General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Trio Pharmacy, 19-21 High Street, SHEPPERTON, Middlesex, TW17 9AJ

Pharmacy reference: 1035108

Type of pharmacy: Community

Date of inspection: 12/03/2024

Pharmacy context

This busy NHS community pharmacy is set in the centre of the Surrey village of Shepperton. The pharmacy opens six days a week. It sells medicines over the counter. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy supplies multi-compartment compliance packs (compliance packs) to a few people who need help managing their medicines. It delivers the NHS Pharmacy First Service to help people who have a minor illness or need an urgent supply of a medicine. And people can visit the pharmacy to get their flu jab or travel vaccination or have their blood pressure checked.

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	1.2	Good practice	The pharmacy continually monitors the safety of its services to protect people and further improve patient safety.
2. Staff	Good practice	2.4	Good practice	Members of the pharmacy team work well together and have a work culture of openness, honesty and learning. And they learn from their own and other people's mistakes.
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 appropriately identifies and manages its risks. It has written instructions to help its team members work safely. It continually monitors the safety of its services to protect people and further improve patient safety. It mostly keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy log and review the mistakes they make and learn from them to try and stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had some plastic screens on its counter to help reduce the spread of airborne infections such as coronavirus. And hand sanitising gel was also available for people to use. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed periodically by the superintendent (SI) pharmacist. Members of the pharmacy team had to read and sign the SOPs relevant to their roles to say they understood them and would follow them. They knew what they could and couldn't do, what they were responsible for and when they might seek help. Their responsibilities were described within the SOPs. And a notice in the pharmacy told people who the responsible pharmacist (RP) was at that time. The team members who were responsible for making up people's prescriptions highlighted the locations of a few medicines, which looked alike and whose names sounded alike, to help reduce the chances of them picking the wrong product. They tried to keep the dispensing workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by one of the pharmacists. The pharmacy had robust processes to deal with patient safety incidents and dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). And these were monitored regularly. Members of the pharmacy team recorded the mistakes they made and any lessons they learnt from them. They reviewed their mistakes regularly to help them spot patterns or trends. And they shared any learnings with one another during team meetings. So, they could try to stop the same sorts of things happening again and improve the safety and quality of the dispensing service they provided. And, for example, a third check of assembled compliance packs and controlled drug (CD) prescriptions was introduced to reduce the chances of mistakes being made.

Some people have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. And it had a notice that told people how they could provide feedback about the pharmacy or its team. People could share their views and make suggestions to the pharmacy team about how the pharmacy could do things better. And, for example, the pharmacy team tried to order a person's preferred make of a prescription medicine when it was asked to do so. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. It kept appropriate records to show which pharmacist was the RP and when. It had a CD register. And the stock levels recorded in the register were checked as often as the SOPs required them

