General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lady Margaret Road Pharmacy, 223 Lady Margaret Road, SOUTHALL, Middlesex, UB1 2PT

Pharmacy reference: 1094901

Type of pharmacy: Community

Date of inspection: 30/10/2019

Pharmacy context

The pharmacy is one of 20 belonging to the same company. It is attached to a health centre on a busy main road running through a residential area of Southall. As well as NHS essential services the pharmacy has an extended-hours dispensing service. And provides medicines in multi-compartment compliance packs for people either living in the community or in a local care home. Other services include: Medicines Use Reviews (MURs), New Medicines Service (NMS) and a delivery service for local residents. The pharmacy also offers a winter flu vaccination service.

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

In general, the pharmacy's working practices are safe and effective. Its team members understand their roles and responsibilities. They listen to people's concerns and try to keep people's information safe. They discuss any mistakes they make and share information to help reduce the chance of making mistakes in future. But team members do not do enough in the way that they gather information and use it to learn and improve.

Inspector's evidence

The pharmacy had procedures for managing risks in the dispensing process. The documented procedure couldn't be found during the inspection, but staff said that incidents, including near misses were discussed and recorded. The pharmacist then reviewed them periodically. This was done to help prevent the same mistakes being repeated and to help the team learn and improve. But, records did not contain much detail and not all near misses had been recorded. Without accurate records of what had gone wrong it may be difficult for pharmacists and staff to conduct a thorough review of their mistakes so that they could learn as much as possible from them. Action taken following near misses required staff to 'double check' but did not specify what should be done differently next time. The dispensing assistant explained that, after several near misses, she had reflected on her dispensing procedure to help prevent future the error. But it was not clear if all members of the team had reflected on their mistakes in this way.

The pharmacist had made staff aware of the risk of error with certain 'look alike sound alike' drugs (LASAs). So that staff took extra care when dispensing them. Staff provide examples of LASAs including amitriptyline and amiodarone, quetiapine and quinine sulphate, and propranolol and prednisolone. The team had also reviewed the order in which it prioritised its tasks so that it had people's prescriptions ready on time. Staff had also prioritised the completion of prescriptions with 'owings', where an item had to be ordered in for someone. Staff now got the 'owings' completed as soon as the items outstanding came in. This meant that they didn't have to rush to prepare them and people didn't have to wait unnecessarily when they came back for them.

Staff worked under the supervision of the responsible pharmacist (RP), whose sign was displayed for the public to see. Staff had standard operating procedures (SOPs) to follow and it was clear that they understood those relevant to their roles. The pharmacy team had a positive approach to customer feedback. A previous survey demonstrated a high level of customer satisfaction. In the survey customers had commented that they had not received general healthy living advice or stop smoking advice. But, the pharmacy had become a healthy living pharmacy just over a year ago. So now, all staff got involved in monthly health awareness campaign and were promoting the Stoptober stop smoking campaign. They were now also trying to introduce healthy living advice in conversation, when appropriate. The team described how they ordered the same brands of medicines for certain people to help them to take their medicines properly. Customer preferences included the Teva brands and Almus brands of various medicines, which were kept aside in a container. This was to ensure they were kept for the people who needed them and not dispensed for anyone else. Notes had been added to individual patient medication records (PMR)s to remind staff when dispensing for these patients.

The pharmacy had a formal complaints procedure. Customer concerns were generally dealt with at the

time by one of the regular pharmacists. Formal complaints were recorded and referred to the Superintendent (SI). But, staff said that complaints were rare. Details of the local NHS complaints advocacy service and PALs were available on request. 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.

The pharmacy kept all the records it needed to keep and, in general, these were in order. Records for private prescriptions, and unlicensed 'Specials' were in order as were controlled drug (CD) registers. The pharmacy also kept records for patient returned CDs. This was for audit trail and to account for all the non- stock CDs which RPs had under their control. Records for emergency supplies were generally in order although did not all give a clear reason for supply. Records for the RP were also generally in order, although there were instances where pharmacists had not recorded the time at which their responsibilities ceased.

Staff were trained to protect patient confidentiality and had signed a confidentiality agreement. They had also received GDPR training. Discarded labels and prescription tokens, containing patients' information, were shredded regularly. Completed prescriptions were stored on shelving behind the counter. While the shelving could be viewed from the customer area, staff had stored the majority of prescriptions in a way that patient details could not be viewed by anyone standing at the counter. Registrants had all completed CPPE level 2 safeguarding training. All remaining staff had been briefed on the principles of safeguarding and were in the process of completing a Numark training module. All staff had also completed dementia friends training. The pharmacy team had not had any specific safeguarding concerns to report. Contact details for the relevant safeguarding authorities were available online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload safely and effectively and team members work well together. They are comfortable about providing feedback to one another which helps the pharmacy to improve the quality of its services.

