General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Vaughan James Pharmacy, 113a West Street, FARNHAM, Surrey, GU9 7HH

Pharmacy reference: 1036581

Type of pharmacy: Community

Date of inspection: 08/08/2023

Pharmacy context

This NHS community pharmacy is set on a row of shops within a conservation area in Farnham town centre. The pharmacy opens six days a week. It sells medicines over the counter. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy supplies multi-compartment compliance packs (compliance packs) to a few people who need help managing their medicines. And its team can check a person's blood pressure.

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	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 manages its risks appropriately. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy talk to each other about the mistakes they make and write them down to try and stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

Members of the pharmacy team knew what to do if the pharmacy needed to close in an emergency. And they also understood what they should do to make sure people could access the care they needed if the pharmacy was closed. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed recently by the pharmacy owner. Members of the pharmacy team were required to read and sign the SOPs to show they understood them and agreed to follow them. They knew what they could and couldn't do, what they were responsible for and when they might seek help. Their roles and responsibilities were described within the SOPs. And the pharmacy displayed a notice that told people who the responsible pharmacist (RP) was at that time. A team member explained that they couldn'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 the pharmacist.

The team members who were responsible for making up people's prescriptions kept the dispensing workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by the RP. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). Members of the pharmacy team discussed and recorded the mistakes they made to learn from them and help them stop the same sort of things happening again. And, following a recent dispensing error, they had put a sticker on the shelf where they kept a medicine used to treat epileptic fits as a reminder for them to pick the right strength. But they didn't always review their near misses. So, they may have missed opportunities to strengthen their processes further by spotting patterns in the mistakes they made.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. People could share their views and make suggestions to the pharmacy team about how the pharmacy could do things better. And, for example, the pharmacy team tried to order a person's preferred make of a prescription medicine when it was asked to do so. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had a controlled drug (CD) register. And the stock levels recorded in the register were usually checked as often as the SOPs asked them to be. But the details of where a CD came from and the headings on each page weren't always completed in full. The pharmacy generally kept adequate records to show which pharmacist was the RP and when. It kept records for the supplies of the unlicensed medicinal products it made. But it could do more to make sure it routinely recorded

when it received an unlicensed medicinal product. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the reason for making a supply of a prescription-only medicine to a person in an emergency wasn't always recorded properly. And the details of the prescriber were incorrect in some of the private prescription records seen.

People using the pharmacy couldn't see other people's personal information. The pharmacy displayed a notice 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. It had a data security and protection policy. And its team completed a self-assessment each year and made a declaration to the NHS that it was practising good data security and it was handling personal information correctly.

The pharmacy had a safeguarding procedure. Members of the pharmacy team knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person. And the pharmacy's consulting room could be used by someone if they felt they were in danger.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. And they work well together and use their judgement to make decisions about what is right for the people they care for. The pharmacy team is comfortable about giving feedback to help the pharmacy do things better. And it knows how to raise a concern if it has one.

Inspector's evidence

The pharmacy team consisted of the pharmacy owner (the RP), a trainee pharmacy technician, two dispensing assistants, a trainee dispensing assistant and two medicines counter assistant (MCAs). The pharmacy depended upon its team or locum pharmacists to cover absences. The people working at the pharmacy during the inspection included the RP, the trainee technician, a dispensing assistant and one of the MCAs. The pharmacy didn't set any targets or incentives for its team. And it had seen an increase in its dispensing volume following the closure of a nearby pharmacy. But its team was up to date with its workload.

Members of the pharmacy team helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they felt able to make decisions that kept people safe. The RP managed the pharmacy team. And they supervised and oversaw the supply of medicines and advice given by the team. A team member described the questions they would ask when making over-the-counter recommendations. And 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 a pharmacist.

People working at the pharmacy needed to complete accredited training relevant to their roles after completing a probationary period. But they sometimes chose to train in their own time as they were often busy at work doing all the things they needed to do. Members of the pharmacy team could ask the RP questions, discuss their development needs and familiarise themselves with products when they had the time to do so. They knew who they should raise a concern with if they had one. They were comfortable about making suggestions on how to improve the pharmacy and its services. And their feedback led to changes to the layout of the dispensary and the pharmacy counter.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver it services from. Its premises are clean and tidy. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was bright and clean. Its public-facing area was adequately presented. And its team members were responsible for keeping its premises tidy. The pharmacy generally had the workbench and storage space it needed for its workload. And it used portable air conditioners during hot weather to help keep its premises cool. The pharmacy had a consulting room for the services it offered that required one. Or if someone needed to speak to a team member in private. The consulting room was locked when it wasn't being used. So, its contents were kept secure. And people's conversations in it couldn't be overheard outside of it. The pharmacy had some sinks and a supply of hot and cold water. And its team members cleaned the pharmacy as often as they could when it wasn't busy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are safe and effective. And its team is friendly and helps people access the services they need. Members of the pharmacy team dispose of people's unwanted medicines properly. And they generally carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. 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 usually stores them appropriately and securely.

Inspector's evidence

The pharmacy didn't have an automated door. But its entrance was level with the outside pavement. And members of the pharmacy team helped people who couldn't open the door easily, such as someone with a pushchair or a wheelchair, access the building. The pharmacy had a seat people could use if they wanted to wait in the pharmacy. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. Members of the pharmacy team were friendly. 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 this showed it had delivered the right medicine to the right person. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And its team assessed whether a person needed a compliance pack. The pharmacy generally kept an audit trail of the person who had assembled and checked each prescription. And patient information leaflets and a brief description of each medicine contained within a compliance pack were usually provided. So, people had the information they needed to make sure they took their medicines safely. The pharmacy team marked prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items, such as a CD or a refrigerated product, needed to be added. But it could do more to make sure assembled CD prescriptions awaiting collection were marked with the date the 28-day legal limit would be reached to ensure supplies were made lawfully. 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. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept most of its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team marked the containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. And they marked products which were soon to expire. These steps helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. 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 to it. 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 the alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And, for example, the pharmacy team had removed and returned pholcodine-containing cough and cold medicines following the receipt of an MHRA medicines recall. But its team could do more to make sure it recorded what actions it took when it received an MHRA medicines recall.

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 a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team 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 a large medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team checked and recorded the refrigerator's maximum and minimum temperatures on the days the pharmacy was open. The pharmacy also had a small medical refrigerator in its consulting room. But this wasn't being used at the time of the inspection. Members of the pharmacy team could check a person's blood pressure when asked. And the monitor they used to do this was replaced recently. 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.