

# Registered pharmacy inspection report

**Pharmacy Name:** Jade Pharmacy (Heston Road), 174-176 Heston Road, Heston, HOUNSLow, Middlesex, TW5 0QU

**Pharmacy reference:** 1034943

**Type of pharmacy:** Community

**Date of inspection:** 29/07/2022

## Pharmacy context

This is a community pharmacy in a residential area of Hounslow. The pharmacy provides a range of services including dispensing prescriptions. And supplying medicines in multi-compartment compliance packs for people living at home who need them. It has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a core range of other services, including a medicines delivery service, a COVID-19 vaccination service and a travel vaccination service.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards not all met	2.1	Standard not met	The pharmacy does not adequately train all its team members for their job roles.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards not all met	4.3	Standard not met	The pharmacy does not store all of its medicines properly. And it does not provide all of its medicines with all the information it should.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

In general, the pharmacy has adequate procedures to identify risk. It has written procedures in place to help ensure that its team members work safely. And it has insurance to cover its services. The pharmacy team has adapted its working practices suitably to minimise risks to people's safety during the COVID-19 pandemic. And it knows how to protect the safety of vulnerable people. But the pharmacy does not do enough to ensure that it keeps all of its records in the way it should.

### Inspector's evidence

The team had a cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. The regular medicines counter assistant (MCA) who was also a dispensing assistant (DA) explained that the pharmacy had been short staffed for several months. The remaining team members had felt the pressures of a heavier-than-usual workload. And they had found it difficult to complete all of the pharmacy's usual tasks. While the team had a system for recording its mistakes it had not recorded any over the previous four months. But it described how the RP generally highlighted and discussed 'near misses' and errors at the time with the team member involved. This enabled them to learn from their mistakes and improve. The team understood that it was also important to monitor and review its near misses and errors so that it could learn as much as possible from them. And that this was especially important for team members in training. The team agreed that records should be kept. And that records should identify what could be done differently next time to prevent mistakes and promote continued improvement. The pharmacy had put measures in place to protect people from the transfer of viral infections. It had put screens up at its medicines counter. And it had hand sanitiser for people and the team to use. Team members had access to personal protective equipment in the form of gloves and masks.

The pharmacy had a set of standard operating procedures (SOPs) to follow. But the SOPs had not had a full and thorough review for several years. The impact of the pandemic and staff shortages had contributed to the delay. The trainee DA had not read and signed the SOPs at this branch. But he recalled reading them at the branch he worked at previously. Other team members had read the existing SOPs relevant to their roles. The MCA DA understood her role and responsibilities. And she consulted the RP when she needed his advice and expertise. The RP had placed his RP notice on display showing his name and registration number as required by law. The inspector and RP discussed the purpose of the RP notice and the importance of ensuring it was visible to people. People could give feedback on the quality of the pharmacy's services. Team members described having had a few complaints. Complaints had been related to people's expectations involving the time taken to get their medicines ready after they had requested their prescriptions from the surgery. And manufacturers' medicines shortages which the team did their best to resolve. The pharmacy had a complaints procedure in place. But, in general, the team sought feedback from conversations with people. The pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints procedure online. But customer concerns were generally dealt with at the time by the regular pharmacists or by the superintendent (SP) if necessary. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers. Those arrangements were in place until 07 November 2022. It is understood that when this date is reached the pharmacy will renew its insurance arrangements for the following year.

The pharmacy generally kept its records in the way it was meant to, including the RP record, the private prescription records and its records of emergency supplies. The team recognised that the pharmacy should ensure that all of its essential records are kept the way they should be. And that its records are accurate and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And had completed general training on confidentiality. Confidential paper waste was discarded into separate waste containers. And it was shredded regularly. People's personal information, including their prescription details, were generally kept out of public view. The RP had completed appropriate safeguarding training. Other team members had been briefed although had not yet had any formal training. but they knew to report any concerns to the RP. The team could access details for the relevant safeguarding authorities online.

## Principle 2 - Staffing Standards not all met

### Summary findings

The pharmacy does not adequately train all its team members for the tasks they carry out. But team members support one another. And they are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services. In general, the pharmacy team adequately manages its workload.

### Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. The RP was a locum who had worked at the pharmacy on several occasions previously. The regular RP had recently left. And so the pharmacy was managing its services using locums for the time being. On the day of the inspection the rest of the team consisted of the MCA DA and a trainee DA who not yet started any formal training. The trainee had worked at the pharmacy for almost four months. And prior to that had worked at another branch where he carried out similar dispensing tasks. The team agreed that the trainee should be registered on a recognised training course as soon as possible. Overall, team members were seen to support one another with their tasks. But while the team attended to the pharmacy's customers promptly, they were behind with the daily workload of prescriptions. And so the MCA DA doubled up her tasks by dispensing multi-compartment compliance packs while working on the counter. The MCA DA kept the packs at a far corner of the counter away from where she attended to people. She had put additional screens up around the compliance packs to help protect patient confidentiality. But she agreed with the inspector that this activity should be done in the dispensary. RPs were generally able to make day-to-day professional decisions in the interest of patients. Team members felt that they could discuss their concerns with the superintendent pharmacist (SP). They did not have formal appraisals or reviews about their work performance, but they felt that they were kept up to date and supported in their work by the RPs and the SP. They described how they could raise concerns and discuss issues with the SP. And had raised their concerns over staff shortages with him. Pharmacists could make their own professional decisions in the interest of people and were not under pressure to meet additional business or professional targets.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. And they are sufficiently clean and secure. The pharmacy has made some sensible adjustments to help keep people safe during the pandemic. But some areas of the pharmacy are cluttered. And its workspace does not fully benefit from the total space available

