General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Earlsfield Pharmacy, 607 - 609 Garratt Lane, Earlsfield, London, SW18 4SU

Pharmacy reference: 9011474

Type of pharmacy: Community

Date of inspection: 05/05/2021

Pharmacy context

This is a community pharmacy set on a parade of shops in Earlsfield. The pharmacy opens six days a week. It sells a range of health and beauty products, including over-the-counter medicines. It dispenses people's prescriptions. And it offers the NHS New Medicine Service. The pharmacy provides multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. It delivers medicines to people who can't attend its premises in person. And it can dispense people's substance misuse treatments too. The pharmacy offers travel and winter flu vaccinations. It provides a stop smoking service. And its team can measure people's blood pressure. The pharmacy can supply the morning-after pill for free. And it offers a chlamydia test and treat service. People can also collect coronavirus (COVID-19) home-testing kits from the pharmacy. This inspection took place during the COVID-19 pandemic.

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	Good practice	3.1	Good practice	The pharmacy is well designed to meet the needs of the people who use it.
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 adequately identifies and manages the risks associated with its services. Members of the pharmacy team review the mistakes they make and learn from them to try and stop them happening again. They can explain what they do, what they're responsible for and when they might seek help. They know how to protect vulnerable people. And they generally keep people's private information safe. People using the pharmacy can provide feedback to help improve the pharmacy's services. The pharmacy mostly keeps the records it needs to by law. And it has appropriate insurance to protect people if things do go wrong.

Inspector's evidence

The pharmacy had a business continuity plan. This identified the potential risks to the pharmacy, its services and its team in the event of an emergency. The pharmacy had completed a risk assessment of the impact of COVID-19 on the pharmacy and its services. And its team had received supplemental guidance to help it manage its services safely during the pandemic. The pharmacy offered to undertake an occupational COVID-19 risk assessment for each team member to help identify and protect those at increased risk. Members of the pharmacy team knew how they would report any work-related infections to the pharmacy's head office. They were self-testing for COVID-19 twice weekly. They wore fluid resistant face masks to help reduce the risks associated with the virus. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were available electronically. But some hadn't been reviewed for a while. Team members were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them.

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 prioritise the dispensing workload. They referred to prescriptions when labelling and picking products. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by one of the pharmacists who also initialled the dispensing label. The pharmacy had systems to record and review dispensing errors and near misses. Members of the pharmacy team discussed individual learning points when they identified a mistake. They reviewed their mistakes periodically to help spot the cause of them. And they shared learning from these reviews with each other. So, they could try to stop the same types of mistakes happening again. The pharmacy team reviewed and strengthened its delivery process following an incident when a prescription which should have been delivered wasn't.

The pharmacy displayed a notice that told people who the responsible pharmacist (RP) was. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. They explained that they wouldn'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 to a pharmacist. The pharmacy had a complaints procedure. And a notice at the counter told people how they could provide feedback about the pharmacy. The pharmacy team hadn't asked people to complete a satisfaction survey so far this year due to the pandemic. But it asked people for their views and suggestions on how to do things better. And, for example, it tried to keep people's preferred makes of prescription-medicines in stock when asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for

the services it provided. The pharmacy kept a record to show which pharmacist was the RP and when. The pharmacy had an electronic controlled drug (CD) register, which was kept in order. The pharmacy team regularly checked the stock levels recorded in the CD register. The pharmacy kept records for the supplies of unlicensed medicinal products it made. But it didn't always record when it had received one of these products. The pharmacy recorded the emergency supplies it made and the private prescriptions it supplied electronically. And these generally were in order. But the prescriber's details were sometimes incomplete in the private prescription records.

The pharmacy had an information governance policy. And its team members needed to read and sign an agreement saying that they would keep people's private information safe. People using the pharmacy generally couldn't see any other people's personal information. The pharmacy had arrangements in place to make sure confidential waste was collected and disposed of securely. But sometimes people's details weren't crossed out or removed from medicines returned to it before being disposed of. The pharmacy had safeguarding procedures. And pharmacy professionals were asked to complete a level 2 safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. And they had the contacts they needed if they wanted to raise a safeguarding concern.

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 pharmacy team consisted of a full-time pharmacist manager, a part-time pharmacist (the RP), a full-time pre-registration pharmacist trainee, a full-time pharmacy technician, two full-time dispensing assistants, a part-time medicines counter assistant, a full-time delivery driver and a part-time cleaner. The pharmacist manager, the RP, the pre-registration pharmacist trainee, the pharmacy technician and two dispensing assistants were working at the time of the inspection. The pharmacy relied upon its team and team members from one of the company's other pharmacies to cover absences. Members of the pharmacy team worked well together. So, people were served promptly, and their prescriptions were processed safely. The pharmacists supervised and oversaw the supply of medicines and advice given by staff. 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, people who were old 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. And they were required to undertake accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with their line manager when they could. They were encouraged to ask questions and familiarise themselves with new products. They were also asked to complete training to make sure their knowledge was up to date. And they could train while they were at work when the pharmacy wasn't busy. The pharmacy held meetings and one-to-one discussions to update its team and share learning from mistakes or concerns.

