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: 26/05/2022

Pharmacy context

The pharmacy is in a street near Euston Station in northwest 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 and Selfcare Pharmacy First. This was a follow-up visit after completion of the action plan issued at the previous visit. It took place during the COVID-19 pandemic. All aspects of the pharmacy were not inspected.

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 mostly safe and effective. It has satisfactory written instructions to help make sure the pharmacy's team members work safely. The pharmacy asks people for feedback so it can improve its services. The pharmacy's team members generally keep the records they need to by law so they can show the pharmacy is providing its services safely. They understand their role in safeguarding the wellbeing of vulnerable people. And they protect people's private information.

Inspector's evidence

The pharmacy team had systems in place to record and review dispensing errors and near misses. They did not always record their mistakes 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 which looked alike or sounded alike (LASA) such as the three strengths of losartan tablets were separated from each other in the dispensary to avoid mistakes when picking medicines for prescriptions. The top 50 medicines were stored together to enhance workflow, but it also separated some medicines which were easily mixed up. 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. (NRLS has since been replaced by Learn from patient Safety Events Service (LFPSE)).

The pharmacy team used baskets to separate people's prescriptions and medicines during the dispensing process. They referred to the prescription when picking medicines. The RP checked allergy status and interactions between medicines for the same person when they were completing the clinical check of the prescription. And interventions, such as the INR value for people taking anti-coagulant medications, were 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 pharmacy. The screen at the medicines counter had been removed but the floor was marked to show people where to stand in order to be two metres apart. Hand sanitiser was available for people to apply. There was personal protective equipment (PPE) if any pharmacy team members wanted to use it. The team members cleaned the dispensary benches and floors regularly.

The pharmacy had standard operating procedures (SOPs) which included responsible pharmacist, controlled drug (CD) and complaints SOPs. The roles and responsibilities matrix was completed. There was a procedure for managing equality and diversity in the workplace. The CD audit was weekly in line with the CD SOP and the CD accountable officer details were current. The RP was observed asking people questions from a sales protocol before selling them an over-the-counter medicine. 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. Members of the public could obtain treatment for minor ailments via the Selfcare Pharmacy First service. The RP said that people accessed one treatment per month and feedback on the service was addressed to the Local Pharmaceutical Committee. 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. The pharmacy protected people using the pharmacy's services with in-date professional indemnity insurance provided by the National Pharmacy Association. The CD registers were complete, and entries were corrected with signed and dated footnotes. The actual stock of a CD matched what was recorded in the CD register. Patient returned CDs were listed as required. The balance of CDs was audited as frequently as the SOP stated. The pharmacy's records for unlicensed or 'specials' medicines were generally complete. Private prescription records included all the required information. The private prescription register was spiral bound which may mean that pages could become detached and lost. The RP explained that the summary care record (SCR) was checked with the person's consent if they requested an emergency supply of medicine. In some circumstances the person was signposted to NHS 111 to arrange an emergency supply.

The pharmacy had not completed 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 collected for safe disposal. 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.
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Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members who work together to deliver its 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 and stop smoking training. Training certificates were seen. The RP said his contingency planning included both pharmacists being on duty with the pharmacy student. And he could call on a family member too. The pharmacy team had meetings and talked about issues such as the effect of the pandemic on the pharmacy and some services. For instance, the Selfcare Pharmacist First service did not attract the expected uptake. Service updates were received via NHS email from the LPC and NHS England. Team members were able to feedback suggestions to improve services and there was a whistleblowing policy. The pharmacy team were signposted to the GPhC Knowledge Hub for examples of notable practice.

Principle 3 - Premises ✔ Standards met

Summary findings

The public facing areas of the pharmacy are tidy and overall, its premises are generally suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so that it keeps its medicines safe and protects people's information.

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. The RP said that during the pandemic, they limited the number of people who could be in the pharmacy at the same time and asked people to wait outside where there was public seating. The pharmacy had older fixtures and fittings. There were flowerpots and an over-the-counter medicine display unit on a higher level of the medicines counter. The floor was marked to show people where to stand to be two metres apart.

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 protected patient privacy when people wanted to talk to the pharmacist. The pharmacy’s staff kitchen and lavatory facilities were beyond the consultation room and were generally clean. 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 reasonably clear. The pharmacy's premises were ventilated and there was sufficient lighting.

Principle 4 - Services ✔ Standards met

Summary findings

People with different needs can easily access the pharmacy's services. The pharmacy opens early and stays open later than is usual. Overall, the pharmacy's working practices are generally safe and effective. It mostly obtains, stores and supplies its stock appropriately. The pharmacy team members know what to do if any medicines or devices need to be returned to the suppliers. But they don’t keep all of the medicines in properly labelled containers. So they may be missed when checking stock in response to an alert or when date-checking. The pharmacy team members make sure people have all the information they need to use their medicines safely. They 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. The pharmacy displayed its opening hours at the entrance and a poster with Coronavirus information. There was hand gel on the counter for people to apply. 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 the Brook Centre nearby for emergency hormonal contraception 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 person was contacted in case they were not home and missed the delivery. To make 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 pharmacist highlighted prescriptions for high-risk medicines with coloured 'post-it' notes to alert the pharmacists to speak to the person about the medication they were collecting. The date on CD prescriptions was checked to ensure supply of CDs within the 28-day period when the prescription was valid. Some people had INR meters at home and informed the doctor of the INR reading when they needed a new prescription for their anti-coagulant medicine. The pharmacy recorded the INR value on the person’s PMR. 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 a valproate. The pharmacy had printed educational information about taking a valproate 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 have an annual specialist review.

The pharmacy provided a stop smoking service, giving advice on stopping smoking, rotating nicotine replacement patches and measuring exhaled carbon monoxide. The pharmacists had completed the

training to provide the NHS flu vaccination service. The Camden NHS minor ailments scheme had been discontinued and replaced by the Selfcare Pharmacy First service after a trial period. 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 a low rate of referrals recently via the community pharmacist consultation service (CPCS).

The pharmacy team prepared multi-compartment compliance aids (compliance aids) in the dispensary for a number of people who had difficulty managing their medicines. The pharmacist managed re-ordering of people's prescriptions and screened new prescriptions for changes in medicines which were checked with the prescriber if necessary. High-risk medicines such as sodium valproate and alendronate were mostly not supplied in the compliance aid. But the pharmacy team checked if a medicine was suitable to be re-packaged and supplied in a compliance aid. 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 to identify each tablet or capsule. But the writing was not easy to read in places. The pharmacy had received very few 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 a small number of lose strips of tablets and capsules on the dispensary shelves so they may not be identified when date-checking stock or responding to an alert or recall. Liquid medicines were marked with a date of opening. Stock was date-checked although not always recorded but the RP said he checked the date as part of his final check of prescriptions. In a random check no date-expired stock was found on the dispensary shelves. One liquid medicine which had been highlighted with the date of opening was removed to the waste medicines bin during the visit. The RP contacted and reminded people 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 stored in the fridge were discussed. 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 had access to a range of reference sources online such as British National Formulary (BNF), 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. The maximum and minimum temperatures were monitored and recorded twice daily. The CD cabinet was fixed with bolts. The pharmacy had a carbon monoxide monitor for the stop smoking service. The sharps bin for flu vaccination sharps disposal was quite full and due to be collected for safe disposal. Confidential wastepaper was collected and disposed of appropriately. The pharmacy computers were password protected. And the RP was using his own NHS smartcard. 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.