General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jade Pharmacy (Southall), 3 Crosslands Parade, Crosslands Avenue, SOUTHALL, Middlesex, UB2 5RB

Pharmacy reference: 1076833

Type of pharmacy: Community

Date of inspection: 04/12/2019

Pharmacy context

An independent community pharmacy. One of fifteen belonging to the same company. The pharmacy is on a small parade of locally run shops and businesses, in a residential area of Southall. As well as NHS Essential Services, the pharmacy provides Medicines Use Reviews (MURs), New Medicines Service (NMS) and a delivery service for urgent prescriptions and the housebound. The pharmacy also provides medicines in multicompartment compliance packs for many people in the community. It also provides a substance misuse prescription service and a stop smoking 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

In general, the pharmacy's working practices are safe and effective. Its team members listen to people's concerns and try to keep people's information safe. They discuss any mistakes they make and share information to help reduce the chance of making mistakes in future. But team members do not do enough in the way that they gather information and use it to learn and improve.

Inspector's evidence

Staff worked in accordance with an up-to-date set of standard operating procedures (SOPs), under the supervision of the responsible pharmacist (RP). The RP notice was displayed for the public to see. Regular staff had read the SOPs relevant to their roles, and although the pre-registration pharmacist (pre-reg) had read them he had yet to sign them. The pharmacy had a procedure for managing risks in the dispensing process. According to procedure, all incidents, including near misses were to be recorded and discussed, so that the team could avoid repeating the same mistakes. But records did not provide details of what had led to the mistake or what would be done differently in future. So, it may be difficult for the pharmacists and staff to conduct a thorough review of their mistakes so that they could continue to learn from them. This could be particularly relevant for staff in training such as the pre-reg. The pharmacist used the quality payments recording system to describe what the team had learnt from their mistakes. This included the action to separate stock and not to rush, but this had been repeated on several occasions suggesting that a new or different approach may be helpful.

However, it was clear that the team discussed any incidents and were aware of the risk of error. The pharmacist described how she would discuss the team's mistakes with them. This was generally done at the time and again during formal team meetings if necessary. This was a small close-knit team and incidents, or any other issues were generally discussed as part of the day to day business, in order to find ways of avoiding mistakes in future. The pharmacist showed how they had separated ramipril tablets from capsules by placing them on a separate shelf. The team felt that this had helped prevent them from selecting the wrong one.

The pharmacy team had a positive approach to customer feedback. The most recent survey had produced a 100% customer satisfaction rating. The pre-reg described how they ordered the same brands of medicines for certain people to help them to take their medicines properly. Customer preferences included the Bristol brand of ramipril 1.25mg and 5mg capsules, and the Teva brand of omeprazole 20mg capsules, amongst others. All preferred brands had been stored separately to make sure they were kept for the people who needed them.

The pharmacy had a documented complaints procedure. A documented SOP for the full procedure was available for reference. Customer concerns were generally dealt with at the time by the RP where possible and the superintendent informed. Staff said that complaints were rare but if they were to get a formal complaint it would be recorded. Details of the local NHS complaints advocacy and PALs were available on a notice on the wall. The most common source of concern from customers recently had been medicines shortages. The dispenser described how they liaised with surgeries to try to find alternatives for people after checking what was available from their wholesalers. The pharmacy had managed to source hormone replacement therapy (HRT) products which people had been unable to obtain elsewhere. The pharmacy had professional indemnity and public liability arrangements so, they

could provide insurance protection for staff and customers. Insurance arrangements were in place until 07 Nov 2020 when they would be renewed for the following year.

All the necessary records were kept and were generally in order including CD registers and records for unlicensed 'specials', the RP, private prescriptions and emergency supplies. Records of CDs which had been returned by patients, for destruction, were kept for audit trail and to account for all the non-stock Controlled Drugs (CDs) which pharmacists had under their control.

