General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Baban Pharmacy, 34 Chalton Street, LONDON, NW1 1JB

Pharmacy reference: 1123567

Type of pharmacy: Community

Date of inspection: 16/09/2021

Pharmacy context

The pharmacy is in a street near Euston Station in north west London. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include seasonal flu vaccinations, prescription delivery, stop smoking, Selfcare Pharmacy First and Pharmacy Collect (supply of lateral flow tests). The inspection took place during the COVID-19 pandemic. All aspects of the pharmacy were not inspected.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	3.1	Standard not met	There are areas of the pharmacy which are not clean and tidy and may represent a risk to the safe provision of some of its services.
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 adequate written procedures which tell team members how to manage risks and work safely. The pharmacy enables people to give it feedback so it can improve its services. The pharmacy's team members mostly keep satisfactory records they need to by law so they can show the pharmacy is providing safe services. They have introduced new ways of working to help protect people against COVID-19 infection. The pharmacy's team members understand their role in protecting vulnerable people. And they keep people's private information safe.

Inspector's evidence

The pharmacy team members had systems in place to review dispensing errors and near misses although they did not always record them or the lessons they learned from them. So, they could be missing opportunities to identify patterns or trends with the mistakes they made. The responsible pharmacist (RP) explained that medicines that looked alike or sounded alike (LASA) such as amitriptyline and amlodipine were separated from each other in the dispensary to avoid mistakes when picking medicines for prescriptions. The complaints procedure had National Reporting and Learning System (NRLS) incident report forms and Community Pharmacy Patient Safety incident report forms to complete and submit in relation to dealing with dispensing errors.

The pharmacy team used baskets to separate each person's prescription and medicines during the dispensing process. They were seen to refer to the prescription when generating labels and picking medicines. Members of the pharmacy team checked online or with the prescriber if there were interactions between two medicines for the same person. And the intervention was noted on the patient's medication record (PMR). The RP took a mental break if working alone between dispensing and checking each prescription. If both pharmacists were working together, one dispensed and the other checked and bagged the medicines. There was a procedure for dealing with outstanding medicines so people received the complete course of treatment.

To protect against infection, the pharmacy team had completed a risk assessment on the effects of COVID-19 on the premises and people visiting the pharmacy. Occupational risk assessments had been completed for both pharmacists and they knew to report any COVID-19 infections contracted in the workplace to the relevant authorities. The screen at the medicines counter had been removed because it was at risk of becoming detached from the counter. The floor was marked to show people where to stand to be two metres apart and a limited number of people were allowed to enter the pharmacy together. Hand sanitiser was available for people to apply. Personal protective equipment (PPE) was also available although one team member preferred not to wear a mask on health grounds. The team members who were present had been vaccinated against COVID-19 infections and were self-testing twice weekly to check for infection. Members of the public were reminded to wear a face cover when entering the pharmacy's premises.

The pharmacy had standard operating procedures (SOPs) which included responsible pharmacist, controlled drug (CD) and complaints SOPs. They had been reviewed recently and there were training records to show staff had read and understood the SOPs. Making sure new team members read and followed the SOPs relevant to their roles was discussed. The pharmacy had a procedure for managing equality and diversity in the workplace. The CD audit was not as frequent as stated in the CD SOP.

Ensuring SOPs reflect actual practice in the pharmacy was discussed. The pharmacy displayed a notice with its contact details inviting members of the public to provide views and suggestions on how the pharmacy could do things better, but the RP said there had been no feedback recently. Members of the public who had accessed the new Selfcare Pharmacy First service which was being trialled were supplied a QR code and website address to provide feedback on the service to the Local Pharmaceutical Committee (LPC). The pharmacy's practice leaflet with information on services and opening times was due to be reprinted and displayed.

The pharmacy displayed an RP notice and kept a record of which pharmacist was RP and when. To protect patients who used the pharmacy's services, there was in-date professional indemnity insurance in place provided by the National Pharmacy Association. The CD registers were complete, and entries were corrected with signed and dated footnotes. When checked the actual stock of two strengths of a CD matched what was recorded in the CD register. Patient returned CDs were listed as required. The balance of CDs was audited but not as frequently as the SOP stated. The pharmacy's records for unlicensed or 'specials' medicines were complete. Private prescription records included all the required information. But the private prescription register was spiral bound and may be at risk of pages becoming detached and lost. Emergency supply records were not seen but the RP explained that the summary care record (SCR) was checked with the person's consent if they requested an emergency supply of medicine. The RP recorded the supply on the PMR showing whether it was 'Script to follow' or at the patient's request. The dispensing label included the wording 'Emergency Supply'. In some circumstances the person was signposted to NHS 111 to arrange an emergency supply.

