General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jays Pharmacy Egham, 56 High Street, Egham, Surrey, TW20 9EX

Pharmacy reference: 9011659

Type of pharmacy: Community

Date of inspection: 08/02/2022

Pharmacy context

This is an NHS community pharmacy set on a parade of shops in Egham town centre. 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 people can collect coronavirus (COVID-19) home-testing kits from its premises. The pharmacy offers winter influenza (flu) vaccinations. It provides a substance misuse treatment service. And it can supply the morning-after pill for free. The pharmacy provides multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. And it delivers medicines to people who can't attend its premises in person. 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	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 clear work culture of openness, honesty and learning.
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 appropriately manages its risks. It has introduced new ways of working to help protect people against COVID-19. And it has procedures to help make sure its team works safely. Members of the pharmacy team know what they can and can't do, what they're responsible for and when they might seek help. They adequately review the safety of the services they deliver. They understand their role in protecting vulnerable people. And they keep people's private information safe. People using the pharmacy can provide feedback to help improve its 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 standard operating procedures (SOPs) for the services it provided. And the superintendent pharmacist had recently reviewed the pharmacy's SOPs. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. And, as a result, it adapted its delivery process to try and stop the spread of the virus. The pharmacy had completed occupational COVID-19 risk assessments for its team members. Members of the pharmacy team knew that any work-related infections needed to be reported to the appropriate authority. They were encouraged to self-test for COVID-19 twice weekly. They wore fluid resistant face masks to help reduce the risks associated with the virus. And they washed their hands and used hand sanitising gel when they needed to.

Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were checked by a pharmacist. The pharmacy had systems to record and review dispensing errors and near misses. Members of the pharmacy team discussed and documented individual learning points when they identified a mistake. They reviewed their mistakes periodically to help spot the cause of them. And they shared any learning from these reviews with each other. So, they could try to stop the same types of mistakes happening again. And, for example, they moved the different types of gabapentinoids to keep them apart on the dispensary shelves following a mistake when the wrong one was picked.

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. And their roles and responsibilities were described within the SOPs and a task matrix. A team member 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, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints procedure. And it had a notice next to its entrance that told people how they could provide feedback about it. The pharmacy had received positive feedback from people online. It asked people for their views and suggestions on how it could do things better. And, for example, it tried to keep people's preferred makes of prescription medicines in stock when its team was 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. But the time when a pharmacist stopped being the RP was occasionally not recorded. The pharmacy kept an electronic controlled drug (CD) register. But the address a CD came from didn't appear in the CD register. And the records for one liquid CD were still written in a paper register. The pharmacy team checked the stock levels recorded in the CD register regularly. The pharmacy kept appropriate records for the supplies of unlicensed medicinal products it made. It recorded the emergency supplies it made and the private prescriptions it supplied electronically. And most of these were in order. But the nature of the emergency wasn't always appropriately recorded in the emergency supply records. And the name and address of the prescriber were sometimes incorrect in the private prescription records.

People using the pharmacy couldn't see any other people's personal information. The pharmacy's owner was registered with the Information Commissioner's Office. The pharmacy had a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. It had a data security protection policy in place. And it had arrangements to make sure confidential information was stored and disposed of securely. The pharmacy had a safeguarding policy. Members of the pharmacy team completed a safeguarding training course relevant to their roles. They 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 ✔ Good practice

Summary findings

The pharmacy has enough suitably qualified team members to provide its services safely and effectively. And it encourages 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 full-time pharmacist (the RP), two dispensing assistants, two trainee dispensing assistants, a medicines counter assistant and a delivery driver. The RP was responsible for managing the pharmacy and its team. The superintendent pharmacist and another pharmacist worked at the pharmacy regularly too. The RP, the superintendent pharmacist, two dispensing assistants, two trainee dispensing assistants and the medicines counter assistant were working at the time of the inspection. The pharmacy relied upon its team members, team members from its sister branch and its pharmacists to cover any absences or provide additional support when the pharmacy was busy.

The RP and the superintendent pharmacist led by example. And they supervised and oversaw the supply of medicines and advice given by the pharmacy team. Members of the pharmacy team worked well together and supported each other. So, people were served promptly, and their prescriptions were processed efficiently and safely. 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.

Members of the pharmacy team 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 line manager. And they helped each other to learn. Team members were encouraged to ask questions and familiarise themselves with new products. They were also encouraged to keep their knowledge up to date by completing regular training and online assessments. And they could learn while they were at work or during their own time. But they had time set aside during their working week to support their development and to complete any training they needed to do. They were comfortable talking about their own mistakes and weaknesses with their colleagues. Team meetings and one-to-one discussions were held to update each other and to share feedback or learning from mistakes or concerns.

The pharmacy had a whistleblowing policy. It didn’t set targets for its team. And it didn’t incentivise its services. Members of the pharmacy team felt able to make professional decisions to ensure people were kept safe. And they didn’t feel under pressure to do the things they were expected to do. Team members 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 them strengthening the pharmacy’s delivery process.

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 last year. Its layout had been carefully considered. It had a large and well-equipped consulting room for the services it offered or when someone needed to speak to a team member in private. The pharmacy had an automated door and wide aisles. And its consulting room had a wide door too. These things made access to the pharmacy, and its services, easier for people who used wheelchairs or mobility scooters. The consulting room was locked when it wasn't being used. So, its contents were kept secure. People's conversations in the consulting room couldn't be overheard outside of it. 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. And it had additional space to expand into if the business grew. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water too. Members of the pharmacy team were responsible for keeping the premises clean and tidy. 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. Its team members are helpful. And they make sure that people have the information they need. So, they can use their medicines safely. 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 dispose of people's unwanted medicines properly. And they carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy had an entrance that was level with the outside pavement. This meant that people who may have difficulty climbing stairs could access its premises easily. The pharmacy 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 offered a local delivery service to people who couldn't attend its premises in person. And it kept an audit trail for each delivery to show that the right medicine was delivered to the right person. The pharmacy supplied COVID-19 tests that people could use at home. And these tests were used to help find cases in people who may have no symptoms but were still infectious and could give the virus to others. The pharmacy had the anaphylaxis resources it needed for its flu vaccination service. And the pharmacy team members who vaccinated people were appropriately trained. The pharmacy kept a record for each flu vaccination it made. And this included the details of the person vaccinated and their consent, an audit trail of who vaccinated them and the details of the vaccine used. The pharmacy team made sure the sharps bin was kept securely when not in use. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked whether a medicine was suitable to be re-packaged. And it assessed new requests for the service to make sure they were appropriate for the patient. The pharmacy provided a brief description of each medicine contained within the compliance packs as well as patient information leaflets. And an audit trail of the people who had assembled and checked each compliance pack was routinely kept. 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. 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. And they knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The pharmacy had the resources it needed for when it dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It generally kept its medicines and medical devices tidily within the dispensary within their original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines at regular intervals. It recorded when it had done these checks. And it marked products which were soon to expire to reduce the

chances of it giving people out-of-date medicines by mistake. 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 needed to keep out-of-date and patient-returned CDs separate from in-date stock. And its team kept a record of the destruction of CDs people returned to it. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from the pharmacy's 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 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 few glass measures to measure out liquids, and some were only used for 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 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 medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of these refrigerators. The pharmacy had a shredder. So, its team could dispose of confidential waste appropriately. 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.