General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sunset Pharmacy, 165 High Street, STAINES, Middlesex, TW18 4PA

Pharmacy reference: 1035135

Type of pharmacy: Community

Date of inspection: 28/09/2022

Pharmacy context

This is an NHS community pharmacy set on a parade of shops and businesses on a main road in Staines. The pharmacy opens six days a week. It sells over-the-counter medicines and some health and beauty products. It dispenses people's prescriptions. And it delivers medicines to people who can't attend its premises in person. The pharmacy supplies medicines to a few care homes and provides multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. And people can get a flu jab (vaccination) and have their blood pressure (BP) checked at the pharmacy too.

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	Good practice	3.1	Good practice	The pharmacy is well designed to meet the needs of the people who use it.
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 adequately manages its risks. It has written instructions to help its team works safely. It mostly keeps the records it needs to by law. It has appropriate insurance 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 can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. They understand their role in protecting vulnerable people. And they talk to each other about the mistakes they make. So, they can learn from them.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. And the responsible pharmacist (RP) gave an assurance that the SOPs would be reviewed following the inspection as they hadn't been for a while. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. The pharmacy had considered the risks of coronavirus. It completed an occupational risk assessment for its team members at the beginning of the pandemic. And a plastic screen was put on the counter to try and stop the spread of the virus. Team members knew that any work-related infections needed to be reported to the appropriate authority. They had the personal protective equipment they needed. And hand sanitising gel was available too. Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were checked by the RP. The pharmacy had processes to review the dispensing mistakes that were found before reaching a person (near misses) and dispensing mistakes where they had reached the person (dispensing errors). Team members generally highlighted and separated medicines involved in dispensing mistakes or were similar in some way, such as medicines that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being picked. They discussed the mistakes they made to learn from them and reduce the chances of them happening again. But they hadn't recorded their mistakes, or the lessons learnt from them, for some time. So, they could have missed opportunities to spot patterns or trends in the mistakes they made.

The pharmacy displayed a notice that told people who the RP was at that time. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were also described within the SOPs. A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints procedure. And an in-store notice asked people to share their views and suggestions about how the pharmacy could do things better. And, for example, the pharmacy team tried to keep a person's preferred make of a prescription medicine in stock when it was asked to do so. People shared their experiences of using the pharmacy and its services online too. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and when. It kept an adequate record of the supplies of the unlicensed medicinal products it made. And it recorded the emergency supplies it made and the private

prescriptions it supplied on its computer. But the prescriber details were sometimes incomplete or incorrect in the private prescription records. The pharmacy had a controlled drug (CD) register. But the details of where a CD came from weren't always completed in full. And the stock levels recorded in the register weren't checked as often as the SOPs asked them to be checked.

People using the pharmacy couldn't see other people's personal information. The pharmacy displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. It had arrangements to make sure confidential information was stored and disposed of securely. It had an information governance policy. And its team had read and signed a confidentiality agreement. The pharmacy had a safeguarding SOP. And the RP had completed appropriate safeguarding training. Members of the pharmacy team had the contacts they needed if they wanted to raise a safeguarding concern. And they knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough team members to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. They work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy team consisted of the RP, two full-time dispensing assistants, a part-time assistant and a part-time delivery driver. The assistant had recently started at the pharmacy. And they were being supported by the rest of the team to help them learn during their probationary period. The RP was the superintendent pharmacist. And they were responsible for managing the pharmacy and its team. The pharmacy relied upon its team members and locums to cover absences. The RP, the dispensing assistants and the assistant were working at the time of the inspection. Members of the pharmacy team worked well together. So, people were served promptly, and their prescriptions were processed safely. The RP 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 the pharmacist on duty.

People working at the pharmacy were required to do accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with the RP when they could. They were kept up to date and could share learning from the mistakes they made during team meetings. And they were encouraged to complete training when the pharmacy wasn't busy or in their own time to make sure their knowledge was up to date. The pharmacy didn't set targets for its team. And it didn't incentivise its services. Members of the pharmacy team felt able to make decisions to keep people safe. And they didn't feel under pressure to do the things they were expected to do. Team members were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And a quick-reference guide about the Discharge Medicines Service was introduced following their feedback.

Principle 3 - Premises ✔ Good practice

Summary findings

The pharmacy is bright, clean, modern and tidy. It provides a safe, secure and professional environment for people to receive healthcare in. It's well designed to meet the needs of the people who use it, and to make sure they can receive services in private when they need to.

Inspector's evidence

The pharmacy premises were air-conditioned, bright, clean, modern, secure and tidy. They were well laid out and organised. They were professionally presented throughout. And their fixtures and fittings were of a high standard. The pharmacy had the workbench and storage space it needed for its current workload. People's compliance packs and medication for care home residents were dispensed in a quieter area of the pharmacy. So, distractions and interruptions to the team members assembling them were minimised. The pharmacy had a well-equipped consulting room for the services it offered and if people needed to speak to a team member in private. The consulting room was locked when it wasn't being used. So, its contents were kept secure. And people's conversations in it couldn't be overheard outside of it. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water too. Members of the pharmacy team were responsible for keeping the premises clean and tidy. And they regularly wiped and disinfected the surfaces they and other people touched.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are generally safe and effective. And its team is friendly and tries to help people access its services. Members of the pharmacy team generally 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. The pharmacy offers flu jabs and keeps appropriate records to show that it has given the right vaccine to the right person. It gets its medicines from reputable sources. And it stores them appropriately and securely.

Inspector's evidence

The pharmacy didn't have an automated door. But its entrance was level with the outside pavement. And a member of the pharmacy team would open the door when necessary. So, people with pushchairs or who used wheelchairs could enter the building. The pharmacy had a digital display in one of its windows that told people about its products and the services it delivered. It had a small seating area for people to use if they wanted to wait. And this was set away from the counter to help people keep apart. Members of the pharmacy team were friendly and helpful. They took the time to listen to people. So, they could help and advise them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. And it kept an audit trail to show when it delivered someone their medicines. The pharmacy often dealt with CPCS referrals when other pharmacies or people's GP surgeries were busy or closed. People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And the pressure on local surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses was reduced too. The pharmacy had the anaphylaxis resources and the patient group directions it needed for its flu jab service. And the pharmacy team members who vaccinated people were appropriately trained. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The dispensing assistant generally took the flu vaccine out of the refrigerator and the pharmacist checked that the correct vaccine had been selected before administering it. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked whether a medicine was suitable to be re-packaged. But it could do more to regularly assess whether a person needed a compliance pack. The pharmacy provided a brief description of each medicine contained within the compliance packs. Its SOPs required its team to provide patient information leaflets with each supply it made. And an audit trail of the people who had assembled and checked the compliance pack needed to be kept. 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. And they had the resources they needed when they dispensed a valproate. The pharmacy team used reminder stickers and notes 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. But it didn't routinely mark prescriptions for CDs with the date the 28-day legal limit would be reached to make sure supplies were made lawfully.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines and medical devices within their original manufacturer's packaging. Team members marked containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines at regular intervals, which they recorded, and before they dispensed them. And they marked products which were soon to expire. These steps 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 the appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy team recorded the destruction of the CDs that people returned to it. And out-of-date and patient-returned CDs needed to be kept separate from in-date stock. But some intact gabapentin and tramadol were found in a pharmaceutical waste bin. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they took and what records they made when they received a drug alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they 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 a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the refrigerator's maximum and minimum temperatures. The pharmacy team could check a person's BP when asked. And the monitor it used to do this was changed every year. 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 put 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.