Staff were aware of the need to protect confidentiality and had signed a confidentiality agreement as part of their contracts. And had been briefed on their responsibilities regarding GDPR. Discarded patient labels and prescription tokens were shredded daily. Completed prescriptions were stored in the dispensary in a way that patient details couldn't be viewed from the counter and customer areas. But, if customers were to lean over the gate opposite the prescription storage area they could view people's prescription bags with their names and addresses. The pharmacist on duty had completed level 2 CPPE training for safeguarding children and vulnerable adults. Support staff had been briefed on their responsibilities. The pharmacy team had not had any specific safeguarding concerns to report. Contact details for the relevant safeguarding authorities were available online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload safely and effectively and team members work well together. They are comfortable about providing feedback to one another which helps the pharmacy maintain the quality of its services.

Inspector's evidence

Services were generally provided by the regular RP. And every alternate Saturday morning was covered by a regular locum. Pharmacists were supported by a pre-reg, a dispenser and a medicines counter assistant (MCA). On the day of the inspection the RP was supported by the MCA and the pre-reg. The dispenser began his shift part way through the inspection. There appeared to be an adequate number of appropriately skilled staff. Staff were up to date with the daily workload of prescriptions, and customers were attended to promptly. Staff were observed to work well together, each attending to their own tasks and assisting one another when required. Although the team were half a day behind with prescriptions, they said they generally managed to get caught up by the end of the day.

The MCA had completed healthy living pharmacy training in preparation for the pharmacy achieving 'Healthy Living Pharmacy' (HLP) status. She did not undertake any formal on-going training but was seen to consult the pharmacist and the pre-reg on a regular basis.

The dispenser had worked at the pharmacy for over seven years. He said that the pharmacy team had regular meetings in which he and his colleagues could raise concerns and make suggestions about how to improve the quality of services. He also had regular informal discussions with pharmacists on a day to day basis. He described how he had suggested that all deliveries go to back door rather than being left on the shop floor, which he felt looked cluttered and un-professional. During the inspection all deliveries arrived at the back door. The pharmacist was not set targets for services such as MURs and was able to make autonomous professional decisions. She felt that she could prioritise her tasks in accordance with the needs of the business and its customers.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a safe, secure environment for people to receive healthcare services. But the pharmacy's storage arrangements meant that it did not look as tidy and organised as it could. And the team did not use the pharmacy's storage facilities effectively enough when trying to keep people's private information safe.

Inspector's evidence

The pharmacy was on a small parade of shops in a residential area of Southall. The pharmacy's premises had a traditional appearance. They had full height windows to the front, and a glass door, which provided natural light. The shop floor was to the front with the dispensary in the corner. The counter was on a side wall alongside the dispensary. The shop floor was small but generally kept clear of obstructions and there were two seats for waiting customers. Items stocked included a range of baby care, healthcare, beauty and personal care items. But the pharmacy was not as tidy as it could be. A lack of storage space meant that stock items for sale were kept in the cardboard boxes in which they had been delivered, until they could be put away. And were kept either on the shop floor or behind the counter. Other stock and prescription bags were also on the floor behind the counter. Shelves, worksurfaces, floors and sinks were clean although cluttered.

The pharmacy had a counter height swing door between the counter and the dispensary to prevent people from crossing into this area from the shop floor. There was a black rubbish bag in a bin just beside the swing gate. The bag was very full and was found to contain patient labels with names and addresses on them. These details could potentially be seen by people standing on the customers' side of the gate. Completed prescriptions were stored on shelves at the edge of the dispensary next to the counter and potentially could also be viewed by people standing at the gate.

The dispensary was small for the number of prescriptions dispensed. Completed prescriptions were stored on shelves in the dispensary but, a lack of storage space meant that bulky stock items, such as 'Ensure' drinks were stored in their original outers, or in tote boxes, on the floor. The dispensary had approximately three to four metres of dispensing bench to the front. This included the top of a drawer cabinet which provided additional work surface. It had a further three metres of dispensing bench, to the side. The front dispensing bench was where most of the dispensing and checking took place.

