General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pearl Chemist, 134-138 Mitcham Road, London, SW17 9NH

Pharmacy reference: 9011674

Type of pharmacy: Community

Date of inspection: 10/03/2022

Pharmacy context

This is an NHS community pharmacy set on a main road in Tooting. The pharmacy is part of a small chain of pharmacies. It opens six days a week. It dispenses people's prescriptions. And it sells a range of health and beauty products, including some over-the-counter medicines, to people visiting its premises in person and through its website. People can get coronavirus (COVID-19) tests from the pharmacy. And they can get their COVID-19 vaccinations from a nearby vaccination centre that's run by the pharmacy. The pharmacy has a travel clinic and offers winter influenza (flu) and chickenpox vaccinations. It provides a substance misuse treatment service. It can supply the morning-after pill for free. And its team can check people's blood pressure and help someone when they want to stop smoking. 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	1.2	Good practice	The pharmacy continually monitors the safety of its services to protect people and further improve patient safety.
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 mostly identifies and manages its risks well. And it continually monitors the safety of its services to protect people and further improve patient safety. Its team members log and review the mistakes they make. So, they can learn from them and act to avoid problems being repeated. People who use the pharmacy can provide feedback to help improve its services. 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 understand their role in protecting vulnerable people. And they generally keep people's private information safe. 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. And this identified potential risks to its premises, its services and its team in the event of an emergency. The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these were reviewed periodically. But the pharmacy team couldn't show that SOPs were in place for the pharmacy's online service. And while the risks associated with online sales had been assessed, the responsible pharmacist (RP) couldn't show that these had been documented. 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 smoking cessation service 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 regularly. 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.

The pharmacy reviewed its dispensing process and workflow. And most people's repeat prescriptions and compliance packs were now assembled offsite by one of the company's hub pharmacies. But only when people agreed to this happening first. This meant the mistakes made at the pharmacy had been reduced and members of the pharmacy team could spend more time talking to people about their medicines or prioritise other tasks. The pharmacy team had separated and highlighted some look-alike and sound-alike drugs on the shelves to reduce the risks of them picking the wrong product. The team members responsible for the dispensing process kept 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 were also seen initialling the dispensing label. The pharmacy had systems for its team to discuss, review, record and learn from patient safety incidents. And its team regularly audited the safety and the quality of its services. Members of the pharmacy team discussed and documented individual learning points when they identified a mistake. They reviewed their mistakes regularly to help spot the cause of them and any trends. They also had regular team meetings to share learning from these reviews. So, they could try to stop the same types of mistakes happening again and improve the safety of the dispensing service they provide. And, for example, they recently highlighted and separated packs of azathioprine and azithromycin after the wrong one was picked during the dispensing process.

The pharmacy displayed a notice that told people who the 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 its website and practice leaflets 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 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 kept an electronic controlled drug (CD) register. And its team checked the stock levels recorded in the CD register regularly. 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 most of these were in order. But the name and address of the prescriber were sometimes incomplete in the private prescription records.

People using the pharmacy couldn't see other people's personal information. The pharmacy's owner was registered with the Information Commissioner's Office. The pharmacy displayed a notice in-store and on its website that told people how their personal information was gathered, used and shared by the pharmacy and its team. It had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always obliterated or removed from the unwanted medicines people returned to it before being disposed of as required by the SOPs. The pharmacy team was required to complete safeguarding and General Data Protection Regulation (GDPR) training every year. And pharmacy professionals were asked to undertake further safeguarding training relevant to the services they delivered. The pharmacy had a safeguarding policy. Its team members 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 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 two pharmacists, a trainee pharmacist, a pharmacy technician, a dispensing assistant, five medicines counter assistants (MCAs) and a delivery driver. The RP was responsible for managing the pharmacy and its team. The RP, the second pharmacist, the trainee pharmacist, the pharmacy technician, the dispensing assistant and four MCAs were working at the time of the inspection. The pharmacy relied upon its team members, team members from one of the company's other branches and its head office support team to cover absences or provide additional support when the pharmacy was busy.

