General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Marcus Jones Pharmacy, 96 Old Oak Common Lane, East Acton, LONDON, W3 7DA

Pharmacy reference: 1041400

Type of pharmacy: Community

Date of inspection: 03/08/2022

Pharmacy context

This is a community pharmacy in the centre of East Acton. 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 and a COVID-19 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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not provide enough direction to all its team members to ensure they are adequately trained. And it does not properly clarify their roles and responsibilities to them.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not do enough to ensure the medicines it stores and supplies are packaged with all the necessary information.
5. Equipment and facilities	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 regular medicines counter assistant (MCA) who was also a trainee dispensing assistant (DA) explained that the pharmacy had been short staffed for several months. And that the regular, long-term pharmacist had left over a month previously. 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 for almost six 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 help reduce 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. And in general staff had read and signed those relevant to their roles. The trainee pharmacist had started approximately two weeks previously and had yet to read the SOPs. The regular MCA who was also a trainee DA understood her role and responsibilities. And she consulted the RP when she needed her advice and expertise. The RP had placed her RP notice on display showing her name and registration number as required by law. The inspector and RP discussed the purpose of the RP notice and the importance of ensuring that the notice was correct and 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 had a notice on the wall near the counter with details of how people could raise a concern. And team members could provide people with details of where people should register a complaint if they needed to. 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 in place until 11 April 2023. This was to provide insurance protection for the pharmacy's services and its customers. 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 its controlled drug (CD)

registers, Its RP record, its private prescription records and its records of emergency supplies. But team members could not locate a record for patient returned CDs or a record of their destruction. The team agreed 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. And it does not make its team members completely clear on their roles and responsibilities. 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 once before recently. The regular RP had left a month previously. 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 a recently recruited trainee , the trainee DA MCA. And a trainee MCA who not yet started any formal dispensing assistant training. But she had been registered on the course and was due to start it soon. The pharmacy team also had a vaccinator who was present at the pharmacy at the beginning of the inspection. The vaccinator was a USA trained nurse. Who had begun a dispensing assistant's course. The RP was unaware that as RP she was the clinical lead for the vaccination service as this had not been explained to her. The vaccination service was still operational but only one or two people were currently being vaccinated each day. 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. Team members undertook other essential training such as GDPR and Health and Safety.

The RPs could 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 they had raised their concerns over staff shortages with her. 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 adequately 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 untidy. 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 screen to help reduce the risk the spreading of viral infections. It kept its pharmacy medicines behind the counter. The pharmacy had a compact dispensary. The dispensary had dispensing benches on all sides which were used for most of the pharmacy's dispensing activities. And it had storage facilities above and below the benches. 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.

The team had not been able to follow its usual cleaning routine in recent weeks due to staff shortages. And some of its dispensary work surfaces weren't as clean as they should be. But the team described how it tried to clean its most commonly used surfaces every other day. It also had hand sanitiser for team members and people to use at the counter and in the dispensary. The pharmacy had a consultation room. And it had a separate curtained off cubicle which it used for its COVID-19 vaccination service. Both the consultation room and the Vaccination cubicle had access from the customer area. The Vaccination cubicle was dark and untidy. And it had an open sharps bin placed on a desk with used sharps inside. The cubicle also contained people's private information. Due to the current reduced demand for COVID-19 vaccinations the cubicle was not used all the time. And while it is unlikely that members of the public would enter the cubicle unattended or unnoticed. The team agreed that security of the room and its contents should be reviewed. The consultation room was bright and tidy. The RP used the consultation room for private consultations. The pharmacy had a back-shop area which contained a stock room and staff area 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 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. 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. But on one of the packs examined the description did not match the medicine inside. Staff explained that this was due to a change in the brand used. The team agreed that the description of the medicines should be accurate as an inaccurate description could be confusing for people. And it could reduce their confidence in what they had been supplied. While the pharmacy supplied patient information leaflets (PILs) with new medicines it did not supply them with regular repeat medicines. And so people may not have all the necessary information about their medicines to help them to take their medicines properly.

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 additional leaflets for 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 she would need to take, and counselling she should give, if it were to be prescribed for someone.

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 several packs of medicines which contained mixed batches of different brands of the same medicine. These included hydroxychloroquine 200mg, perindopril 2mg and paroxetine 20mg. 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. And a

random sample of stock checked by the inspector was out of date. But its expiry date had been highlighted. In general, short-dated stock was identified and highlighted. And the RP and trainee DA MCA described how they usually checked expiry dates when they dispensed, and accuracy checked every medicine. 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 services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information s

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 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 vaccination cubicle. Computers were password protected. And prescriptions were stored in the dispensary out of people’s view. Staff used their own smart cards. They did this to ensure that team members had the appropriate level of access to patient records. And to ensure that it had an appropriate audit trail around access to records.

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.