General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Northolt Pharmacy, Grand Union Village Health Centre, Taywood Road, NORTHOLT, Middlesex, UB5 6WL

**Pharmacy reference:** 1111626

**Type of pharmacy:** Community

**Date of inspection:** 25/10/2019

## Pharmacy context

This is an independently owned pharmacy; one of two owned by the same company. The pharmacy is in a health centre in the midst of a modern housing development in Northolt. And offers an extended-hours dispensing service. As well as NHS essential services the pharmacy provides medicines in multi-compartment compliance packs for many people in the community and in nursing homes. Other services include: Medicines Use Reviews (MURs), New Medicines Service (NMS) and a delivery service for the elderly and housebound. The pharmacy also offers a winter flu vaccination 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 |
|---|---|---|---|---|
| **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 safe and effective. The pharmacy's team members listen to people's concerns and keep people's information safe. They discuss any mistakes they make and share information on what could go wrong to help reduce the chance of making mistakes in future. But they could be better at using the information to learn and improve.

### Inspector's evidence

The pharmacy was predominantly a dispensing pharmacy. 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 had procedures for managing risks in the dispensing process. All incidents, including near misses, were discussed at the time and recorded. And reviewed every three months. They were reviewed and discussed to prevent staff from repeating their mistakes and to help them learn and improve. Staff were required to take extra care when selecting 'look alike sound alike' drugs (LASAs). And had placed a list of LASAs on the wall. The list included drugs such as propranolol and prednisolone, atenolol and allopurinol, amlodipine and amitriptyline and pantoprazole and pravastatin. Several of which had been separated into different drawers to help reduce the chance of selecting the wrong one. Near miss records indicated that mistakes had occurred because of staff rushing or misreading the prescription. As a follow up staff were required to 'read the prescription properly'. But the same causes and follow up actions had been repeated on several occasions, indicating that a more thorough analysis and response may be required for each incident. And so, near miss incidents could be used to greater effect by prompting team members to reflect on their own dispensing technique and identify any steps which could have prevented the error.

The pharmacy team had a positive approach to customer feedback. A previous survey demonstrated a good level of customer satisfaction. Customers had commented that staff had seemed in a hurry and dismissive when taking in and handing out prescriptions. Team members had reviewed their customer skills and it was evident that they were now greeting people more positively. The team described how they ordered the same brands of medicines for certain people to help with compliance. Customer preferences included the Teva brand of codeine 30mg tablets and losartan 100mg tablets. All preferred brands were kept in a separate drawer to make sure they were kept for the people who needed them. Team members had also added notes to individual patient medication records (PMR)s as a reminder.

The pharmacy had a formal complaints procedure. Customer concerns were generally dealt with at the time by the pharmacist or one of the regular full-time members of staff. Formal complaints were recorded although 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 April 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 the RP, private prescriptions, emergency supplies and unlicensed 'Specials' were in order as were controlled drug (CD) registers. The pharmacy also kept records for CDs, returned by patients, for destruction. However, several patient-returned CDs from three years previously could not be found in

the CD cabinet. Staff said that they had been destroyed. But, although a record was made when the drugs were received it had not been completed when they were destroyed. Records are kept for patient-returned CDs for audit trail and to account for all the non- stock CDs which RPs have under their control and therefore should be maintained appropriately.

Staff had been 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 in a room off the dispensary, out of view from customer areas. The Pharmacy had a safeguarding policy in place. Registrants had all completed CPPE level 2 training. All remaining staff had been briefed on the principles of safeguarding. The pharmacy had a flow chart on display, to show the process for reporting a safeguarding concern. All staff had 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 will help the pharmacy maintain the quality of its services.

### Inspector's evidence

The pharmacy had two regular full-time RPs and one regular part-time RP who managed shifts between them. Pharmacists were supported by three full-time technicians and two full-time trainee technicians. On the day of the inspection the team consisted of one of the regular RPs with the support of the technician and two trainee technicians, one of which 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. Staff members described doing regular training through the Numark training modules and were currently completing their safeguarding training. Staff had also recently had training on the new CPCS NHS 111 service where NHS111 referred patients to the pharmacy either for a minor ailment 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 described how he had encouraged the team to review its customer service skills, as he had become aware that staff seemed to be rushing to do their jobs without always paying enough attention to people waiting at the counter. He found that as a result, customers were generally happier which made staff happier too.

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 to help them understand why it was important to take what the doctor had prescribed for them. The pharmacist also takes the opportunity during MURs to offer advice and support with regard to diet and exercise.

## 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 storage arrangements meant that it did not look as tidy and organised as it could.

