General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pyramid Pharmacy, 19-21 Station Parade, Kew, RICHMOND, Surrey, TW9 3PS

Pharmacy reference: 1036716

Type of pharmacy: Community

Date of inspection: 23/11/2023

Pharmacy context

This is a community pharmacy in the centre of Kew. The pharmacy provides a range of services including dispensing prescriptions. And supplying medicines in multi-compartment compliance packs for people living at home who need them. It has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a core range of other services, including a medicines delivery service and a Flu vaccination service.

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 has suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it generally completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy adequately identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The pharmacy risk assessed its services. And it provided non-essential services when the workload allowed and when it had enough support staff available to support the pharmacist. The pharmacy had systems in place for recording its mistakes. The responsible pharmacist (RP) described how he highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. He did this to help prevent the same mistake from happening again. The team had been made aware of the risk of confusion between look-alike sound-alike medicines (LASAs). And it recognised that mistakes could occur between them. These included medicines such as such as citalopram 10mg and citalopram 20mg. The team also described how it gave two different brands of a medicine if two different strengths of the same medicine were prescribed at the same time to the same person. This way each strength was supplied in different packaging. And this helped prevent people from being confused as to which one they had taken. The team was aware that when they were dispensing a LASA it should prompt an additional check of the item they were selecting. The team usually recorded its mistakes, and it discussed them. But the records seen did not show what team members had learned or what they would do differently next time. So that they could prevent the same or a similar mistake. The RP reviewed the records periodically. He agreed that if the team had more details of what it had learned from its mistakes, along with more frequent reviews, he could monitor them more effectively. He agreed that this would provide team members with a better opportunity to learn. And it would allow them to identify steps in their dispensing procedures which would help avoid mistakes in future. And any other follow up actions which would lead to ongoing improvement.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) for its team members to follow. Team members understood their roles and responsibilities. And they had all read the SOPs. Although they had yet to sign them. The apprentice medicines counter assistant (MCA) had been trained on the procedures to follow when selling pharmacy medicines and general items. And when handing out people's prescriptions. She consulted the pharmacist and her other colleagues regularly when she needed their advice and expertise. And she asked people appropriate questions about their symptoms and any other medicines they were taking. She did this to ensure that the medicines she sold to people were right for them. And when appropriate, to help the pharmacist decide on the best course of action for them. The dispensing assistants (DA)s consulted the RP when they needed his advice and expertise. And they accessed, used and updated the pharmacy's electronic records competently. The RP had placed his RP notice on display showing his name and registration number as required by law.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy had a complaints procedure to follow. And the team knew how to provide

people with details of where they should register a complaint if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. The RP commented that, at times, people were unhappy that their prescription had not arrived or that their medicines were not ready or available. These issues were often out of the pharmacy's control, as the problem often arose with medicines which were unavailable from the manufacturer. But, to help the situation, the team chased prescriptions up when they could. And when they could they also called the surgery to arrange for alternatives when they received a prescription for an item that they could not get. But when work pressures meant that they did not have time to do this they returned people's prescriptions so that they could be supplied from another pharmacy which had the stock. Or so that people could go back to their GP themselves for an alternative. The pharmacy also tried to keep people's preferred brands of medicines in stock so that their medicines were available for them when they needed them. The apprentice MCA was observed handling people's queries well. And her colleagues stepped in unprompted to support her when needed. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy generally kept its records in the way it was meant to, including its private prescription records. It had a controlled drug (CD) destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. This was complete and up to date. The pharmacy generally kept its controlled drugs (CD) register properly. And it kept a record of its CD running balances. And random sample of CD stock checked by the inspector matched the running balance total in the CD register. But the RP recognised that its processes for audit required review. The pharmacy's records for emergency supply were generally in order. But they did not all give a clear reason for making the supply. And the pharmacy had yet to receive several prescriptions for emergency supplies requested by a prescriber. Its RP records also had several gaps where RPs had not signed out at the end of their shift. After discussing record keeping with the RP, it was clear that he understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They shredded confidential paper waste throughout the day, as they worked. And the team generally kept people's personal information, including their prescription details, out of public view. But some completed prescriptions stored next to the medicines counter could be viewed by people standing on the other side of the counter. The RP agreed to review this. The RP had completed appropriate training on safeguarding vulnerable adults and children. And team members had been briefed. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. But it had not had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained and skilled team members for the tasks it carries out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's service

Inspector's evidence

On the day of the inspection the RP worked with two DAs, and the apprentice MCA. One of the DAs was due to leave at the end of the month, so a recruitment process was under way. The pharmacy also had a delivery driver which it shared with another pharmacy owned by the same company. The team had the daily workload of prescriptions in hand. And team members attended promptly to people at the counter. They appeared to work closely with one another. And they supported one another, assisting each other when required. The team tried hard to keep on top of its other tasks. And they generally managed to achieve this. The RP and DAs assisted the trainee MCA when needed. Without being asked. And together they dealt with queries promptly.

