would be counselled on PPP and the intervention recorded on the PMR. The prescriber was contacted regarding prescriptions for more than 30 days' supply of a CD as good practice. There was a discussion about ensuring interventions were recorded on the PMR to show checks that medicines were safe for people to take and appropriate counselling was provided to protect patient safety.

Warning stickers were in use to alert staff to high-risk medicines such as fridge items. CD stickers were in use and prescriptions for schedule 4 CDs were highlighted to ensure CDs were not given out after the 28-day validity period. The pharmacist said that when supplying warfarin people were asked for their record of INR along with blood test due dates. INR was not always recorded on the PMR. Advice was given about side effects of bruising and bleeding including internal bleeding. Advice was given 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 and when to take folic acid. Counselling was given to people to seek medical advice if they developed an unexplained fever. During the visit, a parent was advised on how best to administer an antibiotic liquid preparation to a child.

An audit had been conducted to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking a non-steroidal anti-inflammatory drug (NSAID). The audit regarding repeat prescription of inhalers to treat asthma had been conducted. Other audits included asking diabetic patients when they had last attended retinopathy screening and foot checks. To meet quality payments criteria, staff had previously completed risk management training. Health promotion campaigns included reducing treatment with antibiotics to minimise antibiotic resistance, Stoptober and 'Get active'.

Medicines and medical devices were delivered outside the pharmacy by a delivery person shared with another branch of the pharmacy. A drop sheet was prepared of scheduled deliveries and patient

signatures were recorded to indicate a successful delivery of medicines to the patient's home. There was a leaflet to leave explaining what to do in the event of a failed delivery.

Medicines and medical devices were obtained from Alliance, AAH, Phoenix, Sigma and Colorama. Floor areas were not all clear. Stock was stored on the dispensary shelves and in dispensary drawers. Tidying up the medicines on the shelves to maximise space and reduce picking errors was discussed. Stock was date checked and recorded. The pharmacist said he date checked medicines as part of the final check when dispensing. Liquid medicines were marked with the date of opening and medicines were stored in original manufacturer's packaging. Cold chain items were stored in the medical fridge. Uncollected prescriptions were cleared from retrieval every six months. CD prescriptions were highlighted to ensure they were not given out after the 28-day validity period. CDs were stored in an orderly fashion in line with requirements. A small number of prescriptions awaiting collection were stored in a tote box in the public area. Some waste medicines were stored separate from other stock but in the public area. The SI gave an assurance that uncollected prescriptions would be cleared more frequently to free up shelf space and waste medicines would be stored away from the public area. Falsified medicines directive (FMD) hardware and software was operational at the time of the visit. Drug alerts and recalls were printed, actioned and displayed. A copy of the alert was retained if affected stock had been returned to the supplier.

## 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

Current reference sources included BNF, EMC and Google. The dispensary sink was generally clean and there were stamped glass measures to measure liquids. Minimum and maximum fridge temperatures were monitored daily and found to be within the range two to eight Celsius. The CD cabinet was fixed with bolts. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS card. 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. |