General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pearl Chemist, 151 Cannon Hill Lane, LONDON, SW20 9BZ

Pharmacy reference: 1041260

Type of pharmacy: Community

Date of inspection: 20/08/2024

Pharmacy context

This pharmacy is part of a locally owned group of pharmacies. It is in a residential area of South London, between Morden and Raynes Park. It dispenses people's prescriptions, sells over-the-counter medicines and offers healthcare advice. It provides a range of other NHS services and delivers medicines to people who can't get to the pharmacy themselves.

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	There are regular checks and audits carried out by the Clinical Governance lead, to make sure the pharmacy's team members are following the correct procedures.
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 provides its services in line with clear, up-to-date written instructions for its team members to follow when completing their tasks. Team members are clear about their roles and responsibilities. And they work to professional standards, identifying and managing risks effectively. The pharmacy keeps suitable records of the mistakes that happen during the dispensing process. The pharmacy team regularly reviews them so that they can learn from them and avoid problems being repeated. The pharmacy manages and protects confidential information well and tells people how their private information will be used. Team members understand their role in helping to protect the welfare of vulnerable people. The pharmacy has appropriate insurance in place to help protect people if things do go wrong.

Inspector's evidence

There were online standard operating procedures (SOPs) which had been signed by all staff to say that they had read and understood them. Each individual team member had their own signature sheet to show all the SOPs they had signed. There was a notice from the superintendent confirming that all SOPs were still valid, and that they were currently being reviewed with an anticipated completion date of September 2024. There was a superintendent audit checklist which had been completed to show that the pharmacy team was following all the company's procedures. The company's clinical governance lead visited the pharmacy twice a year to complete the audit. They also completed a quarterly risk assessment of the pharmacy overall to help ensure 'patient and staff safety are maintained at all times.' The risk assessment folder also contained a separate risk assessment carried out to ensure the pharmacy was ready to start offering the recently introduced Pharmacy First service. There was a written business continuity plan to help team members maintain services in the event of a power failure or other major problem. They also knew how to contact the owner or superintendent pharmacist (SI) if they needed to. There was a signposting log where team members kept a record whenever they signposted someone to another service provider locally. Examples included the St Helier Hospital and local GPs.

Records of errors (those mistakes discovered after the medicines had been handed out to people) and near miss mistakes (those discovered while still in the pharmacy) were kept in a plastic sleeve on the clinical governance board. These included a reason for the error but there was no space for any learnings on the form itself. But the RP held monthly patient safety meetings during which they discussed any incidents, what had been learned and how they might be prevented in future. They kept records of those meetings and submitted them as their monthly patient safety report. Some medicines had been identified as being prone to error, such as 'look alike sound alike' (LASAs) medicines such as the different strengths of Symbicort Turbohalers. There were labels, with a red triangle, on the shelves highlighting these items among others, so that team members knew to take extra care when selecting them.

Roles and responsibilities of staff were documented in a matrix on the clinical governance board, setting out their key tasks. Those questioned were able to clearly explain what they do, what they were responsible for and when they might seek help. They outlined their roles within the pharmacy and where responsibility lay for different activities. Staff were able to describe what action they would take in the absence of the responsible pharmacist, and they explained what they could and could not do.

The responsible pharmacist (RP) notice was clearly displayed for people to see, and the online RP record was complete.

The pharmacy's complaints procedure was on the clinical governance board for the team to access. This was also set out in the pharmacy practice leaflets on display for people to take, advising them of the process to follow if they wanted to make a complaint in accordance with NHS requirements. A certificate of professional indemnity and public liability insurance, valid until November 2024, was on display in the dispensary.

Private prescription records and emergency supply records were maintained on the patient medication record (PMR) system and were complete with the required details correctly recorded. Records of unlicensed 'specials' were seen, and all of those examined were found to be correct and complete.

The online CD register was seen to be correctly maintained, with all running balances checked at regular monthly intervals in accordance with the relevant SOP. The RP confirmed that there had been no discrepancies. The records of unwanted CDs returned by people for safe disposal were complete. Paper records were in use until May 2024 when the pharmacy transferred to an online record. There were two denaturing kits available, and the RP indicated that he could easily obtain more, or bigger ones, if needed.