The RP was in the process of applying to register with the Information Commissioner's Office (ICO). The leaflet display included NHS – 'Your data matters to NHS'. Displaying a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team was discussed. Confidential wastepaper was shredded. The computer system was password protected and regularly backed up. Both pharmacists were using their own NHS cards. The pharmacy team had undertaken level 2 safeguarding training so they could protect vulnerable people. There was an SOP and a pharmacy safeguarding lead and contact details to report concerns to the relevant authorities.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to deliver services safely and manage the workload. They keep their knowledge and skills up to date. Team members are comfortable in providing feedback about services.

Inspector's evidence

The pharmacy team comprised: two full-time pharmacists and one part-time pharmacy student who worked on Saturdays. The pharmacists managed the delivery service to a small number of people at home. Both pharmacists had undertaken the flu vaccination training although the start date for providing the service had not been decided at the time of the inspection. Training certificates were seen. The pharmacy team had regular meetings and talked about issues such as COVID-19 and its effect on the pharmacy and newer services. For instance, the Selfcare Pharmacist First service which was being trialled at this pharmacy. COVID-19 updates were received by the pharmacists via their NHS email from the LPC and NHS England. The pharmacists were signposted to the Knowledge Hub on the General Pharmaceutical Council (GPhC) website where there were examples of notable practice. Team members were able to feedback suggestions to improve services and there was a whistleblowing policy.

Principle 3 - Premises **Standards not all met**

Summary findings

Some areas of the pharmacy's premises are clutterred and untidy which reduces space to work and increases the risk of things going wrong. But overall, they are generally suitable for the provision of healthcare services. The pharmacy's team members have introduced new ways to help protect people from COVID-19 infection. The pharmacy prevents people accessing its premises when it is closed so that it keeps its medicines and people's information safe.

Inspector's evidence

The pharmacy's premises had a retail area with a medicines counter to the left and some goods for sale to the right. There were seats for people who were waiting for prescriptions although the chairs were not socially distanced. But only two or three people at a time were allowed to enter the pharmacy and the RP said that if there were more people, they were asked to wait outside. There was public seating along the pavements. In line with a risk assessment, and to help protect against infection, the pharmacy team had assessed the effect of COVID-19 on the premises and people visiting the pharmacy. At the time of the visit, the screen at the medicines counter had been removed because it was at risk of becoming detached from the counter. There was a layer of dust on the higher section of the medicines counter where there were flower pots and a Viagra Connect display unit. The floor was marked to show people where to stand to be two metres apart. There was a pharmacy delivery in the retail area. Several sealed boxes were stacked up against the medicines counter prior to contents being put away.

The dispensary was on the same level as the retail area. There was a half-door at the entrance to the dispensary from the retail area but it was not always closed preventing unwanted access. The consultation room was accessed through the dispensary. It was cluttered and untidy so there were no clear surfaces to set out equipment for services. For instance to administer a flu vaccination. Waste medicine containers and a sharps bin were stored here so there was little clear floor space. The door between the consultation room and the staff area was stained and required cleaning.

Beyond the consultation room was a staff kitchen and lavatory facility which was generally clean and there was a handwashing sink although there was nothing to dry hands. There was a round table in the corner of the dispensary which was cleared and used to provide extra space when the pharmacist was preparing multi-compartment compliance aids. The workbench space was cluttered. Tidying would free up more workspace and cleaning pharmacy surfaces would be easier. And it would improve the professional image of the pharmacy as members of the public were escorted via the dispensary to the consultation room for their flu vaccinations. The next day following the visit, the RP confirmed that the pharmacy team had started to tidy up and clean the pharmacy surfaces. The pharmacy's premises were ventilated and there was sufficient lighting.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy opens early and stays open later than is usual. People with a range of needs can easily access the pharmacy's services. The pharmacy's working practices are mostly safe and effective. It generally obtains, stores and supplies its stock appropriately. But it doesn't keep all of its medicines in properly labelled containers. So they may be missed when checking stock in response to an alert or when date-checking stock. The pharmacy team members know what to do if any medicines or devices need to be returned to the suppliers. And they make sure people have all the information they need to use their medicines safely. Pharmacy team members provide a description of each medicine when they pack these together in compliance aids, but the writing may make it difficult to read sometimes.

