General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Village Pharmacy, 86 Church Lane, Doddinghurst, BRENTWOOD, Essex, CM15 0NG

Pharmacy reference: 1030955

Type of pharmacy: Community

Date of inspection: 27/10/2022

Pharmacy context

The pharmacy is located on a small parade of shops in a village. It dispenses NHS prescriptions and provides New Medicine Service (NMS) checks, Community Pharmacist Consultation Service (CPCS) and a flu vaccination service.

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
1. Governance	Standards met	N/A	N/A	N/A
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's working practices are generally safe and effective. People who use the pharmacy can give feedback on its services. The pharmacy mainly keeps the records it needs to by law so that medicines are supplied safely and legally. And the pharmacy team knows how to help protect the welfare of vulnerable people. Team members generally respond appropriately when mistakes happen during the dispensing process. But there is limited evidence that they consistently record near misses. So, this may mean that they are missing out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

Standard operating procedures (SOPs) were available. The superintendent pharmacist (SI) was in the process of implementing new SOPs, which she said would be implemented within the next few weeks. Team members were in the process of reading and signing SOPs relevant to their roles.

The pharmacy had processes to record dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). When a near miss was identified the dispensed medicines were handed back to the trainee dispenser to check. Once the mistake was identified it was rectified. The SI explained that near misses were recorded but there were no records available at the inspection as these had been taken home. A review of past near misses had found that mistakes were caused when there were distractions such as answering phone calls. As a result of this team members had been advised not to answer the phone whilst they were dispensing. Dispensing errors were investigated, rectified and a record made in a book. However, the information recorded was very brief. The SI said that she would ensure new templates were introduced. Past errors had included picking errors with citalopram and statins as a result the shelf edges where these were kept were marked. The dispenser trainee was also made aware of any errors. Reviews were carried out after an incident or when there were a few near misses. Following a review, the team was briefed and changes were made.

The correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and also completed an annual patient satisfaction survey. As a result of feedback received by the pharmacy seating was put for people who were waiting.

Records for private prescriptions, emergency supplies, unlicensed medicines, RP records were well maintained. Electronic controlled drug (CD) registers had been started prior to the inspection and were generally well maintained. CDs that people had returned were recorded in a register as they were received.

The pharmacy had an information governance policy, the SI had verbally briefed the team on confidentiality, data protection and ensuring confidential information was kept securely. Assembled prescriptions were stored behind the medicines counter and people’s private information was not visible to other people using the pharmacy. Both pharmacists had NHS smartcards and had access to

Summary Care Records. Consent to access these was gained verbally. The pharmacy was in the process of trying to get the dispenser trainee a smartcard.

Both pharmacists had completed the level two safeguarding training course. Team members other than the new member of staff had completed the level one training. Contact details for safeguarding boards were available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to dispense and supply its medicines safely. They have completed or are doing the required accredited training for their roles. They do ongoing training to help keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the team comprised of the SI and a trainee dispenser and a trainee medicines counter assistant (MCA). The SI said that there were enough team members to manage the workload. Team member's performance was managed by the SI who completed annual appraisals. The SI sat down with the team member to see how they were doing and discussed if there were any issues or if there were any weaknesses that needed be addressed.

The trainee dispenser counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment.

Team members completing their formal training were given protected learning time to complete their work. Team members described how both pharmacists were helpful and supportive. To keep up to date, team members were required to complete training as required by the Quality Payment Scheme. In the past team members had completed training on antibiotics guardianship and dementia friends. During the peak of the pandemic training had stopped but now the pharmacy was restarting ongoing training for the team.

The team tried to hold meetings on a monthly basis before work. The team worked closely with the both the SI and second pharmacist and things were also discussed as they came up. Any concerns or problems were brought up straight away and discussed. All team members were part of a group chat on an electronic messaging application and could also share any concerns on this. There were no numerical targets set for the services the pharmacy provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean and tidy. There was limited workspace in the dispensary; this was managed well and kept clear. A clean sink was available. Medicines were arranged on the shelves in a tidy and organised manner. Cleaning was done by the team. The consultation room was clean and tidy and allowed for conversations to take place inside which could not be overheard. The premises were kept secure from unauthorised access. The room temperature and lighting were suitable for the provision of healthcare. Air conditioning was available to help regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner. The pharmacy obtains its medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts.

Inspector's evidence

The pharmacy was accessed via a wide door and a small step, team members helped people who required assistance. People were helped at the door and the pharmacy was looking into getting a portable ramp. The pharmacy had the ability to produce large-print labels. This was done when needed. Team members were aware of the need to signpost people to other providers. They were aware of local services and also used the online NHS services finder which showed services that were available.

The SI felt the flu vaccination and New Medicine Service (NMS) had the most impact on the local population. The SI described how the NMS service was one to one and more personal and accessibility to other health care services had not been great during the pandemic. The flu service was convenient and easily accessible for people. The pharmacy also provided the Community Pharmacist Consultation Service which was particularly useful at the weekend when surgeries were closed and people had not had a chance to get their medicines.

The pharmacy had an established workflow in place. Baskets were available and used if there was more than one prescription to be dispensed or if it was busy. Around 90% of prescriptions were received electronically. The pharmacy also had access to an online tracker which showed if a prescription had been issued and if it had been sent to another pharmacy. The trainee dispenser helped with dispensing or the pharmacist would dispense and then self-check. To manage the risks associated with self-checking the SI would take a mental break in between dispensing and checking. There were no audit trails on the dispensing labels to show who had dispensed or checked the medicines. And this could make it harder for the pharmacy to identify the team member responsible in the event of an error. She added that the RP record would be used to identify which pharmacist had completed the check. CDs including Schedule 4 CDs were not dispensed until the person presented to the pharmacy to collect. The SI provided an assurance that she would start initialling labels and also asked the trainee dispenser to do this.

The SI was aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). People in the at-risk group who were not part of the PPP were referred back to their prescriber. A poster was displayed in the dispensary to remind team members. The SI was aware of the need to use the warning labels and cards. Label placement was discussed with the team. Additional checks were carried out when people collected medicines which required ongoing monitoring. People on anticoagulants were handed an anticoagulant alert card. INR levels were checked but not recorded.

Flu vaccinations were provided both on a walk-in and appointment basis. Both pharmacists worked on Saturdays when block bookings were made which made it easier.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and

recorded, and these were observed to be within the required range for the storage of medicines. CDs were held securely. Expiry date checks were carried out by the team. The team tried to complete these every three months. No expired medicines were found on the shelves checked. A date-checking matrix was available but this had not been updated. Medicines which were short-dated were recorded in a book and any action taken was also recorded. Some medicines were seen to be stored on the shelf out of their original containers. The SI provided an assurance that boxes would be used in the future. Drug recalls were received via email. Once actioned the email was saved. When the SI and second pharmacist were away, they forwarded on any alerts to the locum pharmacists.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had glass, calibrated measures, and tablet counting equipment. Separate labelled measures were available for liquid CDs to avoid contamination. Up-to-date reference sources were available including access to the internet. The pharmacy had a fridge of adequate size. Confidentiality was maintained through the appropriate use of equipment and facilities. The computer in the dispensary was password protected and out of view of people using the pharmacy. Confidential waste was shredded.

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.