General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Nima Pharmacy, 56-58 Stoneleigh Broadway, Ewell, EPSOM, Surrey, KT17 2HS

Pharmacy reference: 1036549

Type of pharmacy: Community

Date of inspection: 25/01/2024

Pharmacy context

This NHS community pharmacy is set on a shopping parade in Stoneleigh. 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 Community Pharmacist Consultation Scheme (CPCS) 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 coronavirus booster, 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	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 generally manages its risks appropriately. It has written instructions to help its team members work safely. It largely 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 talk to each other about the mistakes they make to try to 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 recently. Members of the pharmacy team were required 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 also described within the SOPs. And a notice in the pharmacy told people who the responsible pharmacist (RP) was at that time. 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 the pharmacist. The team members responsible for making up people's prescriptions tried to keep the dispensing and checking 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 by the RP who also initialled the dispensing label. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). Members of the pharmacy team 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 talked to one another about the mistakes they made to try to stop the same things happening again. But they could do more to make sure they always recorded and reviewed their near misses to help them spot patterns in the mistakes they made so they could strengthen their dispensing process further.

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. The pharmacy kept appropriate records to show which pharmacist was the RP and when. It had a CD register which was largely maintained as it should be. But its team didn't check the stock levels in the CD register as often as the SOPs asked them to be. The pharmacy kept appropriate records for the supplies of the unlicensed medicinal products it made. And it required its team to record the

emergency supplies it made and the private prescriptions it supplied on its computer. But the pharmacy team was reminded that it needed to make an appropriate record when a prescription-only medicine (POM) was supplied to a person in emergency including requests for an urgent supply of a medicine through the CPCS. The pharmacy team gave an assurance that these records would be maintained 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 had an information governance policy. It displayed a notice that told people how it gathered, used and shared their personal information. And it had arrangements to make sure confidential information was stored and disposed of securely. 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 policy. And its team was asked to complete safeguarding training. Members of the pharmacy team also had access to safeguarding guidance and resources through the 'NHS Safeguarding' mobile phone application. And they 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 ✔ Standards met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. And they work well together and use their judgement to make decisions about what is right for the people they care for. 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

People who worked at the pharmacy needed to complete mandatory training during their employment. And they were required to undertake accredited training relevant to their roles after completing a probationary period. The pharmacy team consisted of a full-time pharmacist (the RP), a part-time pharmacist, two dispensing assistants, a medicines counter assistant and a delivery driver. And a trainee dispensing assistant from a neighbouring pharmacy usually covered the team's lunch break. The pharmacy depended upon its team and team members from one of the company's other pharmacies to cover absences. The people working at the pharmacy during the inspection included the RP and two dispensing assistants. And the RP helped with the day-to-day management of the pharmacy and its team. The pharmacy had seen an increase in its dispensing volume since the last inspection. But the pharmacy team was up to date with the workload. Members of the pharmacy team worked well together. They helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they didn't feel they were asked to do things that stopped them from making decisions that kept people safe. 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 discussed their development needs with their manager when they could. They were encouraged to ask questions and keep their knowledge up to date by completing training. They were sometimes too busy to train while they were at work. But they could choose to train in their own time. The pharmacy had meetings as well as one-to-one discussions to update its team and share learning. The pharmacy team was comfortable about making suggestions on how to improve the pharmacy and its services. Team members knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback led to an additional refrigerator being bought for the pharmacy.

Principle 3 - Premises ✔ Good practice

Summary findings

The pharmacy is bright, clean and modern. 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 premises were air-conditioned, bright, clean, modern and secure. 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 three consulting rooms, a counter, a dispensary, a kitchenette, a retail area, a stockroom and toilets. It had the workbench and storage space it needed for its current workload. And an additional entrance was installed to help people access its coronavirus vaccination service more easily. The consulting rooms were available for services that needed one or if someone needed to speak to a team member in private. They were usually locked when they weren't being used. So, their contents were kept secure. And people's conversations in them couldn't be overheard outside of them. 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 usually 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 notice that told people when it was open, and a digital display in one of its windows told people about its flu jab service. And it had a seating area for people to use if they wanted to wait in the pharmacy. The pharmacy team asked people who were prescribed a new medicine if they wanted to speak to the pharmacist about it. The pharmacy dealt with CPCS 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 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 people who couldn't attend its premises in person. And it kept a record to show the right medicine was delivered to the right person. The pharmacy had, until recently, provided coronavirus boosters. And these were administered under the relevant national protocol. A specified registered healthcare professional completed the stages of the national protocol they needed to. The national protocol afforded the pharmacy some flexibility in arranging vaccinators to be on-site to deliver the service if needed. But the patient group direction (PGD) could also be used if the coronavirus booster was solely provided by a pharmacist. And flu jabs and travel vaccines were administered by a pharmacist under the appropriate PGD. The pharmacy had the anaphylaxis resources it needed for its vaccination services. And the vaccinators were appropriately trained to vaccinate people. 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 pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. It kept an audit trail of the people who had assembled and checked each compliance pack. And an assessment was done to determine if a person needed a compliance pack, and the suitability to re-package a medicine was also checked. The compliance pack had a brief description of each medicine contained within it. And patient information leaflets were usually 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. But its team could do more to make sure assembled CD prescriptions awaiting collection were marked with the date the 28-day legal limit would be reached 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 new 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. It kept most of its medicines and medical devices within their original manufacturer's packaging. But a few opened packets of medicines containing stock from different batches and manufactures that were found during the inspection were quarantined. 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 usually recorded to show they had done so. 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 an appropriate temperature. It stored its CDs, which weren't exempt from safe custody requirements, securely. And its team recorded the destruction of the CDs that people returned to it. 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. But the pharmacy didn't have a pharmaceutical waste bin for any hazardous waste that was returned to it. The pharmacy had a process for dealing with 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 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 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 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 measuring a person's blood pressure. And these appeared to be well maintained with contact details available for servicing when required. 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.