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: 11/08/2023

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 met**

Required Action: None

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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 follows them. The pharmacy has insurance to cover its services. And it generally 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 owner had recently closed one of its other branches close by. And so, people who had used the other pharmacy had transferred over. This had increased the pharmacy's workload. But with the additional assistance of the superintendent (SP) and others, the team had organised its systems and processes to ensure that people were not adversely affected by the pharmacies merging their services. The pharmacy had reorganised its stock to make room for some additional stock. And it had merged the other pharmacy's patient medication records (PMR) with its own. The pharmacy had a system in place for recording its mistakes. The responsible pharmacist (RP) described how he highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. He did this to help prevent the same mistake from happening again. He also encouraged trainee dispensing assistants (DAs) to investigate their own mistakes. So, they could develop an awareness of what things could go wrong. And avoid them. The team had been made aware of the risk of confusion between look-alike sound-alike medicines (LASAs). And it recognised that mistakes could occur between them. These included medicines such as such as lisinopril and linagliptin. The team was aware that when they were dispensing a LASA it should prompt an additional check of the item they were selecting. But while the team usually recorded its mistakes, and discussed them, the RP could not find the pharmacy's near miss records for the previous two months. And the records seen did not show what team members had learned or what they would do differently next time. So that they could prevent the same or a similar mistake. The RP did not have a formal review process. But he reviewed the records periodically. He agreed that if the team had more details of what it had learned from its mistakes, along with more frequent reviews, he could monitor them more effectively. He agreed that this would provide team members with a better opportunity to learn. And it would allow them to identify steps in their dispensing procedures which would help avoid mistakes in future. And any other follow up actions which would lead to ongoing improvement.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) for its team members to follow. Team members had all read the SOPs. And they understood their roles and responsibilities. The trainee medicines counter assistant (MCA) had been trained on the procedures to follow when selling pharmacy medicines and general items. And when handing out people's prescriptions. She consulted the pharmacist and her other colleagues regularly when she needed their advice and expertise. And she asked people appropriate questions about their symptoms and any other medicines they were taking. She did this to ensure that the medicines she sold to people were right for them. And when appropriate, to help the pharmacist decide on the best course of action for them. A trainee DA consulted the RP when he needed his advice and expertise. And he accessed, used and updated the pharmacy's electronic records competently. The RP had placed his RP notice on display showing his

name and registration number as required by law.

The pharmacy had a notice on display explaining how people could raise a concern with the team. Or provide feedback. And people gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy 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 RP commented that, at times, people were unhappy that their prescription had not arrived or that their medicines were not ready or available. These issues were often out of the pharmacy's control, as the problem often arose with medicines which were unavailable from the manufacturer. But, to help the situation, the team chased prescriptions up when they could. And they also called the surgery to arrange for alternatives when they received a prescription for an item that they could not get. But workload pressures meant that they did not always have time to do this. And so, they often returned people's prescriptions to them so that they could be supplied from another pharmacy which had the stock. Or so that people could go back to their GP themselves for an alternative. The trainee MCA was observed handling people's queries well. And her colleagues stepped in unprompted to support her when needed. 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 RP record and its private prescription records. It had a controlled drug (CD) destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. This was complete and up to date. The pharmacy kept its controlled drugs (CD) register properly. And a record of its CD running balances. CDs transferred from the other pharmacy had been appropriately recorded as received into stock. And a random sample of CD stock checked by the inspector matched the running balance total in the CD register. But the RP recognised that its processes for audit required review. The pharmacy's records for emergency supply were generally in order. But they did not all give a clear reason for making the supply. After discussing record keeping with the RP, it was clear that he understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They shredded confidential paper waste in batches throughout the day, as they worked. And the team kept people's personal information, including their prescription details, out of public view. The RP had completed appropriate training on safeguarding vulnerable adults and children. And team members had been briefed. And they knew to report any concerns to the pharmacist. 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

The pharmacy has enough suitably trained and skilled team members for the tasks it carries out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's service.

Inspector's evidence

On the day of the inspection the RP worked with two trainee dispensing assistants (DA)s, and the trainee MCA. One of the trainee DAs had just begun his training and the other had almost completed his. The pharmacy also had a delivery driver which it shared with another pharmacy owned by the same company. Despite the additional workload gained from the pharmacy it had merged with, the team was efficient and calm. It had the daily workload of prescriptions in hand. And team members attended promptly to people at the counter. They appeared to work closely with one another. And they supported one another, assisting each other when required. The team tried hard to keep on top of its other tasks. But the merging of the two pharmacies had happened less than two weeks ago. And so, the team was in the process of adjusting to its new workload. And its new patients. The RP and trainee DAs assisted the trainee MCA when needed. Without being asked. And together they dealt with queries promptly.