### Inspector's evidence

The pharmacy was on the corner of an intersection of two busy roads. It was on a small parade of local shops and businesses. And it was relatively spacious. It had seating for waiting customers. And it had a medicines counter which supported a transparent plastic screen on both sides to help reduce the spread of viral infections. It kept its pharmacy medicines behind the counter. The pharmacy had a spacious dispensary. The dispensary had dispensing benches on two sides which were used for most of the pharmacy's dispensing activities. And it had storage facilities above and below the benches. And on the remaining two walls. The accuracy checking bench faced the customer area so that team members could see people waiting. But the pharmacy's worksurfaces and floors were generally cluttered with stock and prescription baskets with incomplete prescriptions and paperwork. And packs of medicines on shelves were untidy and disorganised with many having fallen over on top of one another

The pharmacy had a spacious back-shop area which could be accessed through a door from the customer area or a door from the dispensary. This area housed the pharmacy's COVID-19 vaccination suite. The vaccination suite had two vaccination booths. And it had enough space for seats for people waiting and for those to sit and recover after they had been vaccinated. The vaccination suite was not currently in use due to lack of demand, but the team expected this to change in the next few months. The back-shop area also contained an office, storage areas, staff facilities and a consultation room. But the team often used the office for consultations, and it also used it for making up multicompartiment compliance packs. When the office was being used for dispensing, the RP used the consultation room for private consultations. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

## Principle 4 - Services Standards not all met

### Summary findings

The pharmacy is not thorough enough in ensuring that it keeps all its medicines for dispensing in the appropriate packaging. And it does not organise them well enough. It also does not do enough to ensure that all the medicines it supplies have the information that people need so they can take their medicines properly. In general, the pharmacy makes its services accessible for people. But it does not always ensure that it gives up-to-date information about its services. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing

### Inspector's evidence

The pharmacy had step free access. And its customer area was generally free of clutter and unnecessary obstacles. The pharmacy had a delivery service for people who found it difficult to visit the pharmacy. And it could also order people's repeat prescriptions for them if necessary. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. It provided medicines in multi-compartment compliance packs for people living at home who needed them. The pharmacy labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. While the pharmacy supplied patient information leaflets (PILs) with new medicines and with regular repeat medicines to give people information about their medicine, its labelling directions did not give the required advisory information to help people take their medicines properly. And so, someone taking soluble aspirin may not realise that they needed to dissolve the tablet in water before taking it unless they had read the leaflet or been advised appropriately. Also some labelling directions on compliance packs were unclear. Such as the direction to take 'daily' without stating how much of the medicine was to be taken. Another had directions to take '1 mane'. Rather than clearly stating 'one to be taken in the morning'.

The RP gave people advice on a range of matters. And he would give appropriate advice to anyone taking high-risk medicines. The RP had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP was aware of the precautions he would need to take, and counselling he should give, if it were to be prescribed for someone new.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines appropriately and in their original containers. But the inspector found a box of oxcarbazepine 15mg and a box of oxcarbazepine 600mg which contained mixed batches of different brands. This meant that the information on the outside of the packs did not accurately describe what they contained. And it increased the risk of mistakes. This could happen if some of the contents had been recalled. And expiry dates on individual strips could be missed during the usual checks. Some of the strips of tablets had also been part-dispensed with their expiry dates removed. The inspector discussed this with the RP. It was agreed that team members should review their understanding of the correct procedures to follow when dispensing a split-pack of medicines. And when putting medicines back into stock after dispensing.

Stock on the shelves was untidy and disorganised in several places. And while the team had previously carried out regular date checks they had not had the resources to do this in recent months. But the RP and MCA DA described how they usually checked expiry dates when they dispensed and accuracy checked every medicine. And a random sample of stock checked by the inspector was in date. In general, short-dated stock was identified and highlighted. And the team put its out-of-date and patient-returned medicines into dedicated waste containers. The team stored its CD and fridge items appropriately. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

### Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Although the team could not locate its tablet counting triangles at the time of inspection. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies. The pharmacy had two computer terminals in its dispensary. And it had a computer dedicated for use for the vaccination service in the consultation room. Computers were password protected. And prescriptions were stored in the dispensary out of people's view.

### 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.