### Inspector's evidence

The pharmacy had been designed as an integral part of the health centre. Although access to the pharmacy could only be gained by entering the health centre, it had its own entry door via the consultation room and a hatch at the prescription reception area. Customer areas were confined to a waiting area outside the pharmacy which was shared with the health centre. The pharmacy stocked only prescription medicines and a small range of counter medicines for sale. The consultation room offered a good level of privacy and the pharmacist described using the room regularly for private consultations such as MURs.

Dispensing space was limited for the number of prescriptions dispensed. There was a four-metre run of bench space to accommodate two work stations with their computers and labellers and a further two to three-metre L-shaped run of bench space next to the sink. This area was used for dispensing and checking repeat prescriptions. The pharmacy had an additional room to one side which was approximately half the size of the dispensary. This room had a small run of bench space and storage shelves and was used for dispensing multi-compartment compliance packs and storing dispensed prescriptions. Bulky prescriptions and incomplete prescriptions with items outstanding (owings) were stored in tote boxes on the floor.
The dispensary was quite enclosed. It was designed as a long arrangement with dispensing benches largely out of sight from the small reception desk to the front. Staff working at the main dispensing bench on the opposite wall to the counter would either be out of view or have their backs to customers. However, staff were constantly checking for waiting customers and were quick to respond to people at the counter. The premises were generally clean and well -maintained. Work surfaces and floors were well utilised and there was not much free space. However, overall, the pharmacy had a professional appearance. It was generally tidy and organised, and floors, shelves and sinks looked clean.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides its services safely and effectively and makes them available to everyone. Members of the pharmacy team give people the advice and support they need to help them use their medicines safely and properly. In general, the pharmacy manages its medicines safely and effectively. The pharmacy's team members store medicines appropriately and dispose of waste medicines safely. They check stocks of medicines regularly to make sure they are fit for purpose. But, it does not carry out all of its checks as thoroughly as it could.

### Inspector's evidence

The entrance to the health centre, and pharmacy area was step-free and suitable for wheelchair access. The consultation room 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 There was a selection of information leaflets available for customer selection.

In general, staff appeared to be providing services in accordance with standardised procedures. CDs were audited on a regular basis as per procedure. A random check of CD stock (Zomorph 30mg 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 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 given a description, including colour and shape, to help people to identify them. Labelling directions gave the required BNF advisory information to help people take their medicines properly. Medicines summary sheets were created for each person and checked against prescriptions each time. Staff would pursue discharge letters after being informed that people had been in hospital. Staff would also prompt surgeries to update people's prescriptions. This was so that the pharmacy could make the necessary changes and supply people's medicines 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. Staff were able to locate the MHRA purple pack which was to hand. The pack contained a guidance sheet for pharmacists, and warning cards and information booklets for patients. Packs of sodium valproate in stock bore the updated warning label and additional warning stickers were available for split packs. All patients taking valproate, had been identified, but the pharmacy did not have any patients in the at-risk group taking the drug. The pharmacy had up-to-date PGDs for both the private and NHS flu vaccination services. People were briefed on what to expect when receiving a vaccination and asked to complete a consent form. Records were kept of the consultation for each vaccination, including details of the product administered.

Medicines and Medical equipment were obtained from established wholesalers; Alliance Healthcare, AAH, OTC Colorama, DE Pharmaceuticals, Sigma and Phoenix. Unlicensed 'specials' were obtained from Chemys Pharmaceuticals. All suppliers held the appropriate licences and stock was generally stored in a

tidy, organised fashion. A CD cabinet and fridge were used 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 had a single scanner for scanning products with a unique barcode in accordance with the European Falsified Medicines Directive (FMD). The team were scanning products as appropriate.

Stock was regularly date checked and records kept. Short-dated stock was identified and highlighted using a dot sticker. However, there was a pack of Oxycodone in the CD cabinet which had been highlighted but had not been separated from current stock, although it had expired at the end of the previous month. 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 had been placed on the wall, 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 aripiprazole 1mg/ml. They had not had any of the affected stock.

## 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. In general, measures were of the appropriate BS standard and clean. But, there was one measure, which was made of plastic and was not crown stamped or have an ISO number. Staff used a separate triangle for counting loose cytotoxic tablets to help prevent cross contamination with other tablets. And amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris.

There were up to date information sources available in the form of a BNF, a BNF for children and the drug tariff. The team also used the Numark advice line service. Pharmacists also had access to a range of reputable online information sources such as the NHS websites, EMC, NICE and meds.org. The pharmacy had three computer terminals with a patient medication record (PMR) facility. Two were in the dispensary and one in the consultation room. Computers 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 shredded. Staff were using their own smart cards when accessing 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.

## 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. |