The pharmacy had some targets. But its team didn't feel under pressure to achieve them. The pharmacists felt able to make professional decisions to ensure people were kept safe. The pharmacy displayed a copy of its whistleblowing process in the dispensary. Members of the pharmacy team 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 changes in the way people's prescriptions were filed.

Principle 3 - Premises ✔ Good practice

Summary findings

The pharmacy is bright, clean and modern. It provides a safe, secure and professional environment for people to receive healthcare in. It's well designed to meet the needs of the people who use it, and to make sure they can receive services in private when they need to.

Inspector's evidence

The pharmacy relocated from smaller premises at the end of last year. Its layout had been carefully considered. It had two automated doors, one for people to enter and the other for them to leave. It had wider aisles than the old pharmacy and part of its counter was at a lower level to the rest. This made access to it easier for people who used wheelchairs. The pharmacy was air-conditioned, bright, clean and modern. It was professionally presented throughout. And its fixtures and fittings were of a high standard. The pharmacy had the workbench and storage space it needed for its current workload. The pharmacy had a large and well-equipped consulting room for the services it offered. And it could be used if people needed to speak to a team member in private. People's conversations in it couldn't be overheard outside of it. The consulting room was locked when it wasn't being used. So, its contents were kept secure. People could also speak to a team member via a hatchway to one side of the dispensary, which was separate from the retail area and the counter. The pharmacy had the sinks it needed for the services its team delivered. And these each had a supply of hot and cold water. Members of the pharmacy team and a cleaner were responsible for keeping the premises clean and tidy. They cleaned the pharmacy on most days it was open. And they regularly wiped and disinfected the surfaces they and other people touched.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access. Its working practices are safe and effective. And its team is helpful. The pharmacy delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources and it stores them appropriately and securely. Members of the pharmacy team generally carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose. And they mostly dispose of people's waste medicines properly too.

Inspector's evidence

The pharmacy had automated doors. And each entrance had its own ramp. This meant that people who may have difficulty climbing stairs could access the premises. The pharmacy had a notice that told people when it was open. It also had a digital display in one of its windows that told people about its products and the services it delivered. A small seating area was available for people who wanted to wait in the pharmacy. And this was set away from the counter to help people keep apart. Members of the pharmacy team were helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy sent some people's prescriptions to an offsite dispensing hub. The hub assembled these prescriptions and returned the medicines to the pharmacy in disposable and tamper-evident compliance packs for its team to hand out or deliver to the person. People were told that their medicines would be dispensed at a different location to the pharmacy before being asked if they wanted to use the service. The pharmacy team checked whether a medicine was suitable to be re-packaged. And an audit trail of the people involved in the assembly of the compliance pack was maintained. A photograph of each medicine contained within a compliance pack was printed next to the medicine's name. This made it easier for people to tell what medicine they were taking. But patient information leaflets weren't routinely supplied with compliance packs. So, people didn't always have the information they needed about their medicines. The superintendent pharmacist gave an assurance following the inspection that the company's compliance pack assembly process would be reviewed to make sure people received the information they needed to take their medicines safely. The pharmacy used clear bags for some dispensed items, such as CDs and insulin, 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 team marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting, such as a high-risk medicine, or if other items, such as a refrigerated product, needed to be added. The pharmacy team generally marked prescriptions for CDs with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully. But some filed CD prescriptions awaiting collection were found to have expired. Members of the pharmacy team 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. The pharmacy had some valproate educational materials available. The pharmacy offered a delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery to show that the right medicine was delivered to the right person.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its

medicines and medical devices tidily on the shelves within their original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines at regular intervals. And it marked products which were soon to expire to reduce the chances of it giving people out-of-date medicines by mistake. But it didn't record when it had done these checks. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy kept its out-of-date, and patient-returned, CDs separate from in-date stock. And its team needed to keep a record of the destruction of patient-returned CDs. But some intact patient-returned pregabalin capsules were found in a pharmaceutical waste bin. The pharmacy had procedures for handling the unwanted medicines people returned to it. These medicines were kept separate from 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 its team members described the actions they took and demonstrated what records they made when they received a drug alert.

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 some plastic screens on its counter. It had markings on its floor to help people keep apart. And its team could restrict the number of people it allowed in the premises at a time if needed. The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had a range of clean glass measures for use with liquids, and some were marked for use only with certain liquids. 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, 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 medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of each refrigerator. The pharmacy team occasionally needed to take people's blood pressure. And the monitor it used to do this was recently replaced. 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. The pharmacy had a cordless telephone system. So, its team could have confidential conversations with people when necessary. Most of the team members responsible for the dispensing process had their own NHS smartcard. And they each made sure their card was 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.