Those team members questioned were able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. They had all signed confidentiality agreements and were able to provide examples of how they protect patient confidentiality, for example checking people's identity before discussing their medication, or inviting them into the consulting room when discussing sensitive information. There was a privacy notice and a chaperone policy on consulting room door. Completed prescriptions were stored at the rear of the dispensary where they could not be seen by people waiting. Confidential waste was kept separate from general waste and shredded offsite.

There were safeguarding procedures in place and contact details of local referring agencies were seen in a clear plastic sleeve on the clinical governance board. The pharmacist had completed level 2 safeguarding training, and most of the team had been trained to the equivalent of level 1 so that they could recognise potential safeguarding risks. There were certificates on display to show who had completed the safeguarding training. All staff were either dementia friends, or undergoing the necessary training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are well-trained and have a clear understanding of their roles and responsibilities. They are well motivated, work effectively together and can make suggestions to improve safety and workflows where appropriate.

Inspector's evidence

There was one dispensing assistant, two medicines counter assistants (MCAs) and the RP on duty during the inspection. This appeared to be appropriate for the workload and everyone was working well together. There was a staff skill set matrix on the clinical governance board. This set out the hourly staffing cover for each day, highlighting the key responsibilities for each person on duty to make sure there was sufficient cover at all times. In the event of staff shortages, part-time staff could adjust their working hours to provide additional cover. The RP added that he could also call upon help from a neighbouring pharmacy branch if necessary. There was a locum folder on the clinical governance board to provide important information about the operation of the pharmacy to those who may be unfamiliar with the pharmacy.

There were staff folders for each team member showing details of their induction, their training certificates and some of the staff policies they were required to sign. Examples of certificates seen included ‘data security awareness’ ‘dementia friends’, ‘introduction to safeguarding’, ‘introduction to health and safety’, ‘risk assessment awareness’ as well as the required accredited training. Some of this was also a requirement of the pharmacy quality scheme (PQS). Twice yearly performance reviews were carried out for each team member. There was a notice on display highlighting the pharmacy’s whistleblowing policy.

Those staff members questioned were able to demonstrate an awareness of potential medicines abuse and could identify patients making repeat purchases. They described how they would refer to the pharmacist if necessary. All staff were seen to serve customers and asking appropriate questions when responding to requests or selling medicines. There was no pressure to achieve specific targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a secure and professional environment for people to receive its services. The team keeps them clean and tidy, presenting a suitably professional image. The premises include a private room which the team uses for some of its services and for private conversations.

Inspector's evidence

The pharmacy premises were clean, tidy and in a reasonable state of repair with step-free access via an automatic door to the street. The retail area was well laid out with sufficient space for wheelchair users. The dispensary was at the rear, behind the medicines counter. There was one main workstation with the pharmacy's patient medication record (PMR) computer system. There were other workbenches providing sufficient space for the team to work safely and effectively. There was a clear workflow in the dispensary and the layout was suitable for the activities undertaken. There was a printed cleaning rota in place.

There was a clearly signposted consultation room available for confidential conversations, consultations and the provision of services. The door to the consultation room was kept closed but not locked when not in use, but there was no confidential information visible. The dispensary sink had hot and cold running water. There was handwash available. Room temperatures were appropriately maintained by a combined air-conditioning and heating unit, keeping staff comfortable and suitable for the storage of medicines. The pharmacy kept a record of the daily maximum and minimum temperatures in addition to the current room temperature.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, and people with a range of needs can access them. It sources, stores and manages its medicines safely, and so makes sure that all the medicines it supplies are fit for purpose. And it keeps suitable records of what it does, as required by law. The pharmacy's team appropriately identifies people supplied with high-risk medicines who may benefit from being offered extra information to help them take their medicines safely. The pharmacy responds well to drug alerts or product recalls to make sure that people only get medicines or devices which are safe for them to take.

Inspector's evidence

The pharmacy was providing a range of NHS services including the Pharmacy First service, the New Medicine Service (NMS) and seasonal flu vaccinations. The pharmacy also offered free deliveries to people who couldn't visit the pharmacy in person. There were some posters and leaflets on display telling people about the pharmacy's services.

Controls were seen to be in place to reduce the risk of picking errors, such as the use of baskets to keep individual prescriptions separate. Prescription labels were initialled to show who had dispensed and checked each item as an audit trail of each step in the dispensing process. Owings tickets were used if the pharmacy was unable to supply the entire prescription. The prescription was kept in the owings box until the stock arrived. In the event of being unable to obtain any items, they contacted their other local branches to see if they had any stock before contacting the GP for an alternative.

