General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sharman Chemist, 3-4 Clive Parade, Maxwell Road, NORTHWOOD, Middlesex, HA6 2QF

Pharmacy reference: 1035063

Type of pharmacy: Community

Date of inspection: 15/02/2023

Pharmacy context

This is an independent community pharmacy. It is on a parade of local shops and businesses in Northwood. It provides a range of services including dispensing prescriptions. And it has a selection of over-the-counter medicines and other pharmacy related products for sale. It dispenses medicines into multi-compartment compliance packs for people who have difficulty managing their medicines. And it delivers medicines to a small number of people who are not able enough to collect them from the pharmacy.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 appropriate 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 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 had a system for recording its mistakes. The team described how pharmacists, accredited checking technicians (ACTs) and accredited checking dispensers (ACDs) highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistake from happening again. The pharmacy had a robot for storing and dispensing its 800 fastest moving lines. The rest of its stock was stored in different areas of the dispensary. It used the robot to make its dispensing process efficient and to help reduce the risk of picking the wrong item. The robot was linked to the pharmacy's electronic stock management system and its patient medication record system (PMR). It identified which medicine to pick from the label information which staff entered onto the PMR. And it used bar code recognition to pick the right one. It then passed the medicine down a chute next to the appropriate workstation. The team member collected it, checked it and completed the dispensing process, before setting it aside for a final accuracy check. The team found that the robot had reduced the number of mistakes it made for the items stored in it. But it also found that a small number had arisen when staff had put incorrect information into the robot's stock management system. Such as an incorrect expiry date. While mistakes were rare, the team realised that it was important to have robust checking processes in place. And in response to a near miss mistake, it now stored its split packs in separate drawers. It did this to help prevent a split pack being dispensed in error instead of a full pack. But while the team had taken measures to reduce its mistakes, it did not fully record what it had learned from them or what it would do differently next time. Team members agreed that if they had more details of what they had learned from their mistakes they could review them and monitor improvement more effectively. And it would provide the team with a better opportunity to prevent mistakes and continue to learn.

The pharmacy had put measures in place to keep people safe from the transfer of infections. The team had a regular cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. The pharmacy had hand sanitiser for team members and other people to use. The pharmacy had a set of standard operating procedures (SOPs) to follow. And the team members understood their roles. The ACT could locate the SOPs and she was observed attending to repeat prescriptions and taking calls on the pharmacy's headset as she worked. The pharmacy manager who was trained in the workings of the pharmacy was seen to assist with managing people at the counter, retrieving counter stock and prescription information. He also consulted one of the dispensing team and the pharmacist as appropriate when he needed their advice and expertise. The manager consulted the pharmacist before selling a pharmacy medicine to someone. He also asked people the appropriate questions so that he could give sufficient information to the pharmacist about their symptoms and any other medicines they were taking. He did this to help the pharmacist decide on the most appropriate course of action for them. The RP had placed her RP notice on display where people could see it. The notice showed her

name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services directly to the pharmacy's team members. This included the pharmacy manager or the RP on the day. They could also give feedback to the superintendent pharmacist (SP) director. They could also give feedback to the pharmacy's other principal pharmacist director. Recent customer comments indicated that many people were unhappy if the pharmacy did not have their medicines in stock. Or when there were manufacturers' delays. And so, team members spent time contacting GPs to arrange alternatives so that people did not go without their medicines. They also encouraged people to allow more time between ordering their prescriptions and collecting them. They did this so that people gave the pharmacy team time enough to order their medicines, sort out any problems and then get their medicines ready. The pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints procedure online. But the RP SP generally dealt with people's concerns at the time. 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 controlled drugs (CD) register. And its private prescription records. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines, but it had not yet recorded a small quantity of patient returned CDs from a few days earlier. It transpired that the CDs had been received by a locum unfamiliar with the pharmacy's processes. And was not in accordance with its usual practice. The pharmacy also kept records of its emergency supplies. But its records did not all give a clear reason for the decision to supply. And it had yet to reconcile some requests made a week earlier. The pharmacy generally kept its RP records properly. But it had some omissions when RP duties ceased. The pharmacy team agreed that all the pharmacy's essential records should have all the necessary details as well as being up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed training on confidentiality. They discarded confidential paper waste into separate waste containers before shredding it. And they generally 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has an appropriate range of skills and experience to support its services. And it manages its workload safely and effectively. Its team members support one another well. And they keep their knowledge up to date. Team members receive sufficient feedback to help them carry out their tasks satisfactorily.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. The RP was a locum who had not worked at the pharmacy before. But she was supported by an ACT, an ACD, two dispensing assistants, a medicines counter assistant (MCA) and the pharmacy manager who was also an MCA. The pharmacy also had two other assistants who managed the beauty counter with the manager's support. The team worked effectively together. Team members assisted each other when required and discussed issues. They supported one another to complete their tasks. And more experienced team members were observed helping those with less experience The team kept its daily workload of prescriptions in hand. And they dealt with customers promptly.

