General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Horn Lane Pharmacy, 142 Horn Lane, London, W3 6PG

Pharmacy reference: 9010666

Type of pharmacy: Community

Date of inspection: 07/08/2024

Pharmacy context

This is an independently owned community pharmacy. The pharmacy is on a parade of local shops and businesses in the west London suburb of Acton. It provides a prescription dispensing service. And it supplies medicines in multi-compartment compliance packs to people who need them. The pharmacy has a selection of over-the-counter medicines and other pharmacy related products for sale. And it provides the NHS Pharmacy First 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 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 identifies and manages the risks associated with its services well. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The responsible pharmacist (RP) was the regular responsible pharmacist (RP). And he worked regularly alongside the superintendent owner. The RP and SI described how they generally highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistakes from happening again. The team did not appear to make many mistakes. And pharmacists felt that this was because there were two pharmacists present most of the time. And three team members were involved in the dispensing process. One team member checked patients' details from the patient medication record (PMR) system and produced the labels. And they alerted a pharmacist to any changes. Another assembled the medicines and attached the labels, checking as they went. And a pharmacist completed the process with a clinical check and an accuracy check. Pharmacists reviewed the team's mistakes as they happened. And they checked for any trends. The RP and SI were present in the pharmacy full time. And they recognised when similar mistakes had been repeated. And when this happened, they reviewed them with the team, to raise awareness and reduce the risk of a reoccurrence. The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs). And in response to near miss mistakes with LASAs it had separated several of these products to different areas of the dispensary. And it had highlighted the shelf edge with an alert label. It had done this with products such as propranolol and prednisolone, to reduce the risk of selecting the wrong one. It was clear that the team acted in response to its mistakes. And it discussed what had gone wrong. The RP, SI and inspector discussed the detail of what the team recorded on its near miss records. And how records should show what its team members had learned and how they would improve further.

The pharmacy had a set of standard operating procedures (SOPs) for its team members to follow. The RP agreed that some of the older SOPs were due for a review. Team members had read them. And they appeared to understand and follow them. The dispensing assistants (DAs) consulted the RP or SI when they needed their advice and expertise. And they asked appropriate questions before handing people's prescription medicines to them. Or selling a pharmacy medicine. They did this to ensure that people got the right advice about their medicines. DAs were observed to attend to their allocated tasks, prioritising the most urgent prescriptions and using the pharmacy's patient medication record system (PMR) competently. 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 agave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy did not receive many complaints. But it 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 and SI commented that, at

times, people were unhappy that their medicines were not available. These issues were often out of the pharmacy's control, as the problem often arose with medicines which were unavailable from the manufacturer. Or only available at a significant cost to the pharmacy. But the Si generally reacted by ordering sufficient stock in advance to ensure that they did not run out. The team also worked closely with local surgeries to ensure that people did not go without essential medicines. It chased prescriptions up when there was a delay. And it arranged for alternatives when it received a prescription for an item it could not supply. It also tried to keep people's preferred brands of medicines in stock so that they did not have to wait while the team ordered them. 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 kept its records in the way it was meant to, including its RP record, its private prescription records, its records for emergency supplies. And its controlled drug (CD) registers. It kept a record of its CD running balances. And a random sample of stock checked during the inspection matched the total recorded in the register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. The register was complete and up to date. It was clear that the team understood the importance of ensuring that all the pharmacy's essential records were in order.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They discarded confidential paper waste into separate waste bins as they worked. And all confidential waste was collected regularly for shredding by a licensed waste contractor. The team also kept people's personal information, including their prescription details, out of public view. Team members had completed appropriate safeguarding training. 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 services.

Inspector's evidence

On the day of the inspection the RP and SI worked with two DAs. One of the DAs was a pharmacist who had qualified overseas. She worked part-time at the pharmacy while undertaking additional studies. She had received in house training. But she had not yet registered on a formal training programme. The SI agreed that all team members should have the right skills for their roles, and so he would ensure that she was enrolled on an appropriate training course as soon as possible. Team members attended promptly to people at the counter. They were efficient and calm. And they supported one another, assisting each other when required. The team had the daily workload of prescriptions in hand. And it kept on top of its other tasks. And together they dealt with queries promptly.

Team members did not have formal meetings or appraisals about their work performance. But they discussed issues as they worked. They described feeling supported in their work. And they could make suggestions about how to improve the general workflow. They could also raise concerns with the RP or SI if they needed to. And pharmacists felt they could make day-to-day professional decisions in the interest of patients.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide an environment which is appropriate for people to receive its services. And they are sufficiently clean, tidy and secure.

