General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jade Pharmacy, 204 Ealing Road, WEMBLEY, Middlesex, HA0 4QG

Pharmacy reference: 1125266

Type of pharmacy: Community

Date of inspection: 25/03/2024

Pharmacy context

The pharmacy is on a busy high street in a mixed commercial and residential area in northwest London. It sells medicines over the counter and provides health advice. The pharmacy dispenses private and NHS prescriptions. It supplies medicines in multi-compartment compliance packs for people who have difficulty taking their medicines at the right time. Its other services include delivery, blood pressure case-finding, travel and seasonal flu vaccinations and Pharmacy First.

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's working practices are mostly safe and effective. It has suitable written instructions for members of the team to follow to help to manage risks in providing its services. Team members learn from their mistakes and take action to prevent the same thing happening again. The pharmacy keeps the records it needs to by law to show how it supplies its medicines and services safely. Members of the pharmacy team protect people's private information. And they understand their role in safeguarding the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. When the responsible pharmacist (RP) identified near misses, members of the pharmacy team were encouraged to discuss and correct their mistakes. They identified the types of mistakes they made, such as picking errors, to learn from them. And they agreed actions they could take to reduce the chances of them happening again. The pharmacy team recorded near misses and the RP used the records to compile a patient safety review regularly. The RP explained that medicines which were involved in incidents, or were similar in some way, for instance gabapentin and pregabalin or allopurinol and amiodarone, were generally separated from each other in the dispensary. They had grouped some medicines stock together such as fast-moving lines and medicines which were prone to picking errors. The pharmacy displayed a complaints procedure to report incidents to the superintendent pharmacist (SI).

A member of the team completed a legal check of prescriptions to make sure the required fields were filled in. Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medicines and to help them prioritise their workload. They referred to prescriptions when labelling and picking medicines. They checked interactions between medicines prescribed for the same person with the pharmacist. If necessary, a member of the pharmacy team called or emailed the prescriber regarding queries on prescriptions and recorded interventions on the patient medication record (PMR). Assembled prescriptions were not handed out until they were checked by the RP. Team members who prepared and checked prescriptions initialled the dispensing labels to create an audit trail. They highlighted prescriptions for delivery to people's homes and high-risk medicines. For instance, controlled drugs (CDs) prescriptions which were only valid for 28 days. And they supplied warning cards such as for warfarin or prednisolone to make sure people had all the information, they needed to use their medicines effectively. Members of the team who handed out prescriptions confirmed the person's details on the address label on the prescription bag and checked the date of birth if needed.

The pharmacy had standard operating procedures (SOPs) for the services it provided. The RP explained that the SOPs had been reviewed recently and the latest SOPs related to the Pharmacy First service. The pharmacy team had trained in the SOPs relevant to their roles. A member of the team described the sales protocol for recommending over-the-counter (OTC) medicines to people. Team members knew what they could and could not do, what they were responsible for and when they should seek help. They explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar medicines, such as medicines liable to abuse to a pharmacist.

The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. In preparation for commencing the NHS Pharmacy First service the RP completed risk assessments to identify and manage risks such as pharmacist training and knowledge and liaising with local surgeries to increase GP support for the new service. The pharmacy assessed whether the pharmacy team needed to make changes to free up the RP's time for consultations and concluded that no changes were required at that time. The RP had read the patient group directions (PGDs) and completed face-to-face training in how to use the otoscope. Records were to be kept on PharmOutcomes. The RP planned to monitor the service through audits of aspects of the service such as general data protection regulation (GDPR) with increased access to people's medical records, referrals to the GP and signposting people elsewhere.

The RP had conducted an audit of people prescribed asthma inhalers and as a result there was a reduction in prescriptions for reliever inhalers because of improved use of steroid preventer inhalers. The audit had also identified children who required a spacer which enhanced the effect of their inhalers. The pharmacy team had completed a clinical audit of people taking valproates and they were aware there were new rules when dispensing a valproate.

The pharmacy displayed a notice that told people who the RP was, and it kept a record to show which pharmacist was the RP and when. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It maintained a controlled drug (CD) register and CDs were audited regularly to check how much stock it had of each CD. A random check of the actual stock of a CD matched the amount recorded in the register. The pharmacy kept records for the supplies it made of private prescriptions and unlicensed medicines ('specials') and these were generally complete. The pharmacy provided travel vaccinations which were administered via online PGDs. The RP explained that the NaTHNaC registration to administer yellow fever vaccinations was up to date. And records for vaccinations included the person's details, the vaccine details such as batch number and expiry date and when they were administered. The pharmacy team recorded the daily fridge temperatures.

The pharmacy was registered with the Information Commissioners Office (ICO). The pharmacy team members had completed GDPR training. They collected confidential wastepaper to be disposed of securely. Members of the team used their own NHS Smartcards. The pharmacy team had all trained in the safeguarding procedure. The RP had completed level 3 safeguarding training. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. The pharmacy team was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team works well together to manage the workload and to deliver its services safely. The pharmacy team members are generally suitably qualified or in training for their roles. The pharmacy team can provide feedback to improve the pharmacy's services.

Inspector's evidence

On the day of the visit, the RP was supported by a trainee pharmacist, a full-time trainee pharmacy technician, one full-time dispensing assistant, two full-time medicines counter assistants and a part-time delivery person who was shared with other branches of the pharmacy. The RP's absences were covered by a relief pharmacist. Team members were enrolled on or had completed accredited training in line with their roles.

