General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lightwater Pharmacy, 48 Guildford Road, LIGHTWATER, Surrey, GU18 5SD

Pharmacy reference: 1036668

Type of pharmacy: Community

Date of inspection: 27/11/2023

Pharmacy context

This NHS community pharmacy is set in Lightwater village 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 some people who need help managing their medicines. And it provides the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine.

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	1.1	Good practice	The pharmacy identifies and manages its risks, especially those associated with its dispensing service, very well.
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 work culture of openness, honesty and learning.
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 identifies and manages its risks, especially those associated with its dispensing service, very well. It has written instructions to help its team members work safely. It largely 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 log and review the mistakes they make to try to 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

The pharmacy had a plan its team would follow in an emergency. This identified the potential risks to the pharmacy, its team and its services. People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had some plastic screens on its counter to help reduce the spread of airborne infections such as coronavirus. And hand sanitising gel was also available for people to use.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed every two years or so by the superintendent pharmacist. 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 responsibilities were also described within the SOPs. And a notice in the pharmacy 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 one of the pharmacists.

The team members responsible for making up people's prescriptions carefully managed the dispensing workflow to reduce the chances of making mistakes. They made up people's multi-compartment compliance packs in an area separate to the main dispensary so they weren't distracted or interrupted by other people. The pharmacy generally kept its pharmaceutical stock alphabetically. And its team separated and highlighted some higher-risk medicines, such as those used to treat diabetes, to help reduce the chances of them choosing the wrong medicine by mistake. Members of the pharmacy team kept the dispensary tidy. They used baskets to keep each person's prescription separate from other people's prescriptions. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were then checked and initialled by one of the pharmacists. But each prescription was checked one last time before being put in a bag ready to be handed out.

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). The pharmacy team discussed and recorded the mistakes it made to learn from them. It reviewed its mistakes periodically to help stop the same sort of things happening again. And, for example, it moved some look-alike and sound-alike drugs

to keep them apart on the dispensary shelves to help reduce the risks of the wrong product being picked.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. And it had a notice that told people how they could provide feedback about the pharmacy or its team. People could share their views and make suggestions to the pharmacy team about how the pharmacy could do things better. And, for example, the seating area people used to wait in the pharmacy was moved to the front of the premises following someone's suggestion.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had an appropriately maintained controlled drug (CD) register. And the stock levels recorded in this register were checked as often as the SOPs required them to be. The pharmacy kept adequate records to show which pharmacist was the RP and when. It recorded the supplies of the unlicensed medicinal products it made. But its team could do more to make sure it always recorded when it received one of these products. The pharmacy team recorded the emergency supplies it made and the private prescriptions it supplied on its computer. And a sample of these records were found to be in order. But the RP was reminded that an appropriate record needed to be made when a prescription-only medicine was supplied to a person in an emergency following a CPCS referral. The RP gave an assurance that the pharmacy records would be maintained as they should be.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. 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 an information governance policy. And arrangements were in place to make sure confidential information was stored and disposed of securely. People working at the pharmacy needed to read and sign an agreement saying that they would keep people's private information safe.

The pharmacy had a safeguarding policy. Its team members 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 RP had completed a level 2 safeguarding training course.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough team members to provide its services safely and effectively. And it asks 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 regular pharmacist (the RP), a trainee pharmacy technician, four dispensing assistants, five medicines counter assistants (MCAs), a delivery driver and an assistant. The assistant helped with administrative and cleaning tasks. And they didn't sell or supply medicines or provide healthcare advice. The pharmacy depended upon its team and locum pharmacists to cover absences. The people working at the pharmacy during the inspection included the RP, a locum pharmacist, the trainee pharmacy technician, two dispensing assistants and two MCAs. The pharmacy didn't set any targets or incentives for its team. It had seen an increase in its dispensing volume since the last inspection. But its team was largely up to date with its workload. Members of the pharmacy team worked well together. They 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 was the superintendent pharmacist. They managed the pharmacy and its team. And a locum pharmacist worked alongside them most days. This meant people could see or speak to a pharmacist when they needed to. The pharmacists led by example. 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. 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.

The pharmacy had an induction training programme for its team. People working at the pharmacy needed to complete accredited training relevant to their roles after completing a probationary period. They helped each other learn. They discussed how they were doing and their development needs with the RP. And, for example, the trainee pharmacy technician felt supported and was completing an accuracy checking course alongside their accredited training to improve their skills further.

Members of the pharmacy team were encouraged to ask questions and familiarise themselves with new products. They kept their knowledge up to date by completing additional training. They had time set aside while they were at work to train and support their development. But they could choose to train in their own time. The pharmacy had a culture that encouraged its team to be open and honest about the mistakes it made and share learning at meetings or during one-to-one discussions. This meant it could improve the safety of the services it offered.

People who worked at the pharmacy were comfortable about making suggestions on how to improve the pharmacy and its services. They knew the pharmacy had a whistleblowing policy and who they

should raise a concern with if they had one. And their feedback led to an additional computer being installed in the dispensary. This allowed them to check the patient medication record (PMR) system more easily especially when the pharmacy was busy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was tidy and secure. And its public-facing area was adequately lit and presented. But it wasn't air-conditioned. So, steps were taken to make sure it didn't get too hot. The pharmacy had a consulting room, a counter, a dispensary, a kitchenette, a retail area, a storeroom and a toilet. The pharmacy generally had the workbench and storage space it needed for its current workload. But some of its fixtures were dated. The consulting room could be used when people wanted to talk to a team member in private. But it couldn't be locked. So, the pharmacy team made sure its contents were kept secure when it wasn't being used. The pharmacy had some sinks. And it had a supply of hot and cold water. Members of the pharmacy team were responsible for keeping the pharmacy's 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 has working practices that are safe and effective. Its team is friendly and helps people access the services they need. It delivers prescription medicines to people's homes. And it keeps a log to show that it has delivered the right medicine to the right person. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team usually dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy didn't have step-free access. So, members of the pharmacy team remained alert to make sure they could help people use the pharmacy and access its services. The pharmacy had notices that told people when it was open and what services it offered. And it had a seating area for people to use if they wanted to wait. The pharmacy team asked people who were prescribed a new medicine if they wanted to speak to a pharmacist about it. The pharmacy dealt with CPCS referrals. People benefited from this service as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses. Members of the pharmacy team were friendly and 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 a few people who couldn't attend its premises in person. It kept a log to show the right medicine had been delivered to the right person. And people were asked to sign the log to say they had received their medicines safely. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And an assessment was done to determine if a person needed a compliance pack.

The pharmacy kept an audit trail of the person who had assembled and checked each prescription. And a patient information leaflet and a brief description of each medicine contained within a compliance pack were routinely provided. The pharmacy 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. And its team usually stamped CD prescriptions with the date the 28-day legal limit would be reached to help make sure 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. They were aware of the new rules on dispensing valproate-containing medicines in the manufacturer's original full pack. 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 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 things 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. It stored its CDs, which weren't exempt from safe custody requirements, securely. Its team recorded the destruction of the CDs that people returned to it. And it kept these and out-of-date CDs separate from in-date stock. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But the pharmacy didn't have a pharmaceutical waste bin for any hazardous waste that was returned to it.

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 a team member described the actions they took and demonstrated what records they made when the pharmacy 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 or Numark to ask for information and guidance. The pharmacy had a 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 restricted access to its computers and PMR 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.