The pharmacy had a small close-knit team who worked regularly together and could raise concerns and discuss issues when they arose. The superintendent director and his wife, a pharmacist director, visited and worked at the pharmacy regularly. They and the pharmacy manager kept team members up to date by providing information and training about services and any new business initiatives. And team members could raise any concerns they had with them. And they felt they were listened to and supported in their work. Team members also kept their knowledge up to date by reading training material. Pharmacists made day-to-day professional decisions in the interest of patients. And although it was the first day that she had worked at the pharmacy, the RP felt that she had been well supported by the team. At the time of the inspection there had been general workforce shortages in pharmacy. But the pharmacy had not had any unplanned closures.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. And they provide enough space for those services. The pharmacy is sufficiently clean and secure. And the team keeps its workspace and storage areas sufficiently tidy and organised.

Inspector's evidence

The pharmacy was clean, tidy and adequately maintained. And it was bright, well-lit and modern looking. The pharmacy had a cleaner who cleaned floors, staff areas and worksurfaces six times a week. And the team cleaned the pharmacy's worksurfaces, equipment and touch points regularly using alcohol wipes. The pharmacy's counter had a backwall behind it for displaying over-the-counter medicines. And it had a large dispensary which sat behind the counter. The robot occupied a significant amount of space in the middle of the dispensary, splitting the dispensary into two distinct areas. The main dispensing area occupied one side of the robot. And it had workbenches along three sides with storage areas above and below. It also had pull-out drawers for storing medicines. The other side of the robot had a run of dispensing worksurface, storage drawers and shelves. This area was mainly used for dispensing multi-compartment compliance packs. And for inputting stock into the robot.

The pharmacy had several consultation rooms. It had a suite of consultation rooms on one side which was used regularly by other health care professionals. And a single separate consultation room on the other. The suite of consultation rooms was used for services such as the private GP prescribing service, podiatry and osteopathy. And they were also used by pharmacists for travel clinics including vaccinations and Covid-19 vaccinations. All these services were provided by appointment unless the rooms were not in use and there was an appropriately trained team member present and available to provide it. Pharmacists often used the single consultation room on the other side for private consultations with people. The pharmacy also had additional worksurface, a storage area, staff facilities and rest area to the rear. It had air conditioning and heating systems. And at the time of the inspection the working temperature was comfortable and 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. 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 team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. But it does not ensure that all the medicines on its shelves are packaged and labelled correctly.

Inspector's evidence

The pharmacy had step-free access at its entrance. And its customer area was generally free of unnecessary obstacles. It also had a delivery service for people who could not collect their medicines. The pharmacy could also order people's repeat prescriptions if required. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. It provided medicines in multi-compartment compliance packs for people living at home who needed them. And it managed the service according to a four-week rota. Each month it checked and verified any changes to prescriptions. And it updated people's records. The pharmacy also had a system for managing any changes made to people's prescriptions within the monthly cycle. And it received hospital discharge letters so that it could make any necessary changes to packs for people after they had left hospital. The team labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And its labelling directions gave the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. So that people could find the information they needed if they wanted to.

The pharmacy team gave people advice on a range of matters. And it would give appropriate advice to anyone taking higher-risk medicines. It had additional leaflets and information booklets on a range of medicines including sodium valproate. It had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. Pharmacists 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 had received a lot of interest in its blood pressure measuring service. When it first introduced the service GPs advised their patients to go to the pharmacy to have their blood pressure measured. The ACD took an active role in delivering the service. She described how she carried out an initial blood pressure reading and then where appropriate she invited people back to fit them with an ambulatory blood pressure monitor, after gaining their consent. She notified the surgery of the readings using the bespoke email communication system the pharmacy had with the surgery (AccuRx). And when necessary, she or one of her appropriately trained colleagues referred people back to their GP for further intervention. She felt that the service was beneficial as several people had returned to the pharmacy with prescriptions for blood pressure tablets. And without the service they may not have realised that they needed them. The service had been well received locally. And now many customers came to the pharmacy of their own accord without having been first advised to do so by their surgery.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. It generally stored its medicines appropriately and in their original containers. But it had a few

packs of medicine with two distinct brands of the medicine inside it. This included simvastatin 20mg tablets and irbesartan 150mg tablets. So, the additional strips could be missed if it were part of a medicines recall. Some strips had two different expiry dates. And others did not have a clear expiry date. And so, they could also be missed during an expiry date check. The inspector discussed this with the team, and they agreed that team members should review its understanding of the correct procedures to follow when putting medicines back into stock after dispensing. The pharmacy stored its medicines stock in a tidy and organised manner. It date-checked its stock regularly. And it kept records of its date checking. The team used the records to track what had been checked and what had not. The team identified and highlighted any short-dated items. 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. And it 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. And the equipment was clean. Team members had access to a range of up-to-date reference sources. And they had access to personal protective equipment (PPE), in the form of sanitiser, face masks and gloves. The pharmacy had enough computer terminals for its workload. And it had placed them at its workstations in the dispensary and in its consultation rooms, where team members needed them. Computers were password protected. And team members used their own smart cards when accessing patient records. They did this to ensure an accurate audit trail. And to ensure that they had the appropriate level of access to patient information. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions 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.