General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ham Parade Pharmacy, 305 Richmond Road, KINGSTON UPON THAMES, Surrey, KT2 5QU

Pharmacy reference: 1036645

Type of pharmacy: Community

Date of inspection: 02/03/2023

Pharmacy context

This is an independent community pharmacy. It is on a parade of local shops and businesses in Kingston-upon-Thames. It provides a range of services including dispensing prescriptions. And it has a selection of over-the counter medicines and other pharmacy related products for sale. It dispenses medicines into multi-compartment compliance packs for people who have difficulty managing their medicines. And it offers a travel vaccination service and a blood pressure monitoring service. It also delivers medicines to a small number of people who are not able enough to collect them from the pharmacy.

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 has suitable written procedures in place to help ensure that its team members work safely. And the team understands and generally follows them. 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 properly. The pharmacy adequately identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The pharmacy had a system for recording its mistakes. The regular responsible pharmacist (RP) was also the owner. And he worked at the pharmacy full time. But the RP on the day of the inspection was a locum who worked at the pharmacy approximately once a month. The team described how pharmacists highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistake from happening again. And in response to a near miss mistake, the team had been made aware of the risk of confusion between look-alike sound-alike medicines (LASAs). And it had identified the possibility that a mistake could occur between them. These included medicines such as such as paroxetine 10mg and pravastatin 10mg, and amlodipine 5mg and amiloride 5mg. Team members now took extra time and care to carry out a thorough name check when dispensing LASAs, reminding each other that they had dispensed one. And to ensure that the pharmacist was also aware of them when conducting a final accuracy check. This approach had reduced the occurrence of mistakes. But while the team recorded its mistakes, it did not fully record what it had learned or what it would do differently next time. Team members agreed that if they had more details of what they had learned from their mistakes they could review them and monitor improvement more effectively. And it would provide the team with a better opportunity to prevent mistakes and continue to learn.

The pharmacy had put measures in place to keep people safe from the transfer of infections. It had a regular cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. It had hand sanitiser for team members and other people to use. And it had put screens up at its medicines counter. The pharmacy had a set of up-to-date standard operating procedures (SOPs) to follow. Staff understood their roles and responsibilities. The medicines counter assistant (MCA) was a family member who was new to the role. He had started his training and he supported the team to manage the shop floor. He consulted the pharmacist and his other colleagues when he needed their advice and expertise. And he described how he always consulted the pharmacist before selling a pharmacy medicine to someone. He also described the questions he asked people so that he could give appropriate information to the pharmacist about their symptoms and any other medicines they were taking. He did this to help the pharmacist decide on the most appropriate course of action for them. The RP had placed his RP notice on display where people could see it. The notice showed his name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services directly to the pharmacy's team members. They could also give feedback directly to the RP owner. A lot of the pharmacy's customers had been regulars for many years. And so, when people expected their medicines to be ready after being advised by the surgery that they would be, the team explained the prescription process to them. It advised people to allow enough time between ordering their prescriptions and collecting their

medicines. It did this to explain that it took time for the pharmacy to be able to access people's prescriptions. And to sort out any problems and get their medicines ready safely. Other people had been concerned when the pharmacy did not have their medicines in stock. Or when there were manufacturers' delays. Again, the team took time to explain the situation to people. But to prevent them from going without their medicines, as soon as the team received a prescription for an item with a supply problem, team members contacted the appropriate GP surgery to suggest alternatives. The pharmacy also tried to keep people's preferred make of medicine in stock so that they were always available for them. The pharmacy had a complaints procedure in place. And team members could provide people with details of where they should register a complaint if they needed to. But the owner generally dealt with people's concerns at the time. 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 controlled drugs (CD) register and its RP records. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. And this was complete and up to date. The pharmacy also kept records of its private prescriptions. And records of its emergency supplies. But its private prescription records did not show the prescribers details. And the emergency supply records did not all give a clear reason for the decision to supply. The pharmacy team agreed that all the pharmacy's essential records should have all the necessary details as well as being up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They shredded confidential paper waste immediately. And they generally kept people's personal information, including their prescription details, out of public view. Some team members had completed appropriate safeguarding training and others had been briefed. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. It had not yet had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has an appropriate range of skills and experience to support its services. And it manages its workload safely and effectively. Its team members support one another well. And they keep their knowledge up to date. Team members receive sufficient feedback to help them carry out their tasks satisfactorily.

Inspector's evidence

The inspector conducted the inspection during the pharmacy’s usual trading hours. The RP was on duty along with a dispensing assistant (DA) and the trainee MCA. The DA had qualified as a pharmacist overseas but had completed her NVQ2 DA training in the UK. The team kept the daily workload of prescriptions in hand. And team members worked closely with one another. They assisted each other when required and discussed issues. And they supported one another to complete their tasks. The trainee MCA sought the help of more skilled and experienced team members when he needed it. And he dealt with customers promptly.