The pharmacists 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 and people with long-term health conditions to one of the pharmacists.

The pharmacy had an induction training programme for its team. This included pharmacists and trainee pharmacists. The trainee pharmacist confirmed that the RP was their designated supervisor. And there was a training plan in place for their foundation training year. The trainee pharmacist felt supported. They were encouraged to improve their skills and attend regular training events with other trainee pharmacists. They had regular discussions and reviews with their supervisor. And they received time to study. 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 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 refresher training and assessments. And they could learn while they were at work or during their own time. But they had time set aside while they were at work to train and support their development. 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 improvements in the way their tasks were rostered.

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 had a website. And this provided the information it needed to in line with the GPhC's guidance for registered pharmacies providing pharmacy services at a distance, including on the internet. The pharmacy sold some over-the-counter medicines through its website. But it didn't offer an online prescribing service. The pharmacy relocated from smaller premises last year. Its layout had been carefully considered. And it had several large and well-equipped consulting rooms for the services it offered or when someone needed to speak to a team member in private. The pharmacy had automated doors and wide aisles. And its consulting rooms had wide doors too. These things made access to the pharmacy, and its services, easier for people who used wheelchairs or mobility scooters. The consulting rooms were locked when they weren't being used. So, their contents were kept secure. People's conversations in the consulting rooms couldn't be overheard outside of them. 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 easily. 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 automated entrance that was level with the outside pavement. It had a seating area 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 delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery. And people were asked to sign an electronic delivery record to say they had received their medicines. The pharmacy sold over-the-counter medicines, including some pharmacy-medicines, through its website. The pharmacy didn't supply medicines outside of the country. People wanting to purchase a pharmacy-medicine needed to complete a questionnaire which was reviewed by a pharmacist. The RP couldn't demonstrate that the decision whether a sale should or shouldn't be made was recorded. But they described occasions when they declined requests for products liable to overuse, misuse or abuse. The pharmacy used its card payment processing company to help prevent fraudulent transactions. But it was working with its website developers to see what more it could do to check that the person making a request was who they say they were. The pharmacy generally used the postal service to deliver over-the-counter medicines ordered through its website. And these medicines could be tracked and their handover to the delivery agent took place at the pharmacy under the supervision of a pharmacist.

The pharmacy supplied COVID-19 tests that people could use at home. And these tests were used to help people who needed to travel abroad and 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 and the patient group directions it needed for its chickenpox, flu and travel vaccination services. And the pharmacy team members who vaccinated people were appropriately trained. The pharmacy kept a record for each vaccination it made. And this included the details of the vaccine used and the details of the person vaccinated and their consent. But an audit trail of who vaccinated them wasn't always maintained. The pharmacy team made sure the sharps bins were kept securely when not in use. The pharmacy used a hub pharmacy to assemble most of its repeat prescriptions. It also used another hub pharmacy to assemble people's medicines in disposable and tamper-evident compliance packs. And these prescriptions were returned to the pharmacy for the team to hand out or deliver. The pharmacy team checked whether a medicine was suitable to be re-packaged. And it assessed most requests for the service to make sure compliance packs were appropriate for the patient. The pharmacy kept an audit trail of the people involved in the assembly of each compliance pack. It routinely provided patient information leaflets. And a brief description and 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. 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 higher-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 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 team recorded the destruction of the CDs that people returned to it. The pharmacy had procedures for handling the unwanted medicines people brought back. And these medicines were kept separate from the pharmacy's stock and were placed in a 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 it was used. 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 provided blood pressure (BP) checks on request. And its BP monitors were replaced recently. The pharmacy made sure the diagnostic equipment its team used, such as blood pressure monitors, was safe and fit to use, and appropriately maintained. And any equipment stored in the consulting rooms was kept secure. 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.