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: 07/03/2024

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 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. It has suitable written procedures in place for the team to follow and manage the risks associated with providing its services. The pharmacy keeps the records required by law showing it supplies its medicines and services safely. Members of the pharmacy team protect people's private information, and they know how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses but the responsible pharmacist (RP) worked alone and did not always record near misses. Medicines were stored alphabetically on shelves and in the dispensary drawers. The RP explained that medicines involved in incidents, or were similar in some way, such as atenolol and allopurinol, were generally separated from each other in the dispensary. The pharmacy received the majority of prescriptions electronically. The RP did not use baskets to separate prescriptions and medicines during the dispensing process due to space constraints. He dispensed and checked one prescription at a time and took a mental break during the dispensing and checking procedures. The RP bagged completed prescriptions and stored them on designated shelves awaiting collection. Prescriptions which required additional items were bagged and stored in a different area.

The RP checked interactions between medicines for the same patient during the clinical check, contacting the prescriber If necessary. And he recorded interventions on the patient medication record (PMR). The RP highlighted prescriptions for high-risk medicines with warning stickers and included warning cards containing additional information on certain medicines. The RP initialled dispensing labels showing that he had checked the prescription. Multi-compartment compliance aids were prepared at another branch of the pharmacy with more space and staff. Electronically prescribing system (EPS) prescriptions were nominated to the other branch.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were being reviewed at the time of the visit. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. The team member serving at the medicines counter knew not to hand out prescriptions or sell medicines if the RP was not present. And they would refer repeated requests for medicines liable to misuse to the RP. The pharmacy had a complaints procedure. And complaints were generally emailed to the superintendent pharmacist (SI).

The pharmacy had cylindrical tanks secured at the far end of its premises and the RP explained that these were the property of the underground station and associated with its sprinkler system. This equipment was maintained and risk-assessed by London Transport who had issued a summary guide and handbook which was retained with the pharmacy's health and safety policy.

Members of the team completed audits in line with the NHS pharmacy quality scheme (PQS) to monitor if people had all the information they needed to use their anti-coagulants, asthma inhalers and antibiotics effectively. The RP had undertaken the clinical audit of people taking valproate medicines

and was aware of the newest rules for dispensing valproates.

The pharmacy displayed a notice that told people who the RP was and it kept a record to show which pharmacist was the RP and when. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It maintained a controlled drug (CD) register and the balance of CDs was audited regularly. A random check of the actual stock of a CD matched the recorded amount in the CD register. The pharmacy kept records for the private prescriptions it supplied. And these generally were in order. Archiving older records to free up space was discussed. The fridge temperatures were monitored daily and recorded.

The pharmacy was registered with the Information Commissioner's Office and the SI was the data protection officer for the company. Following the visit, the SI confirmed that he completed the data security and protection (DSP) toolkit annually and maintained an information governance (IG) folder which included the general data protection regulation (GDPR) handbook for the team to refer to. The pharmacy collected confidential wate paper for shredding and the RP was using his own NHS smartcard. The pharmacy had a safeguarding policy with contact details to report concerns and the team had read through safeguarding modules. The RP was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team works well together to manage the workload and to deliver services safely. The pharmacy has enough team members who are qualified with the appropriate skills and training for their roles. The pharmacy team can provide feedback to improve the pharmacy's services.

Inspector's evidence

On the day of the visit, the full-time pharmacist was supported by one full-time trained medicines counter assistant (MCA). A team member from another branch of the pharmacy could be called on to cover if the MCA was absent. The delivery person was shared with another branch of the pharmacy and the RP understood that the delivery person had completed some training for this role.
The size of the pharmacy limited the range of services it could offer to members of the public who visited the pharmacy. The RP was aware of the training requirements for the pharmacy first service but had not undertaken the training. He planned to train to be able to offer more services from other premises. The RP and the MCA completed their own continuing professional development such as product knowledge. The RP was signposted to the knowledge hub on the GPhC website.