The pharmacy had a small close-knit team who worked regularly together and could raise concerns and discuss issues when they arose. The RP owner kept team members up to date by providing information about new services and new medicines. And they also kept their knowledge up to date by reading medicines information and training material when they could. Team members did not have formal reviews about their work performance but discussed issues as they worked. And they requested a one-to-one with the owner RP if they had anything specific to discuss. The RP could make day-to-day professional decisions in the interest of patients.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a suitable environment for people to receive its services. And they provide enough space for those services. The pharmacy is sufficiently clean and secure. The pharmacy is generally organised. But it is not tidy enough in some areas.

Inspector's evidence

The pharmacy was clean and adequately maintained. And it had a bright, modern appearance. The team had a regular cleaning routine. And it cleaned the pharmacy’s worksurfaces, floors and touch points regularly. The pharmacy had a long shop floor. And down its centre, it had a gondola for displaying products for sale. The pharmacy’s counter had a curved shape. And it was divided in two by an opening into the dispensary. This created a small medicines counter on one side and a small dispensary counter on the other. The medicines counter had a half height backwall behind it for displaying over-the-counter medicines. And screens along the countertop helped to prevent the spread of infections. The dispensary counter area on the other side, had a higher-height display unit next to the dispensary opening. And a small open hatch area. Due to curved shape of the counter, the open hatch area faced away from the medicines counter and shop floor. And so, it provided a more private area for the pharmacist to hand out prescriptions and counsel people if required. The pharmacy had a consultation room. And a small waiting area. These were located near to dispensary counter. And so, together they created a professional consultation area away from the main retail space. The pharmacy’s consultation room was clean, tidy and organised. And as well as having an entrance from the shop floor, it also had an access door from the dispensary for the pharmacist.

The dispensary had workbenches along two sides with storage areas above and below. And it also had pull-out drawers for storing medicines. Completed prescriptions ready for collection were stored in the dispensary out of people’s view. But the dispensary floor was cluttered with tote boxes, stock, delivery items and waste bins. And when the team was at its busiest, work surfaces did not have much free space. The inspector and team members agreed that it was important to maintain a tidy and organised dispensing environment to reduce the risk of error. And to maintain efficiency. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines. The pharmacy had a staff area and additional storage to the rear.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. And it ensures that it supplies its medicines with the information that people need to take their medicines properly. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. But it does not ensure that all the medicines on its shelves are packaged and labelled correctly.

Inspector's evidence

The pharmacy had step-free access. And its customer area was generally free of unnecessary obstacles. And it had a delivery service. The service was limited to people who had no other way of getting their medicines. The pharmacy could also order people's repeat prescriptions if required. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. And it updated people's records. The team labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And its labelling directions gave the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. So that people could find the information they needed if they wanted to. But while team members placed its labels and prescriptions in a basket next to the compliance packs, they did not always label them before the final accuracy check, and some unchecked packs had not been sealed. Team members agreed that this increased the risk of the contents becoming dislodged. And they agreed that a final check taking place before the dispensing process was complete increased the risk of error. The pharmacist gave people advice on a range of matters. And he would give appropriate advice to anyone taking higher-risk medicines. The pharmacy 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 described how he would counsel at-risk people when supplying the medicine to ensure that they were on a pregnancy prevention programme. The pharmacy also knew to supply the appropriate patient cards and information leaflets each time. The regular RP also provided an ear wax removal service and a travel vaccination service. He had certificates to show that he had completed the appropriate training by a suitable training provider. And he provided these services under the appropriate, protocols.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. It generally stored its medicines appropriately and in their original containers. But the inspector found packs of medicines with two distinct brands of the medicine inside. And some of the strips had different expiry dates, or no expiry date at all where they had been cut from the original strip. And so, the additional strips could be missed during expiry date checks. And those added from a different brand could be missed if they were part of a medicines recall. In addition, a brown dispensing bottle containing loose tablets had been labelled to contain 'Mirtazepine 30mg'. The label also showed

a date. But it was not clear if this was an expiry date. And it was later discovered that the date referred to the date on which the medicine had been placed in the bottle. The label contained no other information about the contents. And so, it did not give a clear and appropriate description of the contents. The inspector discussed this with the team, and they agreed that team members should review their understanding of the correct procedures to follow when putting medicines back into stock after dispensing.

The pharmacy stored its medicines stock in a tidy and organised manner. It date-checked its stock regularly. And it kept records to show what had been checked and when. The team identified and highlighted any short-dated items. And it removed them from stock. It only dispensed them with the patient’s agreement where they could use them before the expiry date. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. But it did not always reset the thermometer after checking the temperatures and so it could not be sure at which date the maximum temperature had been reached and for how long. 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 services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's confidential information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. And they had access to personal protective equipment (PPE), in the form of sanitiser, face masks and gloves. The pharmacy had two computer terminals which it had placed at a workstation in the dispensary and in the consultation room. Computers were password protected. But due to the pharmacy having only one computer in the dispensary, team members all used the RP’s smart card. This meant that access to patient records were not accurately audited. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions 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.