General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pearl Chemist, 127 High Street, EPSOM, Surrey, KT19 8EF

Pharmacy reference: 1036557

Type of pharmacy: Community

Date of inspection: 20/02/2024

Pharmacy context

This NHS community pharmacy is set in a pedestrianised area of Epsom town centre. The pharmacy is part of a chain of pharmacies. It 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	2.2	Good practice	The pharmacy provides its team members with the training and support they need. And it actively encourages them to improve their skills.
		2.4	Good practice	Members of the pharmacy team work well together and have a work culture of openness, honesty and learning.
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

Members of the pharmacy team knew what to do if the pharmacy needed to close. They understood what they should do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had standard operating procedures (SOPs) for the services it provided. But they were due to be reviewed soon. A notice in the pharmacy told people who the responsible pharmacist (RP) was at that time. Team members were required to read and sign the SOPs to show they understood them and agreed to follow them. They knew what they could and couldn't do, what they were responsible for and when they might seek help. 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 who were responsible for making up people's prescriptions 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 the RP. The pharmacy had reviewed its dispensing process. And most people's repeat prescriptions and compliance packs were now assembled offsite by one of the company's hub pharmacies. But only when people agreed to this happening first. This meant the pharmacy team could spend more time talking to people about their medicines or deliver other services. 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 the safety and the quality of its services were monitored monthly. 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 of the dispensing service they provided. And, for example, they 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.

The pharmacy had a complaints procedure. And some people have left online reviews about their experiences of using the pharmacy and its services. 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 had a computerised controlled drug (CD) register which was

maintained as it should be. And its team checked the stock levels in the CD register regularly. The pharmacy kept records to show which pharmacist was the RP and when. But the pharmacist didn't always record the time they stopped being the RP. 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 incomplete in a few of the private prescription records seen. And sometimes the reason for making a supply of a prescription-only medicine to a person in an emergency wasn't recorded properly. The RP 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 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 it asks them to give feedback. Members of the pharmacy team work well together and have a work culture of openness, honesty and learning. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets. The pharmacy provides its team members with the training and support they need. It actively encourages them to improve their skills. And its team makes appropriate decisions about what is right for the people it cares for.

Inspector's evidence

The pharmacy team consisted of a regular pharmacist (the RP), five dispensing assistants, a trainee dispensing assistant, two trainee medicines counter assistants (MCAs) and a delivery driver. The people working at the pharmacy during the inspection included the RP, four dispensing assistants and a trainee MCA. The pharmacy depended upon its team and locum pharmacists to cover absences. But team members from one of the company's other branches could provide cover too. Members of the pharmacy team were mostly up to date with their workload. They worked well together and helped each other so people were served quickly, and prescriptions could be dispensed safely. The RP managed the pharmacy and its team. They led by example. And 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. The pharmacy had an induction training programme for its team. Members of the pharmacy team needed to complete mandatory training during their employment. They were required to undertake accredited training relevant to their roles after completing a probationary period. They regularly discussed how they were doing and their development needs with their manager. And, for example, some of the dispensing assistants had completed appropriate training and were authorised under a national protocol to administer covid boosters and flu jabs to people. Team members could ask questions, read updates or newsletters from head office and familiarise themselves with new products. They kept their knowledge up to date by completing online training. They were encouraged and supported to train while they were at work. But they could choose to train in their own time if they preferred. 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 team meetings. This meant it could improve the safety of the services it offered. People who worked at the pharmacy didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback led them to review and strengthen their process for filing assembled prescriptions.

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.

Inspector's evidence

The pharmacy was located within a listed building and was subject to strict planning conditions. And this made it difficult for the pharmacy owner to make improvements to the pharmacy's layout and workflow. The pharmacy had a consulting room, a counter, a dispensary, a retail area, a staffroom and a toilet. It also had several rooms upstairs. And though some of these rooms were used as stockrooms, most weren’t used at all. The pharmacy was tidy. And its public-facing area was air-conditioned, bright and adequately presented. The dispensary was narrow. Its fixtures were dated and worn. And it had limited workspace and storage available. But its floor and dispensing benches were uncluttered. The consulting room could be used when people wanted to talk to a team member in private. And people’s conversations in it couldn’t be overheard outside of it. But it couldn’t be locked. So, the pharmacy team needed to make sure its contents were kept secure when it wasn’t being used. The pharmacy had a contract with a pest control company to deal with any unwanted pests. And its team was responsible for keeping the premises clean and tidy. The pharmacy had the sinks it needed for the services it provided. It only had a supply of cold water at the time of the inspection as the water heater wasn’t working. But an assurance was given that this would be addressed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are generally safe and effective. Its team is friendly and helps people access the services they need. And it keeps adequate 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 stores them appropriately and securely. 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.

Inspector's evidence

The pharmacy didn't have an automated door. And its entrance wasn't level with the outside pavement. But it had a portable ramp that could be placed outside. And a member of the pharmacy team would open the door when necessary. So, people with mobility difficulties, such as wheelchair users, could access the pharmacy. The pharmacy had some notices that told people when it was open and what services it offered. It had a small 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 Pharmacy First 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 some minor illnesses. Members of the pharmacy team were friendly and helpful. And they took the time to listen to people. So, they could help and advise them, and signpost them 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 an electronic record to show the right medicine was delivered to the right person. The pharmacy had, until recently, provided NHS coronavirus boosters. And these boosters and NHS flu jabs 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 or flu jab was solely provided by a pharmacist. And private 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 service. 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 hub pharmacy to assemble most of its repeat prescriptions. It also used another hub pharmacy to dispense people's medicines into disposable and tamper-evident compliance packs. The pharmacy team was responsible for the accuracy of the data entered into the computer for prescriptions dispensed at each hub pharmacy. And the pharmacist needed to make sure the prescription was clinically appropriate too. The pharmacy team told people that their prescription may be sent to another pharmacy to be made up. And the assembled prescriptions were returned to the pharmacy for the team to hand out or deliver. The pharmacy team checked whether a medicine was suitable to be re-packaged. And an assessment was done to decide if a person needed a compliance pack. The pharmacy kept an audit trail of the people involved in the assembly of each compliance pack. And a brief description and a photograph of each medicine was printed next to the medicine's name. This made it easier for people to tell what medicine they were

taking. But the compliance pack didn't make it clear that it had been assembled elsewhere. And patient information leaflets weren't always supplied. So, sometimes people didn't have all the information they needed to take their medicines safely. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. The pharmacy used reminder stickers to alert its team when these items needed to be added or if extra counselling was needed. But a few assembled CD prescriptions awaiting collection had expired. So, these were quarantined during the inspection to prevent them being handed out by mistake. 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. And it kept its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team usually 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 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. 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 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 two refrigerators 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 Pharmacy First service as well as for measuring a person's blood pressure. 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.