

# Registered pharmacy inspection report

**Pharmacy Name:** Vauxhall Street Pharmacy, 22 Suffolk Square,  
Vauxhall Street, NORWICH, Norfolk, NR2 2AA

**Pharmacy reference:** 1035367

**Type of pharmacy:** Community

**Date of inspection:** 18/02/2020

## Pharmacy context

The pharmacy is co-located with a Post Office and it is on a parade of shops in a largely residential area and near to a city centre. The people who use the pharmacy are mainly older people. The pharmacy receives around 95% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations, stocking measurement, smoking cessation, blood pressure checks. It also provides medicines as part of the Community Pharmacist Consultation Service. It supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people.

## 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	1.2	Good practice	The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk.
<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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It protects people's personal information and it regularly seeks feedback from people who use the pharmacy. Team members understand their role in protecting vulnerable people. The pharmacy largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

### Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Team members had signed to indicate that they had read and understood the SOPs. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Following a review of the near miss log, bendroflumethiazide 5mg tablets were now kept separated from the 2.5mg tablets. The superintendent (SI) explained that dispensing incidents where the product had been supplied to a person would be recorded on the computer and the person's medication record. He said that he was not aware of any dispensing incidents at the pharmacy.

Workspace in the dispensary was largely free from clutter and baskets were used to minimise the risk of medicines being transferred to a different prescription. There was an organised workflow which helped staff to prioritise tasks and manage the workload. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The dispenser said that the pharmacy would not open if the pharmacist had not turned up in the morning. But she said that she would carry out dispensing tasks before the pharmacist had arrived. The inspector reminded her about the tasks which should not be carried out if there was no responsible pharmacist (RP). The trainee medicines counter assistant (MCA) knew that he should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The responsible pharmacist (RP) log was completed correctly and the right RP notice was clearly displayed. The emergency supply record was completed correctly. And there were signed in-date Patient Group Directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly. The CD running balances were checked at regular intervals and any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. All necessary information was not recorded when a supply of an unlicensed medicine was made. The SI said that he would ensure that this information was recorded in the future. The private prescription records were largely completed correctly, but the prescriber's details were not usually recorded. The SI said that he would speak with the software provider and ensure that these were recorded in the future.

Confidential waste was shredded, computers were password protected and the people using the

pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. Some of the pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website. Results showed that 100% of respondents rated the pharmacy as very good or excellent. The complaints procedure was available for team members to follow if needed. The SI said that the pharmacy had not received any recent complaints. He said that he had a good relationship with people who used his pharmacy and also with the other local pharmacies. So, any issues were usually resolved promptly.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The SI said that there had not been any safeguarding concerns at the pharmacy.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. The team discusses adverse incidents and uses these to learn and improve. And they can raise any concerns or make suggestions. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe.

### Inspector's evidence

The SI was working during the inspection alongside one trained dispenser, one trainee dispenser and one trainee MCA. Most team members had completed an accredited course for their role and the rest were undertaking training. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The dispenser was patient when training the trainee MCA. During the inspection, she was explaining to him about some of the over-the-counter medicines which had the potential for misuse of required additional care. The trainee dispenser appeared confident when speaking with people. She was not aware of the restrictions on sales of pseudoephedrine containing products. But she said that she would refer to the pharmacist if a person asked to purchase more than one box of an over-the-counter medicine. She used effective questioning techniques to establish whether the medicines were suitable for the person.

The SI was aware of the continuing professional development requirement for the professional revalidation process. He explained that he had recently undertaken some training about meningitis and infections. The dispenser was in the process of completing the NVQ level 3 diploma in pharmacy service skills. She said that she had been fully supported during her training and was allowed time during quieter times to complete the modules. The dispenser said that all team members had recently undertaken training about sepsis. The SI said that he felt able to take professional decisions. He had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The dispenser said that team members had informal ongoing appraisals and performance reviews with the SI. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. They also had regular reviews of any dispensing mistakes and discussed these openly in the team. Targets were not set for team members. The SI said that he carried out the services for the benefit of the people who used the pharmacy.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The premises provide a safe, secure, and largely clean environment for the pharmacy's services. People can have a conversation with a team member in a private area. But the pharmacy could do more to keep some areas tidy and free from clutter.

### Inspector's evidence

The pharmacy was secured from unauthorised access and it had the same opening hours as the Post Office. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available; the room temperature was suitable for storing medicines.

There was one chair in the shop area. It was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The toilet, hand washing facilities and kitchen area in the dispensary were clean and not used for storing pharmacy items.

The consultation room was located in the shop area. The SI said that the room was accessible to wheelchair users, but the door could not be closed after they had entered the room. A bed took up a lot of floor space in the room. The room was suitably equipped and well-screened. It was not kept locked when not in use, but there were no medicines or confidential information kept in there. Low-level conversations in the consultation room could not be heard from the shop area. The room was cluttered on the day of the inspection. The SI said that these items were due to be cleared out and this would make the room more presentable. The dispenser cleared the clutter and cleaned the room during the inspection. The toilet area to the rear of the room was not clean and it was cluttered. Team members did not use these facilities.

## Principle 4 - Services ✓ Standards met

### Summary findings

Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and largely stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

### Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with a power assisted door. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available. The SI said that an induction hearing loop was available at the Post Office.

Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. And made it harder for the pharmacy to check that the person was having the relevant blood tests done at appropriate intervals. The SI said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy did not have the relevant patient information leaflets or warning cards available. The SI said that he would order replacements from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next twelve months was marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Part-dispensed prescriptions were checked daily. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked frequently. The SI said that items remaining uncollected after around six weeks were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber.

The SI explained that the pharmacy carried out assessments for people to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the SI said that people contacted the pharmacy if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any

hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. But the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. The SI said that he would ensure that these were attached in the future. Medication descriptions were put on the packs to help people and their carers identify the medicines, but patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The SI said that he would ensure that these were supplied in the future.

CDs were largely kept secure. Some CDs were not always kept in accordance with legislation, but following the inspection the SI took action and confirmed that they now were. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not always obtain people's signatures for deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. Signatures were recorded when CDs were delivered and these were recorded in a way so that another person's information was protected. The SI said that he would ensure that signatures were recorded for all deliveries where possible in the future.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The SI explained the action the pharmacy took in response to any alerts or recalls. The pharmacy kept a record of drug alerts and recalls which had been actioned.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The SI said that he had undertaken some training on how the system worked. But he was not sure about the sequence that the items should be scanned. He said that he would discuss this with the appropriate people and the pharmacy would likely be using the equipment fully in the near future.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

### Inspector's evidence

Suitable equipment for measuring liquids was available and separate measures were marked for methadone use only. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The SI said that the blood pressure monitor had been in use for around 18 months. He said that this was replaced every two years in accordance with the manufacturer's guidance. The carbon monoxide testing machine was calibrated by an outside agency. The weighing scales and the shredder were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

### 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.