Inspector's evidence

The pharmacy had two regular full-time responsible pharmacists (RPs) and a regular part-time RP who managed shifts between them. Pharmacists were supported by two full-time trainee technicians and two full-time trainee dispensers. On the day of the inspection the RP was one of the regular RPs. The rest of the team consisted of a trainee dispenser and a trainee technician, who arrived part way through the inspection.

Team members were observed to work well together. It was evident that they could discuss matters openly, and they were seen assisting each other when required. The daily workload of prescriptions was in hand and customers were attended to promptly. Although the pharmacist was regularly distracted from her tasks while she dealt with telephone queries.

Team members described doing regular training through the Numark training modules and were currently completing their safeguarding training. The trainee dispenser described the recent training she had completed on the new CPCS NHS 111 service where NHS111 referred patients to the pharmacy either for a minor ailment medication or an emergency supply of their prescription medicine. The pharmacy had a small close-knit team. The trainee technician said he had regular informal discussions with his colleagues and felt able to raise concerns with them. He was an overseas pharmacist and was hoping to complete his pharmacist training in Great Britain. He described how since he came he had suggested calling patients to let them know when their prescriptions were ready for collection. This prompted people to collect them especially when it may be urgent, or they were due to run out.

The pharmacist could make her own professional decisions in the interest of patients and offered services such as an MUR when she felt it beneficial for someone. She was targeted with managing the daily workload and to provide a good service and an MUR whenever it was appropriate to do one. The pharmacist said it was useful to discuss patients' medicines with them. She felt it was useful because she was able to help people understand why it was important that they took the medication in the way that it had been prescribed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean and professional looking. They provide a safe, secure environment for people to receive healthcare services. But the pharmacy's storage arrangements meant that it did not look as tidy and organised as it could. And its décor needs to be refreshed.

Inspector's evidence

The pharmacy occupied a self-contained unit attached to a medical centre. The pharmacy had its own external entrance. Internally, it had a shared connecting doorway with the medical centre, so patients could pass between the two without going outside. The doorway between the medical centre and the pharmacy were kept open during normal business hours.

The pharmacy had a traditional appearance and customer areas were generally clean and tidy. It had a small shop floor with a distinct health promotion area. The pharmacy had access to a staffroom and toilet which it shared with health centre staff. The dispensary was situated at right angles to the counter and staff could access it easily from the counter. The pharmacy's dispensary had separate dispensing benches on three sides with open shelving and drawers, for storing stock, above and below. There was a clear work flow with clearly defined areas for dispensing and accuracy checking and for making up multi-compartment compliance packs. The main dispensary work surface was close to the counter and shop floor, allowing the pharmacist to counsel people and help them at the counter when necessary.

The pharmacy had a multi-purpose room which was used for private consultations such as MURs. The room was also used as an office and for storing prescriptions for delivery. And for storing staff bags and coats. The tote box containing items for delivery also contained a delivery record sheet with patients' details on it. But, staff said that all names and addresses and delivery sheets would be placed out of sight when people came into the room for a consultation. In general, dispensed prescriptions were stored so that patients' details could not be viewed by the public. The pharmacy was bright and well ventilated with temperature control systems in place. It had a professional appearance and stocked a small range of items for health and personal care. The dispensary was generally clean and appropriately maintained but it was not as tidy as it could be and needed to be refreshed. The floor was badly scuffed in areas of high traffic and paintwork was marked.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes them available to everyone. The pharmacy generally manages its medicines safely and effectively and gives people the advice they need to help them take their medicines properly. The pharmacy's team members check stocks of medicines regularly to make sure they are in date and fit for purpose. But, it does not store all of its medicines appropriately, once they have been removed them from their original packs. This means that it may be more difficult for them to identify those medicines if there was a problem.

Inspector's evidence

The pharmacy had steps up to its entrance, but it also had a ramp suitable for wheelchair access. The consultation room had a customer entrance which was also suitable for wheelchair access. The pharmacy had a repeat prescription collection service and a prescription ordering service. The service was offered to a small number of patients who needed help to manage their prescriptions. Services were advertised on posters near the waiting area although not at the front of the pharmacy for people to see. There was a variety of information leaflets available for customer selection. Information leaflets were placed in a rack in the customer area and in the consultation room.

