General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Windlesham Village Pharmacy, 20 Updown Hill, WINDLESHAM, Surrey, GU20 6AF

Pharmacy reference: 1036819

Type of pharmacy: Community

Date of inspection: 09/10/2019

Pharmacy context

A community pharmacy set on a row of shops in the centre of Windlesham. The pharmacy opens six days a week. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers winter influenza (flu) vaccinations. It supplies multi-compartment compliance packs to help people take their medicines. And it delivers medicines to people who can't attend its premises in person.

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 has written procedures to help make sure its team works safely. It adequately monitors the safety of its services. It has appropriate insurance to protect people if things do go wrong. It usually keeps all the records it needs to by law. And it asks people using its services for their views. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They work to professional standards and identify and manage risks appropriately. They record the mistakes they make and learn from them to try and stop them happening again. They understand their role in protecting vulnerable people. And they generally keep people's private information safe.

Inspector's evidence

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, through the National Pharmacy Association (NPA). It also had standard operating procedures (SOPs) in place for the services it provided. And these have been reviewed since the last inspection. The pharmacy's team members were required to read and sign the SOPs relevant to their roles.

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 the responsible pharmacist (RP) who was also seen initialling the dispensing label. The pharmacy had systems to record and review dispensing errors and near misses. The pharmacy's team members discussed and documented individual learning points when they identified a mistake. They also reviewed their mistakes periodically to help spot the cause of them. And they tried to stop them happening again; for example, they have separated look-alike and sound-alike drugs to help reduce the risks of them picking the wrong product.

The pharmacy displayed a notice that identified the RP on duty. The pharmacy team member's roles and responsibilities were described within the SOPs. A member of staff explained what they could and couldn't do, what they were responsible for and when they might seek help; for example, a member of the pharmacy team explained that repeated requests for the same or similar products were referred to a pharmacist.

The pharmacy had a complaints procedure in place. And its practice leaflet told people how they could provide feedback about the pharmacy or its services. Patient satisfaction surveys were undertaken each year. And the results of a recent survey were displayed at the pharmacy's counter. People's feedback led to the pharmacy team asking people if they wanted to talk to them privately in the pharmacy's consultation room.

The pharmacy's controlled drug (CD) register was adequately maintained. But its team didn't check the CD register's running balance regularly. So, some opportunities to spot mistakes or discrepancies within the CD register could be missed. The nature of the emergency within the pharmacy's records for emergency supplies made at the request of patients didn't always provide enough detail for why a supply was made. The prescriber's details were sometimes incomplete or incorrect within the pharmacy's private prescription records. The pharmacist occasionally forgot to record the time at which

they stopped being the RP within the pharmacy's RP records. The date an unlicensed medicinal product was obtained wasn't included in the pharmacy's 'specials' records.

The pharmacy had an information governance policy in place which staff were required to read and sign. Arrangements were in place for confidential waste to be collected. But it had been allowed to accumulate and needed to be destroyed securely. People's details were routinely removed from patient-returned pharmaceutical waste before being disposed of. And prescriptions awaiting collection were stored in such a way to prevent people's names and addresses being visible to the public.

Safeguarding procedures and a list of key contacts for safeguarding concerns were available at the pharmacy. Pharmacy professionals were required to complete level 2 safeguarding training. And staff could explain what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to deliver its services safely. And it encourages and supports its team members to provide feedback and keep their knowledge up to date. The pharmacy team makes appropriate decisions about what is right for the people it cares for. Staff know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy opened for 49 hours a week. It dispensed between 2,500 and 2,600 NHS prescription items a month. The pharmacy team consisted of a full-time pharmacist (the RP), two part-time dispensing assistants, a part-time medicines counter assistant (MCA), a part-time trainee MCA and a part-time delivery driver. The RP was the pharmacy's superintendent pharmacist and he managed the pharmacy and its team. The pharmacy relied upon its team and locum pharmacists to cover any absences. The RP and one of the dispensing assistants were working at the time of the inspection.

Staff supported each other so prescriptions were processed in a timely manner and people were served promptly. The RP supervised and oversaw the supply of medicines and advice given by staff. A sales of medicines protocol was in place which the pharmacy team needed to follow. The dispensing assistant described the questions she would ask when making over-the-counter recommendations and when she would refer people to a pharmacist; for example, requests for treatments for infants, people who were pregnant, elderly people or people with long-term health conditions.

The pharmacy's team members needed to undertake accredited training relevant to their roles. They discussed their performance and development needs with the RP throughout the year. They were encouraged to ask questions and familiarise themselves with new products. They were also encouraged to complete other training to make sure their knowledge was up to date. And they sometimes got time to train while they were at work when the pharmacy wasn't busy. Meetings were held to update staff and share learning from mistakes or concerns. Members of the pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. And they knew how to raise a concern if they had one. Their feedback led to changes to the dispensary's layout.

