

# Registered pharmacy inspection report

**Pharmacy Name:** Central Pharmacy, 68 High Street, ESHER, Surrey,  
KT10 9QS

**Pharmacy reference:** 1087722

**Type of pharmacy:** Community

**Date of inspection:** 25/07/2019

## Pharmacy context

A community pharmacy set in a parade of shops in the centre of Esher. The pharmacy opens six days a week. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It provides multi-compartment compliance packs to help people take their medicines. It offers winter influenza (flu) vaccinations and a private travel clinic.

## Overall inspection outcome

✓ **Standards met**

**Required Action:** None

Follow this link to [find out what the inspections possible outcomes mean](#)

## Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy adequately monitors the safety of its services. It has appropriate insurance to protect people if things do go wrong. And it generally keeps all the records it needs to by law. But it could do more to make sure they're checked regularly. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They work to professional standards and identify and manage risks appropriately. And they keep people's private information safe. The pharmacy team logs and learns from the mistakes it makes. And it understands its role in protecting vulnerable people.

### Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place for the services it provided. And these were scheduled to be reviewed within the next month. The pharmacy's team members were required to read and sign the SOPs relevant to their roles.

The team members responsible for the dispensing process tried to keep the dispensing workstations tidy. They used plastic baskets to separate people's prescriptions and to help them prioritize the dispensing workload. The pharmacy had systems to record and review dispensing errors and near misses. The pharmacy's staff discussed and documented individual learning points when they identified a mistake. They reviewed their mistakes to help spot the cause of them. And they tried to stop them happening again; for example, they have strengthened the pharmacy's prescription handing-out process after a prescription was given to the wrong person.

The pharmacy displayed a notice that identified the responsible pharmacist (RP) on duty. Members of the pharmacy team explained what they could and couldn't do, what they were responsible for and when they might seek help; for example, a member of the pharmacy team explained that repeated requests for the same or similar products were referred to a pharmacist.

The pharmacy had a complaints process in place. And details on how people could provide feedback about it were included in its practice leaflet. Patient satisfaction surveys were undertaken annually. And the results of last year's survey were published online. Staff tried to keep people's preferred makes of medicines in stock when they were asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, through the National Pharmacy Association (NPA). The pharmacy's controlled drug (CD) register, its private prescription records and its 'specials' records were adequately maintained. The CD register's running balance wasn't checked regularly as required by the pharmacy's SOPs. The nature of the emergency wasn't included in the pharmacy's records for emergency supplies made at the request of patients. And the pharmacy team couldn't retrieve the pharmacy's records for emergency supplies at the request of practitioners.

An information governance policy was in place and the pharmacy team members were required to read and sign a confidentiality agreement. Prescriptions awaiting collection were stored in such a way to prevent people's details being visible to the public. Arrangements were in place for confidential waste to be collected and destroyed securely by a third-party company.

Safeguarding procedures were in place and key contacts for safeguarding concerns were available. The RP had completed level 2 safeguarding training. And staff could explain 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 staff to deliver its services safely. And it encourages its team to provide feedback and keep its knowledge up to date. The pharmacy team makes appropriate decisions about what is right for the people it cares for. Staff 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 pharmacy opened for 59 hours a week and it dispensed about 4,500 prescription items a month. The pharmacy team consisted of a full-time pharmacist (the RP), a part-time pharmacist, a full-time pre-registration pharmacist trainee, a full-time medicines counter assistant (MCA) and a full-time trainee MCA. There was a vacancy for a full-time dispensing assistant. The RP managed the pharmacy. He was the company's superintendent pharmacist. And he also provided the pharmacy's delivery service. The pharmacy relied upon its team, staff from the company's other pharmacy and locum staff to cover planned and unplanned absences. A pharmacy undergraduate student was scheduled to start at the pharmacy to provide additional dispensing support over the remainder of summer. The pharmacy team was required to complete or undertake accredited training relevant to their roles. The RP, the pre-registration pharmacist trainee, the MCA and a counter assistant from another branch were working at the time of the inspection.

Staff supported each other so prescriptions were processed in a timely manner and people were served promptly. The RP supervised and oversaw the supply of medicines and advice given by staff. A sales of medicines protocol was in place which the pharmacy team needed to follow. The MCA described the questions she would ask when making over-the-counter recommendations and when she would refer people to a pharmacist; for example, requests for treatments for animals, infants, people who were pregnant, elderly people or people with long-term health conditions.

Staff discussed their performance and development needs with the RP. Members of the pharmacy team were encouraged to ask the pharmacist questions, familiarise themselves with new products, complete their accredited training and read through training materials provided by third-party companies to keep their knowledge up to date. They sometimes got time to train while they were at work when the pharmacy wasn't busy. But they could train in their own time if they wanted to. Team meetings were held to update staff and share learning from mistakes or concerns. Staff unable to attend these meetings were updated during one-to-one discussions. Members of the pharmacy team felt comfortable in providing suggestions about the pharmacy during team meetings. And they knew how to raise a concern if they had one. Their feedback led to changes to the way the pharmacy managed its prescription owing process. The company didn't set targets nor incentives for its staff.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare.