In general, staff appeared to be providing services in accordance with standardised procedures. CDs were audited on a regular basis as per procedure. And a random check of CD stock (Longtec 20mg capsules) indicated that the running balance quantity in the register, was correct. Dispensing labels were initialled by the person dispensing and the person checking, to provide a dispensing audit trail. This was as per the SOP.

Multi-compartment compliance packs were provided for patients who needed them. Patient information leaflets (PILs) were offered with new medicines and on a regular basis thereafter. The medication in compliance packs was generally given a description, including colour and shape, to help people identify them. Although there was one pack which didn't have this information. Labelling directions gave the required BNF advisory information to help people take their medicines properly. Backing sheets were created for each person and checked against prescriptions each time. Staff obtained hospital discharge letters electronically after people had been in hospital so that their medicines could be dispensed in accordance with their most up-to-date prescription.

The pharmacy had procedures for targeting and counselling all patients in the at-risk group, taking sodium valproate. Staff said that, where appropriate, they would include valproate warning cards with prescriptions. Valproate information leaflets had been placed alongside other information leaflets on display. The pharmacist had the valproate safety pack issued by the MHRA. The pack contained a guidance sheet for pharmacists, warning cards and information booklets. Packs of sodium valproate in stock bore the updated warning label. The pharmacy was currently conducting an audit of valproate patients. They were also conducting an audit of patients taking NSAIDs and methotrexate. This was to ensure that patients were given the correct advice and to help ensure that they understood how to take their medicines safely. The audit included checks to make sure that patients on NSAIDs were also prescribed with gastrointestinal protection. All patients taking valproate, had been identified, but the pharmacy did not currently have any patients in the at-risk group taking the drug. NHS Flu vaccines were administered in accordance with an up-to-date PGD. Patients were asked for their consent and

asked to sign a consent form. The pharmacy kept records of all consultations and details of the product administered. But, the PGD seen did not give details of the pharmacists authorised to provide the service.

Medicines and medical equipment were obtained from established wholesalers; Alliance Healthcare, AAH, Sigma and Phoenix. Unlicensed 'specials' were obtained from Quantum Pharmaceuticals. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. A CD cabinet and fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read, recorded and monitored to ensure that the medication inside was kept within the correct temperature range. The pharmacy team was not yet scanning products with a unique barcode in accordance with the European Falsified Medicines Directive (FMD). Staff were aware of the requirement but were awaiting further direction from the superintendent.

But, there were dispensing bottles of loose tablets or capsules (pregabalin 150mg capsules and quetiapine 300mg tablets) which had been de-blistered from their original packs. The bottles contained only a brief description of the contents and did not show all the manufacturer's information, including the product licence number, batch number or PIL. And, there was no indication that the label description and contents had been checked by a pharmacist. Products stored in this way could be missed when checking product recalls or expiry dates, and if any mistakes had been made when bottling the products, they may lay undetected.

Stock was generally stored in an organised fashion although some shelves were untidy. The pharmacy team regularly checked the expiry dates of its medicines and kept records to show what it had checked and when. Short-dated stock was identified and highlighted, so that it could be removed from stock easily, once it approached its expiry date. Waste medicines, including denatured CDs, were disposed of in the appropriate containers. The containers were collected by a licensed waste contractor for safe disposal. A list of hazardous waste was available in the SOP folder, to help staff dispose of hazardous waste medicines properly. Drug recalls and safety alerts were responded to promptly and records were kept. Staff could recall responding to the recent recall for Zantac 75mg tablets. They had not had any of the affected stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities for the services it provides. In general, its facilities and equipment are clean and used in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures were of the appropriate BS standard and clean. But, amber dispensing bottles were not all stored with their caps on to prevent contamination with dust and debris. And one tablet triangle was found to have a slight dusty residue on it. Staff said they would clean triangles before use.

The pharmacy had up-to-date information sources in the form of a BNF, a BNF for children, and the drug tariff. The pharmacist said he also used the Numark advice line service. Team members also had access to a range of reputable online information sources such as the NHS websites, EMC, Pharmadoctor, NICE and the Drug Tariff. The pharmacy had two computer terminals in the dispensary. Both computers had a patient medication record (PMR) facility. They were password protected and were out of view of patients and the public. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was collected for safe disposal by a licensed waste contractor. In general staff were using the pharmacist's smart cards when accessing PMRs. Staff use their own smart cards to maintain an accurate audit trail and to ensure that access to patient records is appropriate and secure. But the pharmacist had covered over her ID photograph which made it difficult to identify if it was hers or not.

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.