General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Anachem Pharmacy, 210 Chessington Road, West Ewell, EPSOM, Surrey, KT19 9XA

Pharmacy reference: 1036553

Type of pharmacy: Community

Date of inspection: 11/11/2022

Pharmacy context

This is an NHS community pharmacy on a small row of shops in a residential area of West Ewell. 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 multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. It provides a substance misuse treatment service. And people can get a flu jab (vaccination) at the pharmacy too.

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 appropriately manages its risks. It has written instructions to help its team members work 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 review and talk to each other about the mistakes they make. So, they can learn from them and try to stop the same sort of things happening again.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. And an assurance was given that the SOPs would be reviewed following the inspection as most of them 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 agreed to follow them. Members of the pharmacy team responsible for making up people's prescriptions kept the dispensing and checking workstation 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 the responsible pharmacist (RP). The pharmacy team separated a few medicines which 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. The pharmacy had processes to deal with dispensing mistakes that were found before reaching a person (near misses) and those which hadn't (dispensing errors). And its team members discussed, documented and occasionally reviewed the mistakes they made to learn from them and reduce the chances of them happening again.

The pharmacy had 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 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. People shared their experiences of using the pharmacy and its services online. The pharmacy had a complaints procedure. It had leaflets which 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. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had a controlled drug (CD) register. And the stock levels recorded in this register were checked regularly. The pharmacy kept appropriate records of the supplies of the unlicensed medicinal products it made. It had a record to show which pharmacist was the RP and when. And it recorded the emergency supplies it made and the private prescriptions it supplied on its computer. But the prescriber details were sometimes incomplete in the private prescription records and the reason for making an emergency supply wasn't always recorded properly.

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. And it had an information governance policy which its team needed to read. The pharmacy had a safeguarding policy and procedure. 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 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 regular pharmacy team consisted of a pharmacist manager, a part-time pharmacist, a full-time dispensing assistant, a part-time dispensing assistant, two part-time medicines counter assistants and two part-time delivery drivers. The part-time pharmacist (the RP) and a dispensing assistant were working at the time of the inspection. The pharmacy relied upon its team, locum pharmacists and staff from the company's other pharmacy to cover absences or provide additional support when the pharmacy was busy. Members of the pharmacy team have worked at the pharmacy for several years. They have all completed accredited training relevant to their roles. And they 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 discussed their performance and development needs with the pharmacist manager when they could. They could share learning from the mistakes they made during team meetings. And they were encouraged to train 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. The pharmacy had a whistleblowing policy. 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 their feedback led to the installation of a retractable barrier and a plastic screen during the coronavirus pandemic.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate environment to deliver it services from. And people can receive services in private when they need to. But members of the pharmacy team don’t always have the space they need to work in when it’s busy.

Inspector's evidence

The pharmacy had a consulting room if people needed to speak to a team member in private. The pharmacy was air-conditioned, bright, clean and appropriately presented. But its dispensary was small. It had limited workbench and storage space available. And its dispensing worksurfaces could become cluttered when the pharmacy was busy. So, some prescriptions were assembled in the consultation room. And excess stock and bulky prescriptions were often stored in an outbuilding which wasn’t air-conditioned. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water. But the tap in the dispensary needed descaling. Members of the pharmacy team were responsible for keeping the premises clean and tidy. And they 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 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 step-free access and the entrance to its consulting room was narrow. These things made it harder for some people, such as those who used a wheelchair or a mobility scooter, to enter the building and access some services. So, members of the pharmacy team remained alert to make sure they could help these people use the pharmacy's services. And, for example, the pharmacy had a portable ramp that could be put out for people to use when needed. The pharmacy had some notices 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 keep people 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. But its delivery team didn't routinely ask people to sign to say they had received their medicines as required by the SOPs. The pharmacy had the anaphylaxis resources and the patient group directions it needed for its flu jab service. And the pharmacists 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 pharmacist generally asked another team member to check that the correct vaccine had been selected before administering it. The pharmacy provided substance misuse treatments and a needle exchange service. The pharmacist could supervise the consumption of some substance misuse clients' treatments. And the pharmacy team asked needle exchange clients to return spent sharps within the containers provided and deposit these into a designated receptacle. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked if a medicine was suitable to be re-packaged. And the pharmacist assessed whether a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. It provided a brief description of each medicine contained within the compliance packs. And patient information leaflets were supplied. So, people had the information they needed to make sure they took their medicines safely. 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. 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 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 and recorded when they had done these. 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. 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 an appropriate pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And a team member described the actions they took and demonstrated what records they made when a drug alert was received.

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 Numark for information and guidance too. 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 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.