General Pharmaceutical Council

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: 21/09/2023

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 for people who need it 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
1. Governance	Standards not all met	1.1	Standard not met	The pharmacy does not identify and manage the risks associated with all its services thoroughly enough.
		1.3	Standard not met	The pharmacy does not do enough to ensure that its team members understand and follow its standardised procedures properly.
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 not all met**

Summary findings

The pharmacy does not do enough to identify and manage the risks associated with all its services. It has written procedures in place to help ensure that its team members work safely. But it does not ensure that its team members understand and follow them properly. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information suitably.

Inspector's evidence

The pharmacy had a system for recording its 'near miss' mistakes and errors. But the team could not locate the records when the inspector first requested them. Once the records were found they showed that team members had not recorded any mistakes over the previous three months. A previous inspection last year identified that, at that time, the team had not recorded any in the previous four months. And so, it appeared that the pharmacy still did not always record them. The responsible pharmacist (RP) agreed that if the pharmacy were to keep the record book close to hand, team members would be more likely to use it each time they made a mistake. But she described how she generally highlighted and discussed 'near misses' and errors at the time with the team member involved. To help prevent them from making the same mistake in future. And she reviewed and discussed them again at weekly team meetings.

The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs) such as atorvastatin, atenolol and amlodipine. And in response to several near miss mistakes with LASAs it had separated several of these products including ramipril capsules and ramipril tablets, by putting different products in between them. It had done this to reduce the risk of selecting the wrong one. But the team recognised that preventing mistakes also required on going monitoring and intervention. And while it was clear that the team discussed what had gone wrong. And it acted in response to its mistakes, it did not record what its team members had learned or how they would improve. And they did not always identify the steps they could add to their own procedures to prevent future mistakes. The RP and inspector discussed this and agreed that it was important to ensure that all near miss mistakes should lead staff to reflect on their own dispensing procedures. And improve them. And that this would also help the RP to monitor their learning and improvement more effectively. And it would help support trainees to learn safer practice.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) for its team members to follow. And they had read them. And in general, they appeared to understand and follow them. Team members worked on their own tasks. And they assisted each other when necessary. The pharmacy offered a range of services under patient group direction (PGD). But it did not appear that a full and proper risk assessment had been carried out for all the services on offer. Including a thorough assessment of the resources required to deliver them safely and effectively alongside the pharmacy's other services. Such as having enough team members with the appropriate skills and knowledge to deliver them. This included the COVID-19 vaccination service. Team members were not clear on the vaccination protocol they were following or what their roles and responsibilities were within the protocol. The pharmacy could not explain who the clinical supervisor for the service was or which registered healthcare professional was responsible for the clinical assessment of each person. To ensure their suitability for the vaccination. The RP agreed that this should be discussed with the

superintendent pharmacist (SI). And that it required a thorough review.

The medicines counter assistant, who was also a trained dispensing assistant (DA) consulted the RP when she needed her advice and expertise. And she asked appropriate questions before handing people's prescription medicines to them. And when selling a pharmacy medicine. She did this to ensure that people got the right advice about their medicines. The RP had placed her RP notice on display where people could see it. The notice showed her name and registration number as required by law. People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy also had a complaints procedure to follow. And the team knew how to provide people with details of where they should register a complaint if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. The team worked closely with local surgeries to ensure that people did not go without essential medicines. And it arranged for alternatives when they received a prescription for an item that they could not get. It also tried to keep people's preferred brands of medicines in stock so that they did not have to wait while the team ordered them. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy generally kept its records in the way it was meant to, including its private prescription records. Its controlled drug (CD) registers were generally in order. But some registers were used to combine different brands or strengths of the same CD. Which meant that records could be confusing and could lead team members to make incorrect entries. The pharmacy kept a record of its CD running balances. And a random sample of stock checked during the inspection matched the total recorded in the register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. Its RP record was generally in order although it had some gaps where pharmacists had forgotten to log out at the end of their shift. Its emergency supply records were also in order, other than some entries which did not give a clear reason for the decision to supply the prescription only medicine (POM) without a prescription. The team recognised that the pharmacy should ensure that all 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 they had completed suitable training. They discarded confidential paper waste into separate waste containers as they worked. And they discarded the contents of the containers into confidential waste bags each day. The pharmacy's confidential waste was discarded into separate waste containers. And team members shredded it regularly. And they kept people's personal information, including their prescription details, out of public view. Most team members had completed appropriate safeguarding training. And they knew to report any concerns to the pharmacist. But the trainee pharmacist had not yet completed the training even although he was delivering the COVID-19 vaccination service. He was also due to start delivering seasonal flu vaccinations. The team could access details for the relevant safeguarding authorities online. But it had not had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