The pharmacy team was encouraged to promote the pharmacy's services. But the company didn't set targets nor incentives for its staff. Medicines Use Reviews (MURs) and New Medicine Service (NMS) consultations were only provided by a suitably qualified pharmacist when it was clinically appropriate to do so and when the workload allowed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate and secure environment for people to receive healthcare. It has a room where people can have private conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy was organised. And it had the workbench and storage space it needed for its current workload. But it wasn’t air-conditioned. So, staff relied upon a portable air-conditioning unit and some to keep the premises and themselves cool during hot weather. The pharmacy was cleaned once a week by a cleaner. And the pharmacy team was also responsible for keeping the registered pharmacy premises clean and tidy. The pharmacy was bright and appropriately presented. But some parts of the building were starting to show signs of wear and were in need of attention.

The pharmacy had a consultation room for the services it offered and if people needed to speak to a team member in private. But it couldn’t be locked. So, the pharmacy team made sure its contents were appropriately secure when it wasn’t being used. The pharmacy’s sinks were clean. And the pharmacy had a supply of hot and cold water. It also had appropriate handwashing facilities for its staff.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. The pharmacy helps people access its services. It 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. The pharmacy's team members check stocks of medicines to make sure they are fit for purpose. And they dispose of people's waste medicines safely too.

Inspector's evidence

The pharmacy didn't have a step-free entrance. So, the pharmacy team needed to make reasonable adjustments to help some people, such as people with mobility difficulties, access the pharmacy's services. The pharmacy's services were advertised in-store and were included within its practice leaflet. The pharmacy's team members were helpful. They knew what services were offered and where to signpost people to if a service couldn't be provided.

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 a delivery record to say they had received their medicines. The pharmacy had appropriate anaphylaxis resources in place for its flu vaccination service. And its team made sure its sharps bin was kept securely when not in use. People could choose to be vaccinated at the pharmacy rather than their doctor's surgery when a suitably trained pharmacist was on duty. The pharmacy provided about 30 MURs and one to two NMS consultations a month. People were required to provide their written consent when recruited for these services.

The pharmacy used a disposable and tamper-evident system for people who received their medicines in multi-compartment compliance packs. The pharmacy team checked whether a medicine was suitable to be repackaged into a compliance pack. And it had started to review the eligibility of people using this service. The pharmacy team provided a brief description of each medicine contained within the compliance packs. But it didn't always provide patient information leaflets. And cautionary and advisory warnings about the medicines weren't printed on the backing sheets. So, sometimes people didn't have all the information they needed to make sure they took their medicines safely.

Prescriptions were highlighted to alert staff when a pharmacist needed to counsel people and when CDs or refrigerated items needed to be added. The pharmacy team took the time to explain to people how to take their medicines safely. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. Valproate educational materials were available at the pharmacy.

The pharmacy used recognised wholesalers, such as AAH, Alliance Healthcare, Phoenix, Sigma and Trident, to obtain its pharmaceutical stock. It kept most of its medicines and medical devices in an organised fashion within their original manufacturer's packaging. But a few split packs were found to contain stock from different batches and manufacturers. So, they were quarantined to prevent them from being supplied. The pharmacy's stock was subject to date checks, which were documented, and products nearing their expiry dates were appropriately marked. The pharmacy stored its stock, which needed to be refrigerated, appropriately between two and eight degrees Celsius. And it also stored its

CDs, which were not exempt from safe custody requirements, securely. A record of the destruction of patient-returned CDs was maintained. The pharmacy team was required to keep patient-returned and out-of-date CDs separate from in-date stock. But it had allowed these to accumulate and they needed to be destroyed in the presence of an authorised witness.

Staff were aware of the Falsified Medicines Directive (FMD). They could check the anti-tampering device on each medicine was intact during the dispensing process. But they weren't decommissioning stock at the time of the inspection despite the pharmacy having the appropriate equipment and computer software to do so. The pharmacy's SOPs hadn't been revised to reflect the changes FMD would bring to the pharmacy's processes. But the pharmacy was scheduled to be FMD compliant by the end of the year.

Procedures were in place for the handling of patient-returned medicines and medical devices. Patient-returned waste was emptied into a plastic tray and was checked for CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. Suitable pharmaceutical waste receptacles were available and in use.

A process was in place for dealing with recalls and concerns about medicines and medical devices. Drug and device alerts were retained, actioned and annotated following their receipt.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and the facilities it needs to provide its services safely. And, it uses these to keep people's private information safe.

Inspector's evidence

The pharmacy had a range of clean glass measures. It also had equipment for counting loose tablets and capsules too. The pharmacy team had access to up-to-date reference sources. And it could contact the NPA to ask for information and guidance. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the refrigerator's maximum and minimum temperatures. The pharmacy provided blood pressure checks on request. And its blood pressure monitor was replaced every year.

Access to the pharmacy computers and the patient medication record system was restricted to authorised team members and password protected. The computer screens were positioned so only staff could see them. A cordless telephone system was installed at the pharmacy to allow staff to have confidential conversations when necessary. The team members responsible for the dispensing process each had their own NHS smartcard. And they made sure it was 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.