The trainee pharmacist was enrolled on an external foundation training course and attended their monthly training days. The pharmacy allocated regular study time to read and revise topics such as sections of the British National Formulary (BNF) and the RP was the trainee pharmacist's tutor. The trainee pharmacist was able to ask the RP for referrals to information sources appropriate to the role. The RP provided feedback to the trainee pharmacist via the required program of appraisals and review. The pharmacy team members were signposted to the GPhC knowledge hub. The RP had completed training as well as a training day provided by the pharmacy's head office to deliver the Pharmacy First service. The RP attended regular face-to-face training to administer travel vaccinations. And he was also training as an independent prescriber.

Team members were allocated protected learning time if needed for accredited training. And they read about product knowledge in the wholesalers' publications which they received. They had also trained in topics in line with the NHS Pharmacy Quality Scheme (PQS) including sepsis, risk assessment and asthma. Team members could discuss issues and provide feedback and suggestions to improve services. One team member had suggested a different schedule for preparing multicompartment compliance packs to improve time management in the dispensary. The RP described informal ongoing appraisals with members of the team and regular team meetings during which they could exchange feedback. And the pharmacy had a whistle-blowing policy for sensitive feedback.

Members of the pharmacy team worked well together. So, people were served quickly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an OTC sales and self-care SOP which described the questions the team member needed to ask people when making OTC recommendations. And when they should refer to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are bright, clean and secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed to protect people's private information and to keep its medicines stock safe. People can have a private conversation with a team member in the consultation room.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. There were chairs for people who wanted to wait. And action had been taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a long retail area and a medicines counter at the back of the pharmacy where people could buy medicines or other sundry items. The dispensary was behind the retail area. There was room for storage. The pharmacy’s consultation room was signposted, and people could have a private conversation with a team member. It was a bit untidy. Team members kept dispensary worksurfaces clear to help avoid them becoming cluttered when the pharmacy was busy. The pharmacy team cleaned the workbenches daily.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy and its services are easily accessible to people with different needs. And its working practices are generally safe and effective. The pharmacy obtains its medicines from reputable sources so that they are fit for purpose. It stores them securely at the right temperature to help make sure they are safe to use. People are provided with the information they need to help them use their medicines properly. The pharmacy team members respond to medicine alerts and recalls to help make sure people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy entrance had double doors and a ramp from the pavement. The team tried to make sure people with different needs could access the pharmacy services. The pharmacy displayed its opening hours and service information at the front entrance. There was seating available for people who were waiting. Members of the pharmacy team were helpful. They could speak or understand Gujarati and Hindi to assist people whose first language was not English. And they signposted people to another provider if a service was not available at the pharmacy such as the Wembley walk-in centre or local Central Middlesex or Northwick Park hospitals. The pharmacy's delivery person delivered medicines for people who could not attend the pharmacy in person and maintained an audit trail via a delivery tracking app to help show the medicines had been delivered to the correct person. The pharmacy offered the blood pressure case-finding service and actively invited people at the medicines counter to have their blood pressure checked. If appropriate they reported the reading on PharmOutcomes which forwarded the information to the person's GP.

The pharmacy supplied medicines in disposable multi-compartment compliance packs for people who had difficulty taking them on time. The pharmacy team re-ordered prescriptions for these people and checked them for changes in medicines since the previous time. Members of the team said they would make sure medicines were suitable to be re-packaged if necessary. They provided a brief description of each medicine contained in the compliance packs and patient information leaflets (PILS) with each set of packs to help ensure people had the information they needed to take their medicines safely. High-risk medicines were generally supplied separately to the compliance pack. Following a patient's hospital stay, the pharmacy sometimes received a discharge summary via PharmOutcomes showing changes in treatment. The pharmacy provided services to care homes such as flu vaccinations and they visited the homes to provide training and monitor the services. And they prepared packs well in advance to be able to resolve any issues such as obtaining stock. Care homes managed ordering their own prescriptions and informed the RP about new medicines which were prescribed.

In the event of a systems failure people would be signposted to another pharmacy and their nomination switched to that pharmacy. Members of the team initialled dispensing labels so they could identify who prepared a prescription. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting. The RP counselled people on how best to use their medicines. For people taking warfarin, the RP checked the INR was monitored. The RP reminded people about foods and medicines which may affect their INR. The pharmacy provided the new medicines service (NMS) and after the initial consultations, people were followed up by phone. The RP and the pharmacy team members were aware of the new up-to-

date guidance and rules for supplying valproate-containing medicines which must always be dispensed in the manufacturer's original full pack. And no-one under the age of 55 – both men and women - should be started on a valproate unless two specialists independently agree and document that there is no other safe and effective medication, or that there are compelling reasons why the reproductive risks linked to valproate, do not apply.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It generally kept medicines and medical devices in their original manufacturer's packaging although there were some medicines which were not stored appropriately. Liquid medicines were marked with the date of opening. The dispensary was tidy. The pharmacy team carried out regular date checks of stock. The pharmacy stored its stock, which needed to be refrigerated, between two and eight Celsius. And it stored its CDs securely in line with safe custody requirements. The pharmacy's waste medicines were kept separate from stock in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the pharmacist described the actions they took and explained what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately and keeps people's private information safe.

Inspector's evidence

The pharmacy team had access to up-to-date and online reference sources. It had clean measures to measure liquid medicines stored near the dispensary sink which was clean. The pharmacy stored its pharmaceutical stock requiring refrigeration between two and eight Celsius which its team regularly checked and recorded. The CD cabinet was fixed securely. There were bins for clinical waste disposal. The blood pressure monitor was new. The pharmacy team collected confidential wastepaper to be disposed of securely. The pharmacy restricted access to its computers and PMR system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure they used their own NHS smartcards.

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.