In general, the pharmacy adequately trains its team members for the tasks they carry out. The pharmacy team generally manages its workload safely and effectively. And team members adequately support one another. In general, they are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's service. But it does not do enough to ensure that all its team members follow the appropriate procedures to necessary for the safe and effective delivery of services.

Inspector's evidence

The responsible pharmacist (RP) had been in her role for approximately one year. On the day of the inspection the rest of the team consisted of the trainee pharmacist of two months, the MCA DA and the trainee DA who not yet started any formal training. The trainee had worked at the pharmacy for almost 18 months. And prior to that had worked at another branch where he carried out similar dispensing tasks. The SI had previously agreed that the trainee should be registered on a recognised training course. And so, he was working towards this by supporting the trainee with his pre-course entry qualifications. In the meantime, while the trainee still needed to complete recognised DA training, he had read the SOPs relevant to his role and his experience as a DA reduced the level of risk posed by the lack of formal training to some extent. But the trainee was aware that he must begin his training as soon as possible.

Overall, team members, attended to their allocated tasks. But it appeared that they were not all aware of their shared responsibility to support each other in keeping the pharmacy, clean, tidy and organised. In general, the team attended to the pharmacy’s customers promptly. And it was up to date with the daily workload of prescriptions. Team members felt that they could discuss their concerns with the RP and the SI. They had team meetings every week. And regular one-to-ones with the RP where they could discuss their concerns and their work performance. The trainee pharmacist did not currently work regularly with his tutor, but this had been discussed with the General Pharmaceutical Council (GPhC) and the situation was shortly due to change. This was necessary to ensure that the trainee was provided with good quality training. And to comply with GPhC requirements. Team members felt that they were kept up to date and supported in their work. They described how they could raise concerns and discuss issues with the SI. And previously they had raised their concerns over staff shortages with him which had since been addressed. In general, pharmacists could make their own professional decisions in the interest of people and were not under pressure to meet additional business or professional targets. But it appeared that when introducing new pharmacy services, the SI could involve the regular RP further. The SI could do this to provide further support to the regular RP to ensure that she is able to oversee the safe and effective delivery of all services. And exercise her full responsibilities as RP.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. They are bright and well lit. And they are generally tidy, and organised. They are also mostly clean and secure. But some areas of the pharmacy are untidy.

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. The pharmacy kept its pharmacy medicines behind the counter. And it 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. The pharmacy's worksurfaces and floors were generally tidy. But packs of medicines on shelves were untidy and disorganised in places with many having fallen over on top of one another. This resulted in different strengths of medication, and different types of medication being mixed up on some shelves.

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 enough space for seats for people waiting and for those to sit and recover after they had been vaccinated. The vaccination suite consisted of a vaccination room and two vaccination booths. But the booths were not currently needed. And so, were not in use. 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 multicompartment 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 met

Summary findings

The pharmacy makes its services accessible for people. The pharmacy gets its medicines and medical devices from appropriate sources. And it generally stores its medicines properly. It makes the necessary checks to ensure that the pharmacy's medicines and devices are safe to use. And to protect people's health and wellbeing. But it does not do enough to ensure that it gives people all the information they need to help them take their medicines properly. And it does not fully comply with proper procedures for all of its services.