### Inspector's evidence

The pharmacy was recently refurbished. And it had a consultation room if people needed to speak to a team member in private. Its dispensary was enlarged. So, it had the storage and workspace it needed for its current workload. It was bright, clean, air-conditioned and professionally presented. But some areas of flooring in the dispensary and the consultation room were unfinished.

The pharmacy team was responsible for keeping the premises clean and tidy. The pharmacy's sinks were clean. The sink in the consultation room wasn't working. But the pharmacy had a supply of hot and cold water. And it had appropriate handwashing facilities for its staff.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's working practices are safe and effective. It provides services that people can access easily. And it gets its medicines from reputable sources and it stores them appropriately and securely. The pharmacy's team members check stocks of medicines to make sure they are fit for purpose. They generally dispose of people's waste medicines safely too. But they could do more to make sure people have all the information they need to take their medicines safely.

### Inspector's evidence

There was no automated door into the pharmacy. But its entrance was level with the outside pavement and staff would open the door when necessary. So, people with mobility difficulties, such as wheelchair users, could access the premises. The pharmacy's services were advertised in-store. Staff were helpful and knew where to signpost people to if a service was not provided.

The pharmacy provided a delivery service to a few people who couldn't attend its premises in person. But it didn't keep an audit trail of each delivery as required by the pharmacy's SOPs. The pharmacy provided about two Medicine Use Reviews a month. But it didn't provide many New Medicine Service consultations. The pharmacy offered a winter flu vaccination service. Some people chose to be vaccinated at the pharmacy rather than their doctor's surgery for convenience or because they were not eligible for the NHS service. People were required to provide their written consent when recruited for these services.

The pharmacy's travel clinic offered people travel vaccinations and malaria prevention medicines following a consultation with a suitably trained pharmacist. The pharmacy had valid and up-to-date patient group directions in place for its travel clinic. People requiring travel vaccinations were asked to make appointments when two pharmacists were working at the pharmacy. So, the pharmacy's dispensing workload could be appropriately managed and its core services weren't disrupted.

The pharmacy used disposable and tamper-evident multi-compartment compliance packs to help a few people take their medicines. The pharmacy team was required to maintain an audit trail for its dispensing service. A brief description of each medicine contained within the compliance packs was provided. But the date of dispensing wasn't always included on each compliance pack. And sometimes patient information leaflets weren't supplied. So, people didn't always have the information they needed to take their medicines safely.

Prescriptions were highlighted to alert staff when a pharmacist needed to counsel people and when CDs or refrigerated items needed to be added. Staff were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. Valproate educational materials were available at the pharmacy.

The pharmacy used recognised wholesalers, such as AAH, Alliance Healthcare, B&S, Phoenix and Sigma, to obtain medicines and medical devices. It stored its stock, which needed to be refrigerated, appropriately between two and eight degrees Celsius. It kept its medicines and medical devices in an organised fashion within their original manufacturer's packaging. Pharmaceutical stock was subject to date checks, which were documented, and short-dated products were marked.

CDs, which were not exempt from safe custody requirements, were appropriately and securely stored. A record of the destruction of patient returned CDs was maintained. Staff were required to mark and keep patient-returned and out-of-date CDs separate from in-date stock.

Staff were aware of the Falsified Medicines Directive (FMD). They could check the anti-tampering device on each medicine was intact during the dispensing process. And they were verifying and decommissioning stock as the pharmacy had the appropriate equipment and software to do so. But the pharmacy's SOPs hadn't been revised to reflect the changes FMD has brought to the pharmacy's processes.

Procedures were in place for the handling of patient-returned medicines and medical devices. Patient-returned waste was checked for CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. The pharmacy had suitable pharmaceutical waste receptacles available. But its team wasn't always disposing of hazardous waste, such as cytostatic and cytotoxic products, in the appropriate receptacle.

A process was in place for dealing with recalls and concerns about medicines or medical devices. Drug and device alerts were received electronically and actioned by staff. And they sometimes annotated the alerts with the actions they took following their receipt. The pharmacy team recently raised a patient's concern with the manufacturer that a 'parallel-import' medicine wasn't the same quality as the UK product. And the manufacturer provided an assurance that both products were the same.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely.

### Inspector's evidence

The pharmacy had up-to-date reference sources available. And it had access to the NPA's information department. The pharmacy had a range of clean glass measures. And it had equipment for counting loose tablets and capsules too.

The pharmacy provided blood pressure checks on request. And its blood pressure monitor was replaced recently. The pharmacy had two medical refrigerators to store its pharmaceutical stock requiring refrigeration. The maximum and minimum temperatures of the refrigerators and the pharmacy were monitored and recorded regularly.

Access to the pharmacy's computers and its patient medication record system was restricted to authorised personnel and password protected. The computer screens were out of view of the public. A cordless telephone system was installed at the pharmacy to allow staff to have confidential conversations when necessary.

### 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.