Team members did not have formal meetings or appraisals about their work performance. But they had discussions with the RP as they worked. And if necessary, they could have a one-to-one with him or the SP to raise concerns or receive feedback. The RP felt he could make day-to-day professional decisions in the interest of patients. And he could discuss his concerns with the SP if he needed to. Team members felt supported in their work. And the RP was not under pressure to meet business or professional targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises generally provide a suitable environment for people to receive its services. And they are adequately clean and secure. But the pharmacy has some areas which are tired and dated. And it does not do enough to ensure that the areas it uses for private conversations are appropriate. The pharmacy's 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. 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. And the pharmacy's worksurfaces and floors were generally free of unnecessary clutter. But some areas of the pharmacy looked tired and dated. Its facia and some internal walls, fixtures and fittings looked in need of a refresh.

The team had a regular cleaning routine. It cleaned its work surfaces and contact points daily. And it cleaned its floors weekly. The team also had hand sanitiser for team members and people to use. The pharmacy had two consultation rooms. One of the rooms was a cubicle with a curtain. The curtain separated the cubicle from the retail space directly in front of the counter where people stood. Team members pulled the curtain across when the room was in use. But the curtain would not have provided enough of a sound barrier to prevent customers overhearing conversations inside the cubicle. The pharmacy had installed the cubicle for its COVID-19 vaccination service. But it now used it as a consultation room. The second room was originally the consultation room. But its sliding door was broken. And it was used for storing stock. Both rooms had access from the customer area. The cubicle was dark and untidy. And it had a file which contained people's private information. And while it is unlikely that members of the public would enter either of the rooms unattended or unnoticed. The RP agreed that security of the rooms and their contents should be reviewed. 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 met

Summary findings

The pharmacy generally 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, in general, team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy generally stores its medicines correctly, but it does not do enough to ensure that it stores all its medicines in the appropriate environment.

Inspector's evidence

The pharmacy had information on its windows promoting its services. And it had a doorway which provided step-free entry. Its customer area was free of unnecessary obstacles, making it suitable for people with mobility issues. The team could also order people's repeat prescriptions if required. And it had a delivery service. It prioritised the service for people who had no other way of getting their medicines. And it 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. And it labelled the packs with the required advisory information to help people take their medicines properly. It supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. But it did not label its compliance packs with a description of each medicine, including colour and shape, to help people, including other healthcare professionals, to identify them. The team agreed with the inspector that it was important to ensure that people had all the information they needed about their medicines. 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 pharmacy offered a hypertension case finding service. The RP had referred several people to their GPs following a high blood pressure reading. The pharmacy also offered a microsuction ear wax removal service. And it had a fully trained member of the team who provided the service. She provided the service with the oversight of the RP. She had attended an intensive face-to-face training session, provided by an established training provider. And she kept records of each consultation. People identified as not suitable for the process had been referred to another healthcare professional where appropriate.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And it generally stored its medicines appropriately. Stock on the shelves and in drawers was tidy and organised. The pharmacy checked the expiry dates on all stock items every 12 weeks. And it kept records. The team identified and highlighted any short-dated items. And it removed any items with a less than a three-to-four-month expiry date from stock. It only dispensed them with the patient's

agreement where they could use them before their expiry dates. 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 items appropriately. And it stored its fridge items in two separate fridges. One of the fridges was not as clean as it could be. And it did not have a thermometer for staff to monitor the temperature. The other fridge did have a thermometer. But the team did not appear to know how to read or reset it. Instead, team members judged the temperatures by assessing how cold the fridges were when they opened them. So, the single set of temperatures recorded did not reflect the temperatures at which any of the medicines had been stored. The RP and the inspector agreed that the team must monitor fridge temperatures properly to ensure that the medication inside it was kept within the correct temperature range. The RP agreed that he would purchase two new thermometers and train himself and his team how to read them. He would also train them on what action to take if the temperature readings fell out of the required range. 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 generally 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. The pharmacy had two PMR computer terminals in the dispensary. And two non-PMR computers in the consultation rooms. It used these for its non-prescription services. Computers were password protected. Team members had their own smart cards. But occasionally they shared each other's. The inspector and team members discussed the importance of using their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in shelves which were 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.