Inspector's evidence

The pharmacy was on a parade of shops and businesses serving the local community. It had a small retail area with seating for waiting customers. It also had a consultation room which was close to the counter and dispensary. The consultation room provided privacy for people. And so, it provided a place for people to receive pharmacy services or have a private conversation with one of the pharmacists. The pharmacy had a short pharmacy counter which was open on one side. The opening provided access to the dispensary and the area behind the counter for staff and authorised visitors. This provided easy access for staff retrieving prescriptions for people. The pharmacy had a medicines counter. The counter had been built with a lower level at one end suitable for wheelchair users. And it kept its pharmacy medicines behind the counter.

The pharmacy had a compact dispensary. But it had enough space for team members to dispense the pharmacy's multi-compartment compliance packs. The dispensary had dispensing worksurfaces on three sides, and a central island which were all used for the pharmacy's dispensing activities. And it had storage facilities above and below these work surfaces. One of the dispensary's worksurfaces faced the retail space and the back of the medicines counter. And team members working here could see people waiting. The pharmacy had a cleaning routine. And it kept its worksurfaces tidy and organised. It cleaned its work surfaces and equipment regularly. Team members cleaned floors periodically and they tried to keep them tidy. 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 provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. 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 ensures that all its medicines are stored correctly and safely.

Inspector's evidence

The pharmacy had information on its windows promoting its services. Its doorway had a small step up to the entrance. But it had a small ramp close to hand which it put in front of the entrance when people needed it. It did this to provided step-free entry. Its customer area was free of unnecessary obstacles, making it suitable for people with mobility issues. The pharmacy could also order people's repeat prescriptions if required. And it had a delivery service. But the pharmacy tried to prioritise the service for people who were housebound. And had no other way of getting their medicines. The team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. It also supplied medicines against private prescriptions, some of which came from private online prescribing services.

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 DA processed the prescriptions for the compliance packs. Compliance packs had been labelled with a description of each medicine, including colour and shape, to help people to identify them. And it supplied patient information leaflets (PILs) with each month's supply. But the pharmacy did not include the required British National Formulary (BNF) advisory information on compliance pack labels. And so, people may not have all the necessary information to help them to take their medicines properly. The inspector and the team agreed that it was important to ensure that people had all the information they needed about the way they should take their medicines. Pharmacists gave people advice on a range of matters. And they 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 understood that he must counsel people when supplying the medicine to ensure that they were aware of the risks associated with it. And to ensure they were on a pregnancy prevention programme as appropriate. The RP also knew to provide warning cards and information leaflets with each supply. And he was aware of recent changes in the law about supplying valproate medicines in their original packs. The service was proving popular with local people.

The pharmacy offered the NHS pharmacy First service. This allowed people to access medicines for seven common conditions after an appropriate consultation with the pharmacist. And without having to see a GP. The pharmacy had received requests directly from people. And from its local GP surgeries. Its most common requests were from people seeking treatment for uncomplicated urinary tract infections (UTIs). Pharmacists had the appropriate protocols to follow. And they kept the necessary records for each supply. It was clear that they understood the limitations of the service and when to refer people to an alternative health professional.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And in general, the team stored its medicines, appropriately. And stock on the shelves was tidy and organised. But it had some packs of medicines which contained strips of tablets from different manufacturers. This meant that the description on the pack did not exactly match the contents. And not all the strips had details of the batch numbers and expiry dates on them. It also had a loose strip of medicine on the shelf which had no batch number or expiry date. This meant that team members could not be sure that it would be appropriate to supply them. Staff had put these items back into stock after dispensing prescriptions requesting a split pack quantity. The inspector and RP discussed this. And the team agreed that all medicines should be stored in the manufacturer's original packaging where possible. And while this did not present a high risk of error, it may mean that the strips could be missed if subject to a recall or an expiry date check. The RP agreed that the team should review its understanding of the procedures to follow when putting medicines back into stock after dispensing.

The pharmacy checked the expiry dates of its stock, regularly. And team members described checking expiry dates when they dispensed each item. When the team identified any short-dated items it highlighted them. 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. 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. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources. The pharmacy had several computer terminals which had been placed in the consultation room and in the dispensary. Computers had password protection. Team members used 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 the dispensary 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.