Completed prescriptions for CDs were highlighted so that staff would know that they needed to look for a bag in the CD cupboard. Uncollected schedule 3 and 4 CDs were also highlighted to ensure they weren't handed out after their expiry date. The RP explained that they checked the retrieval shelves every week and that any prescriptions that had remained uncollected for more than two months, or CDs for more than 28 days, were removed and details recorded with a reminder being sent to people. Any expired EPS tokens were returned to the NHS spine. Fridge lines in retrieval awaiting collection were also highlighted so that staff would know that there were items to be collected from the fridge.

Most prescriptions for whole packs, and for multi-compartment compliance aids were now dispensed in the company's hub. The RP described how they dispensed any acute or interim prescriptions for people whose regular medicines were normally supplied in compliance aids. The RP completed the necessary clinical checks and initial processing before sending the prescriptions to the hub for assembly. The PMR system enabled the RP to see how each prescription was progressing through their system, so they knew when to expect the completed prescription back. There was a file for managing their compliance aid service, to make sure prescriptions were ordered on time and dispensed before people ran out of any medicine. Any discrepancies were followed up with the surgery and assembly only started when they had prescriptions for all the required items. The final accuracy check was carried out at the hub.

Staff were aware of the risks involved in dispensing valproates to women who could become pregnant. The RP confirmed that they didn't currently supply any valproates to women in the at-risk group. He confirmed that they had the necessary information leaflets available, that they dispensed complete original packs, and that they didn't obscure any warnings with their dispensing labels. The RP was

advised to record any interventions on the PMR system. That also included any interventions relating to other high-risk medicines such as lithium or methotrexate, and associated blood tests.

Deliveries were made by the pharmacy's employed delivery drivers who kept appropriate records of each delivery using an online app. They obtained a signature upon delivery, and any failed deliveries were returned to the pharmacy. The app also enabled the pharmacy to track the driver so that they could give people an estimated delivery time if required.

The pharmacy received referrals from the NHS111 service and walk-ins for the Pharmacy First service. All the necessary records were completed on the Sonar online platform. This also included the treatment pathways, red flags and the Patient Group Directions (PGDs) necessary for supplying Prescription-Only Medicines (POMs).

The NHS contraception service was mostly for repeat supplies, although the pharmacy did initiate the supply in some instances. The RP explained how they simply followed the steps as laid out on Sonar, completing the necessary records as they progressed through the consultation. They would conduct a blood pressure check if necessary and then share the results with the person's GP.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance, Day Lewis. Unlicensed 'specials' were obtained from Alliance Specials. There was a date check matrix showing which sections of the pharmacy had been checked, when and who by, with those items due to expire in the next three months highlighted. due to expire within the next month were removed for safe disposal. No out-of-date stock was found. Opened bottles of liquid medicine were annotated with the date of opening. There were no plain cartons of stock seen on the shelves and no boxes were found to contain mixed batches of tablets or capsules.

Fridge temperatures were checked daily and records kept. All those records examined were found to indicate the correct temperature range. Pharmacy medicines were displayed behind clear Perspex screens on each shelf, preventing unauthorised access or self-selection of those medicines.

Patient-returned medicines were screened to ensure that any CDs would be appropriately recorded, and that there were no sharps present. Patients with sharps were signposted to the local council for disposal. The disposal bins were kept in a separate room away from other stock items. Denaturing kits for the safe disposal of CDs were available for use.

The pharmacy received drug alerts and recalls from the MHRA. They also kept a monthly drug alerts audits sheet in a clear plastic sleeve on the clinical governance board to keep track of those actioned. There was a record of what action had been taken, who by and when. The team knew what to do if they received damaged or faulty stock and they explained how they would return them to the wholesalers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has suitable equipment and facilities for the services it provides, and it makes sure that they are properly maintained. It also ensures that people's private information is kept safe and secure.

Inspector's evidence

The pharmacy had a set of crown-stamped cylindrical measures and suitable equipment for counting loose tablets and capsules. All the necessary equipment was available for the Pharmacy's services, including a blood pressure monitor and an otoscope. The consultation room was used for many of the pharmacy's services. The purchase date of the BP monitor was written on it.

All computer screens were positioned so that they were not visible to the public and were password protected. NHS smartcards were in use, and team members were using their own NHS smartcards. The pharmacy made use of online reference sources such as the electronic medicines compendium and the BNF.

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.