In line with the pharmacy quality scheme (PQS), the RP had previously completed training in sepsis and risk management. The SI was in the process of updating the SOPs such as what to do and who to contact when the team have concerns about the welfare of a vulnerable person. The pharmacy had a whistleblowing policy. And members of the team were able to provide feedback which they believed would improve services. The pharmacy had modified the ticketing system which helped the RP and the MCA locate prescriptions people had come to collect. A numbered coloured ticket was attached to the prescription bag which was placed on shelves awaiting collection. A duplicate ticket was attached to the prescription token which was annotated indicating the location of the medicines before being filed alphabetically by the patient’s name. When the person arrived at the pharmacy to collect their medicines, a member of the team pulled out the prescription token and was able to locate the corresponding ticket and bagged medicines. The ticketing system provided an additional check that the medicines were transferred correctly.

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. People could access the pharmacy 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.
The pharmacy had two seats for waiting customers in the public area. But they also provided somewhere to place tote boxes when MCA was putting away the orders delivered by wholesalers. The dispensary and work bench space were both limited in size. Keeping the limited workbench space as clear as possible was discussed.

The team was responsible for cleaning the pharmacy and found that wet dusting the fixtures and fittings was most effective. The team were permitted to use the lavatory facilities in the station next door. 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

The pharmacy tries to make sure its services are accessible to people with different needs. The pharmacy team members give advice to people about where they can get other support. The pharmacy gets its medicines from reputable sources and manages them so they are safe to use. It takes the right action if any medicines or devices need to be returned to the suppliers. And it makes sure that people have all the information they need to use their medicines safely.

Inspector's evidence

The pharmacy could not offer wheelchair access, but the team could go to the door to assist people. The opening hours were displayed at the entrance. The pharmacy could print large font labels which were easier to read and converse in Cantonese to assist people whose first language was not English. The team signposted people to other local services if the pharmacy could not help.

Members of the team initialled dispensing labels so they could identify who prepared a prescription and that the prescription had been checked. The RP marked some prescriptions to highlight fridge and CD items which might need to be added. And he highlighted prescriptions when he wanted to speak to the person about the medicines they were collecting. The RP counselled people on how best to use their medicines and supplied warning cards for high-risk medicines such as steroids. The PQS anti-coagulant audit showed that fewer people took warfarin and had been switched to a newer preparation to thin the blood, but the RP explained that for people who took warfarin the INR was monitored and recorded on the PMR. The RP reminded people about foods and medicines which may affect their INR.

The RP was aware of the new up-to-date guidance and rules for supplying valproate-containing medicines which must always be dispensed in the manufacturer's original full pack. And no-one under the age of 55 – both men and women - should be started on a valproate unless two specialists independently agree and document that there is no other safe and effective medication, or that there are compelling reasons why the reproductive risks linked to valproate, do not apply. Medicines and medical devices were delivered outside the pharmacy by a delivery person shared with another branch of the pharmacy. The RP cleared uncollected prescriptions after three months except for CDs which were removed after 28 days. Multi-compartment compliance packs were prepared for people at another branch of the pharmacy which had more space. And Electronically prescribing system (EPS) prescriptions were nominated to the other branch.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices in their original manufacturer’s packaging and marked liquid medicines with the date of opening. The dispensary was not very tidy. The RP checked the expiry dates of medicines when he dispensed them and a few times a year. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs securely in line with safe custody requirements. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock or were removed regularly by a waste contractor. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took and demonstrated what records they kept when the pharmacy received a concern about a product.

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

The RP had access to current reference sources including online. The dispensary sink was generally clean and there was a stamped glass measure to measure liquids. The team monitored minimum and maximum fridge temperatures daily to help make sure they were within the range two to eight Celsius. The CD cabinet was fixed with bolts. The pharmacy team disposed of confidential wastepaper appropriately. The pharmacy computer was password protected and backed up regularly. And the appliances had stickers to show they were portable appliance tested. The pharmacy maintained a health and safety folder which contained a summary guide for tenants of London Transport, a Transport for London customer handbook and familiarisation with the station.

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.