Inspector's evidence

The pharmacy had step-free access. And its customer area was generally free of clutter and unnecessary obstacles. It 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. And to prevent error. The pharmacy dispensed multi-compartment compliance packs for people living at home who needed them. It ordered their prescriptions every four weeks and checked them against people's patient medication records (PMR) for any changes, mistakes or missing items. It did this so that it could sort out any issues with the surgery in time for people's next delivery of their medicines. The pharmacy labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And it supplied patient information leaflets (PILs) with new medicines and at the beginning of the cycle. This was to provide people with additional information about their medicines. But it did not add the advisory warnings and information as required by the British National Formulary (BNF) which is required to help people take their medicines properly. The inspector also found one pack which had been labelled with a prescription abbreviation rather than clear directions on how the medicine should be taken.

The pharmacy provided a COVID-19 vaccination service. But when asked which protocol it was following, team members were unsure. The pharmacy had two different protocols in place and neither had been appropriately signed by team members. This risked the service being delivered without all the appropriate, steps and checks. And without team members being aware of their responsibilities for its safe delivery. The RP agreed that she would discuss this with the SI and ensure that the team were complying with the correct protocol. The RP gave people advice on a range of matters. And she would give appropriate advice to anyone taking high-risk medicines. 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 she would need to take, and counselling she should give, if it were to be prescribed for someone new. And team members were aware of the need to supply the appropriate warning leaflets and cards each time. The pharmacy provided a travel vaccination service. And it offered vaccinations for protection against Hepatitis A and B, Japanese Encephalitis, Yellow Fever and Typhoid. It also offered vaccinations for protection against Meningitis (ACWY), Measles, Mumps and Rubella (MMR), shingles and chickenpox. And it provided tests for tick-borne blood disease. It provided these services under individual patient group direction (PGD). The PGDs in use were up to date. And the RP understood that only pharmacists named in the PGDs could provide the service. The pharmacy kept appropriate records of each consultation. Records showed details of the vaccines administered, including their batch numbers and expiry dates.

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 packs of medicines which had been put away untidily. This had resulted in packs of different medicines falling on top of each other. And packs of different strengths of the same medicine becoming mixed in together. This increased the risk of mistakes. The inspector discussed this with the team. It was agreed that team members should review their understanding of the correct procedures to follow when putting stock away. And when putting medicines back into stock after dispensing.

The pharmacy checked the expiry dates of its medicines and devices every three months. And during the inspection, a random stock check found medicines to be in date. But the pharmacy did not keep records to show what had been checked, when they had been checked and who had checked them. This posed a risk that some areas of stock could be missed and other areas checked more often. The pharmacy team members explained that they highlighted any short- dated stock so that it could be easily identified during the dispensing process. And they ensured that they conducted an expiry date check on all items as they dispensed them. But team members agreed that they should keep records to ensure that their date checking processes were robust. The team put its out-of-date and patient-returned medicines into dedicated waste containers.

The team generally stored its CD items appropriately. And it had a fridge for storing its fridge items. But team members had not been reading and recording the pharmacy's fridge temperatures properly. And so, the records it kept were not complete or accurate. The inspector discussed this with the RP who agreed that all dispensing team members should be re-trained on how to read the maximum and minimum temperatures on each fridge thermometer. And on how to reset it every time a reading is taken. The team understood that keeping accurate records of fridge temperatures would ensure that they could monitor fridge temperatures properly and provide assurance that the medicines within it were being stored appropriately. The pharmacy responded promptly to drug recalls and safety alerts. And it kept records of these. 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. It used suitably calibrated and clean conical measures during the dispensing process. And it had separate conical measures and tablet counting triangles for higher risk medicines. This was to prevent cross contamination. Team members had access to a range of up-to-date reference sources. Including online versions of the BNF and the electronic medicines compendium (emc). The pharmacy had enough computer terminals in its dispensary. And it had a dedicated computer for managing the COVID-19 vaccination service in the vaccination room. Its computers were password protected. And out of people's view. Team members had their own smart cards to access patient medication records. And they understood that they should use their own smart cards to ensure that they had the appropriate level of access to patient records for their job roles. And to ensure an accurate audit trail. Team members used cordless phones to help them have private conversations with people if needed. And they stored dispensed prescriptions out of people's view. The team were aware of what would be classed as confidential waste. And it had a shredder which it used to dispose of it appropriately.

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.