to be. But the details of where a CD came from weren't always completed in full. The pharmacy recorded the supplies of the unlicensed medicinal products it made. But its team could do more to make sure it recorded when it received one of these products. The pharmacy required its team to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the details of the prescriber were wrong in a few of the private prescription records seen. And the pharmacy team was reminded that it needed to make an appropriate record when a prescription-only medicine was supplied to a person in an emergency including requests referred to it by NHS 111. The pharmacy team gave an assurance that these records would be kept as they should be.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy displayed a notice that told people how it gathered, used and shared their personal information. It had arrangements to make sure confidential information was stored and disposed of securely. And its team needed to complete training on confidentiality and data security. But people's details weren't always crossed out or removed from the unwanted medicines returned to it before being disposed of. The pharmacy had a safeguarding procedure and a chaperone policy. And its team was asked to complete safeguarding training. Members of the pharmacy team knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough team members to provide its services safely and effectively. And its team makes appropriate decisions about what is right for the people it cares for. Members of the pharmacy team do the right training for their roles. They work well together and have a work culture of openness, honesty and learning. And they learn from their own and other people's mistakes. The pharmacy team is comfortable about giving feedback to help the pharmacy do things better. And it knows how to raise a concern if it has one.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist (the SI), three part-time pharmacists, five dispensing assistants, five trainee dispensing assistants, a trainee medicines counter assistant (MCA) and a delivery driver. And one of the directors provided administrative support to the pharmacy and its team. But this director didn't sell or supply medicines or give people advice about their health or their medicines. The people working at the pharmacy during the inspection included three pharmacists, two dispensing assistants, four trainee dispensing assistants and the trainee MCA. The pharmacy depended upon its team to cover absences. And generally, two pharmacists worked alongside each other when the pharmacy was open. The pharmacy had seen an increase in its dispensing volume since the closure of a nearby pharmacy. But the pharmacy had taken on more team members as a result. And the pharmacy team was generally up to date with its workload. Members of the pharmacy team worked well together and helped each other so people were served quickly, and prescriptions could be dispensed safely. The SI was one of the directors. They managed the pharmacy and led its team. And they were supported by the other directors. The pharmacists on duty supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist. Members of the pharmacy team needed to complete accredited training relevant to their roles after completing a probationary period. They could ask questions and familiarise themselves with new products. And they could keep their knowledge up to date by completing online training when they weren't busy. The pharmacy had a culture that encouraged its team members to be open and honest about the mistakes they made and share what they learnt with each other at regular team meetings. And this meant the safety of the services offered by the pharmacy could be improved. People who worked at the pharmacy didn't feel they were asked to do things that stopped them from making decisions that kept people safe. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. They were asked to make suggestions on how to improve the pharmacy and its services. They felt comfortable in providing feedback to the pharmacists and the directors. And, for example, a handover now happened routinely between the pharmacists when they started or finished their shifts.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was air-conditioned, bright and tidy. Its public-facing area was adequately presented. And a prescription collection kiosk (kiosk) had been installed in an area of the building that wasn't part of the registered premises. The pharmacy had a small leak in its roof when there was heavy rain. But the pharmacy team mopped up any water and put out signage to warn people that the floor may be slippery. And the directors had already raised the matter with the landlord. The pharmacy had two consulting rooms, a counter, a dispensary, an office, a retail area, a staffroom, stockrooms and toilets. And it had the workspace and storage it needed for its current workload. The consulting rooms were available for services that needed one or if someone needed to speak to a team member in private. And they could be locked when they weren't being used to make sure their contents were kept secure. The pharmacy had the sinks it needed for the services its team delivered. It had a supply of hot and cold water. And its team was responsible for keeping its premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are safe and effective. And it keeps appropriate records for its vaccination service to show that it has given the right vaccine to the right person. The pharmacy gets its medicines from reputable sources. And it largely stores them appropriately and securely. Members of the pharmacy team are friendly and helpful. They dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy had an automatic door. And its entrance was level with the outside pavement. The pharmacy had a seating area for people to use if they wanted to wait in the pharmacy. And it had a notice that told people when it was open, and a digital display told people about some of the services it delivered. People could ask to use the kiosk to collect their medicines at a time convenient to them. But the pharmacy team needed to assess the suitability of each request. And, for example, newly prescribed or bulky medicines as well as medicines requiring secure storage or refrigeration couldn't be collected from the kiosk. The pharmacy notified people and provided them with a code when their medicines were ready to collect. People were reminded if they hadn't collected their medicines. And their medicines were generally removed from the kiosk if they weren't collected within a week or two. The pharmacy team asked people who were prescribed a new medicine if they wanted to speak to the pharmacist about it. And people could book a follow-up appointment at a time that suited them. The pharmacy dealt with NHS Pharmacy First Service referrals. People benefited from this service as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for a few minor illnesses. Members of the pharmacy team were friendly and helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a local delivery service to a few people who couldn't attend its premises in person. It kept a log to show the right medicine had been delivered to the right person. But people weren't generally asked to sign the log to say they had received their medicines safely despite the SOPs asking the delivery person to do so. The pharmacy offered winter flu jabs and travel vaccinations. It had the anaphylaxis resources and the patient group directions it needed for its vaccination service. And the pharmacists providing these services were appropriately trained. The pharmacy kept a record for each vaccination it made to show it had given the right vaccine to the right person. And the records included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And an assessment was done to determine if a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. And a patient information leaflet and a brief description for each medicine contained within a compliance pack were routinely provided. The pharmacy marked prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items, such as a CD or a refrigerated product, needed to be added. And its team usually marked CD prescriptions awaiting collection to help make sure supplies were made lawfully. Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention

programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. They were aware of the rules on dispensing valproate-containing medicines in the manufacturer's original full pack. And they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept most of its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team marked the containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. And they marked products which were soon to expire. These things helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. It stored its CDs, which weren't exempt from safe custody requirements, securely. Its team recorded the destruction of the CDs that people returned to it. And it kept these and out-of-date CDs separate from in-date stock. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. The pharmacy had a process for dealing with the alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And a team member described the actions they took and demonstrated what records they made when the pharmacy received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy usually has the equipment and the facilities it needs to provide its services safely. And its team makes sure the equipment it uses is clean and suitable for what it's being used for.

Inspector's evidence

The pharmacy had some glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out or count medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had the medical refrigerators it needed to store pharmaceutical stock requiring refrigeration. And its team checked and recorded each refrigerator's maximum and minimum temperatures on the days the pharmacy was open. The pharmacy had suitable equipment for the NHS Pharmacy First Service as well as for other diagnostic tests such as measuring a person's blood pressure and blood cholesterol and glucose levels. And this equipment appeared to be well maintained. The pharmacy restricted access to its computers and patient medication record 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 their NHS smartcards were stored securely when they weren't working.

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.