Team members did not have formal meetings or appraisals about their work performance. But they had discussions with the RP as they worked. And if necessary, they could have a one-to-one with him or the Superintendent pharmacist (SI) to raise concerns or receive feedback. The RP felt he could make day-to-day professional decisions in the interest of patients. And he could discuss his concerns with the SI if he needed to. Team members felt supported in their work. And the RP was not under pressure to meet business or professional targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an environment which is suitable for people to receive its services. And they are sufficiently clean, tidy and secure.

Inspector's evidence

The pharmacy was in the centre of Kew, on a parade of local shops and businesses. It was relatively spacious. And it had seating for waiting customers. It also had a consultation room and a medicines counter, behind which it kept its pharmacy medicines. The pharmacy's dispensary was in the downstairs basement. And it used a 'dumbwaiter' lift system to transfer prescriptions and messages between the dispensary and counter. Prescriptions were generally labelled and dispensed in the downstairs dispensary. Walk in prescriptions were transferred downstairs via the lift. The pharmacist would then check them either upstairs or downstairs depending on where he was at the time. Once dispensed and checked, prescriptions were passed back up in the lift where they were bagged and stored ready for collection. Those awaiting delivery were stored separately downstairs.
The dispensary had dispensing benches on three sides which were used for most of the pharmacy's dispensing activities. And it had storage facilities above and below the benches. The pharmacy's worksurfaces and floors were generally free of unnecessary clutter. The consultation room was located off the shop floor to the side of the chemist counter and could be easily accessed from the counter. The door to the consultation room was often open when not in use to make it welcoming to customers and to promote its use. Patient confidential information had been stored out of sight in locked cupboards in the room to prevent unauthorised access. The team had a regular cleaning routine. It cleaned its work surfaces and contact points daily. And it cleaned its floors weekly. The team also had hand sanitiser for team members and people to use. The pharmacy also had a stock storage room and staff area in the basement. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. And it ensures that it supplies its medicines with the information that people need to take their medicines properly. The pharmacy team gets its medicines and medical devices from appropriate sources. And in general, it stores them correctly. Team members make the necessary checks to ensure medicines are safe to use and protect people's health and wellbeing.

Inspector's evidence

The pharmacy had a step up to its entrance. But team members could see people outside and would go out to help anyone who had difficulty getting up the step and in the door. Once inside, the pharmacy's customer area was free of unnecessary obstacles. The team could order people's repeat prescriptions for them if required and if they found it difficult to visit the pharmacy or surgery. And it had a delivery service. It used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. It labelled the packs with a description of each medicine, including colour and shape, to help people, including other healthcare professionals, to identify them. And it supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. But some packs did not have the required advisory information to help people take their medicines properly. The team agreed with the inspector that it was important to ensure that people had all the information they needed about their medicines. The pharmacist gave people advice on a range of matters. And he would give appropriate advice to anyone taking higher-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP described how he would counsel at-risk people when supplying the medicine to ensure that they were on a pregnancy prevention programme. The pharmacy also knew to supply the medicine in the appropriate manufacturer's pack with patient cards and information leaflets each time.

The pharmacy offered a hypertension case finding service. The RP had referred several people to their GPs following a high blood pressure reading. The pharmacy also provided a flu vaccination service under both a private and the NHS protocols. And it kept appropriate records. People identified as not suitable for the service had been referred to another healthcare professional where appropriate. The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And it generally stored its medicines appropriately. But it had a box of levothyroxine on its shelves which contained mixed brands of the same medicine. This meant that the details on the packaging did not fully reflect the contents. And while this did not present a high risk of error, it may mean that the contents could be missed if subject to a recall or an expiry date check. Stock on the shelves and in drawers was tidy and organised. The pharmacy checked the expiry dates on all stock items approximately every 12 weeks. And it kept records. The team identified and highlighted any short-dated items. And it removed any items with a less than a two-to-three-month expiry date from stock. It only dispensed them with the patient's agreement where they could use them before their expiry dates. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a

random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures daily. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's confidential information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And team members had access to a range of up-to-date reference sources. The pharmacy had two patient medication record (PMR) computer terminals in the dispensary. And one on the upstairs counter. It had a further non-PMR computer in the consultation rooms. It used this for its non-prescription services. Computers were password protected. Team members had their own smart cards. But occasionally they shared each other's. The inspector and team members discussed the importance of using their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in shelves which were out of people's view.

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.