Inspector's evidence

There was a slight step at the entrance to the pharmacy, but the pharmacy team said people with mobility issues could enter the pharmacy. They could speak in Arabic, Kurdish and Bengali to assist people whose first language was not English. Large font labels could be printed to assist people with visual impairment. Members of the public were signposted to the nearby out of hours doctor's service, dentist or NHS 111 or another provider if a service was not available at the pharmacy. People were signposted to a private COVID-19 testing centre nearby and to call NHS 119 for COVID-19 information.

The pharmacy offered a delivery service to a small number of people who could not attend its premises in person. Before delivering, the patient was contacted. To be sure the right medicine was delivered to the right person, the delivery person checked their identity before handing over the medicines and a patient signature was obtained if appropriate. CDs were not delivered. The pharmacy supplied COVID-19 rapid lateral flow tests for people to test themselves at home. The pharmacist highlighted prescriptions for high-risk medicines with coloured 'post-it' notes to alert either pharmacist to speak to the person about the medication they were collecting. The date on CD prescriptions was managed to ensure supply of CDs within the 28-day period when the prescription was valid. The RP was aware of the valproate pregnancy prevention programme. And knew that people needed to be counselled if they were in the child-bearing potential at-risk group who were prescribed valproate. The pharmacy had printed valproate information to give to people in this at-risk group. Valproate must be dispensed with a patient information leaflet (PIL) and for valproate which was re-packaged, there should be a warning on the container. The patient should be reminded to have an annual specialist review.

The pharmacy provided a locally commissioned stop smoking service although at the time of the visit, there were no clients. The pharmacists had completed the training to provide the NHS flu vaccination service, but they had not been given a start date yet to commence administering the vaccines. The minor ailments service had been discontinued and replaced by the Selfcare Pharmacy First service which was trialled for three months. There was a limited list of treatment and a reduced formulary so people who were eligible to access the service could have one supply of medication per month. The pharmacy had received no referrals recently via the community pharmacist consultation service (CPCS).

The pharmacy prepared multi-compartment compliance aids (compliance aids) in the dispensary for a number of people who had difficulty managing their medicines. Upon receipt, the pharmacist screened prescriptions for changes in medicines which were checked with the prescriber if necessary. The pharmacy team re-ordered prescriptions on behalf of people. High-risk medicines such as sodium

valproate and alendronate were generally supplied separately from the compliance aid. But if it was appropriate to supply them in a compliance aid, the pharmacy team checked if a medicine was suitable to be re-packaged. Compliance aids awaiting collection included patient information leaflets (PILs), so the patient had the most up-to-date information on their medicines. The backing sheet included a hand-written description of each tablet or capsule, so the patient or carer could identify individual medicines. But the writing was not easy to read in places. The pharmacy had not yet received any referrals via the discharge medicines service (DMS).

The pharmacy obtained medicines and medical devices from reputable suppliers. Medicines were generally stored in manufacturer's original packaging. But there were some lose strips of tablets and capsules on the dispensary shelves. Medicines not kept in original packaging may be missed when checking stock in response to an alert or when date checking stock. Liquid medicines were marked with a date of opening. Stock was date-checked and recorded. In a random check no date-expired stock was found on the dispensary shelves. Two date-expired liquids had been highlighted but not removed to the waste medicines bin. These were removed during the visit. Patients were contacted and reminded if there was a prescription awaiting collection in the retrieval system. Cold chain items were stored in the medical fridge between two and eight Celsius. A small number of non-pharmaceutical items were removed from the fridge at the beginning of the visit. Waste medicines were stored separate from other stock. The RP described the actions taken when drug alerts were received by email and stock was checked for affected batches. The alert was filed in a folder on the pharmacy computer. Keeping a record to show the actions taken by the team in response to an alert was discussed.

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 pharmacy team accessed a range of reference sources online such as British National Formulary, electronic medicines compendium (EMC), Medicines, Ethics and Practice (MEP)and Drug Tariff (DT). The pharmacists also called the information line at the National Pharmacy Association (NPA). The pharmacy had a fridge to store medicines requiring refrigeration and the maximum and minimum temperatures were monitored and recorded twice daily. The CD cabinet was fixed with bolts. The carbon monoxide monitor for the stop smoking service was supplied and maintained by NHS Camden. The pharmacy had a sharps bin for flu vaccination sharps disposal and two in-date adrenaline devices to deal with anaphylaxis. The pharmacists used the shredder to safely dispose of confidential wastepaper. The pharmacy restricted access to its computers and PMR. Authorised team members could use them when they entered their password and made sure their NHS smartcards were removed when they were not working. The pharmacy computer screens could not be seen by members of the public.

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.