There was a consultation room, which had a door for customers on shop floor. The door was closed but not locked. The room was used to store a large number of multi-compartment compliance packs which contained patient confidential information. While it was unlikely that a member of the public would enter the room unnoticed, the information could be kept more securely if the room was locked. There was another door into the consultation room behind the counter for staff, but the doorway was blocked on the counter side, with stock boxes and prescription bags. And it was blocked by the desk and tote boxes full of compliance packs, on the consultation room side. The pharmacy had a stock storage room to the rear of the dispensary. The room was also used for storing files and folders. And it had a sink which was used for both dispensing purposes and for washing staff cups and utensils. The sink was clean. The pharmacy had an outside toilet with hand washing facilities. All these areas were clean and tidy. Access to the dispensary and consultation area was authorised by the Pharmacist.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes its services available to everyone. The pharmacy generally manages its medicines safely and effectively and gives people the advice they need to help them take their medicines properly. The pharmacy's team members check stocks of medicines regularly to make sure they are in date and fit for purpose.

Inspector's evidence

A selection of pharmacy's services were advertised at the front window although this needed to be updated. A cholesterol testing service was promoted but this was no longer on offer. There were no information leaflets available for customer selection. The pharmacy had step-free access from the pavement outside. So, wheelchair users could enter the premises. The pharmacy offered a prescription collection service although the need was rare. It also offered a prescription ordering service for those who had difficulty managing their own prescriptions. And it offered a prescription delivery service for those who were unable to come to the pharmacy to collect them.

There was a set of SOPs in place. In general, staff appeared to be following the SOPs. A CD stock balance was carried out on a regular basis and the quantity of stock checked (Sevredol 20mg tablets) matched the running balance total in the CD register. Multi-compartment compliance packs were provided for people who needed them. Patient information leaflets (PILs) were offered to patients with new medicines but not on a regular basis thereafter. While labels on compliance packs had the required BNF advisory information, to help people take their medicines properly, the packs were supplied without a description of colour and shape, so it would have been difficult for people to identify which medicine was which.

The pharmacy had procedures for targeting and counselling all patients in the at-risk group taking sodium valproate. Staff could locate warning cards and leaflets. The RP was aware of the risks and would point them out and counsel all patients in the at-risk group as appropriate. Packs of sodium valproate in stock bore the updated warning label. Medicines and Medical equipment were obtained from: Alliance Healthcare, Sigma, Phoenix, DE Pharmaceuticals, Colorama and AAH. Unlicensed 'specials' were obtained from Sigma. All suppliers held the appropriate licences.The pharmacy had the equipment and software for scanning products in accordance with the European Falsified Medicines Directive (FMD) and were scanning all packs with a unique barcode. Stock was generally stored in a tidy, organised fashion. But there was a pack of Tegretol PR 400mg on the shelf which contained an extra eight tablets from the same batch, but the pack quantity had not been amended accordingly.

A CD cabinet and a fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read and recorded daily. Stock was regularly date checked and records kept. Short-dated stock was highlighted with a biro dot and the expiry date circled. Waste medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. Staff had a list of hazardous waste to refer to, which would help ensure that they were disposing of all medicines appropriately. The list had been placed on the side of the fridge for easy reference. Drug recalls and safety alerts were generally responded to by the dispenser and records kept. None of the affected stock was found in any recent recalls, including the recall for ranitidine tablets and paracetamol tablets.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

In general, the pharmacy, has the right equipment and facilities for the services it provides. Its facilities and equipment are clean and generally used in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had a CD cabinet for the safe storage of CDs. The cabinet was affixed securely into place. CD denaturing kits were used for the safe disposal of CDs. The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures were of the appropriate BS standard and generally clean. The pharmacy had separate measures for measuring methadone which were also clean. Tablet triangles were clean, to prevent cross contamination. And amber dispensing bottles were stored with their caps on. Bottles were capped to prevent contamination with dust and debris.

There were up to date information sources available in the form of hard copies of the BNF, the BNF for children and the drug tariff. Pharmacists also used the NPA advice line service and an online interaction checker. They also had access to a range of reputable online information sources such as the NHS and EMC websites. There were two computer terminals available for use in the dispensary. Both computers had a patient medication record (PMR) facility. They were password protected and out of view of patients and the public. Patient sensitive documentation was generally stored out of public view in the pharmacy and confidential waste was collected for shredding. The pharmacist and the dispenser were both seen to be using the pharmacist's smart card when working on PMRs. Staff should use their own smart cards to maintain an accurate audit trail and to ensure that access to patient records is appropriate and secure.

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.