General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Horsell Pharmacy, 91 High Street, Horsell, WOKING, Surrey, GU21 4SY

Pharmacy reference: 1036841

Type of pharmacy: Community

Date of inspection: 29/09/2020

Pharmacy context

A community pharmacy set on a row of shops in a residential area of Woking. The pharmacy is part of a small chain of pharmacies. It opens six days a week. And most people who use it live nearby. The pharmacy sells a range of over-the-counter (OTC) medicines. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy provides multi-compartment compliance packs (compliance packs) to help people take their medicines. And it offers a winter influenza (flu) vaccination service. This inspection took place during the coronavirus (COVID-19) pandemic.

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 generally manages its risks appropriately. And it has written procedures to help make sure its team works safely. The pharmacy keeps most of the records it needs to. And it has adequate insurance to help protect people if things do go wrong. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They discuss and record the mistakes they make. They understand their role in protecting vulnerable people. And they keep people's private information safe.

Inspector's evidence

The pharmacy team had risk assessed the impact of COVID-19 on the pharmacy and its services. And, as a result, some of the pharmacy's services, such as blood pressure checks, Medicines Use Reviews and the NHS New Medicine Service, were suspended. The pharmacy team had received some supplemental guidance from head office to help it manage the pharmacy services safely during the pandemic. The pharmacy offered to undertake an occupational risk assessment for each team member to help identify and protect those at increased risk in relation to COVID-19. The responsible pharmacist (RP) was aware of the need for community pharmacy employers to report instances of exposure to COVID-19 in the workplace. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed and updated centrally by the pharmacy's head office. Members of the pharmacy team were required to read, sign and follow the SOPs relevant to their roles. But some team members hadn't signed the SOPs.

The team members responsible for making up people's prescriptions highlighted look-alike and sound-alike drugs on the dispensary shelves to reduce the chances of the wrong product being picked. They used baskets to separate each person's medication and to help them prioritise their 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 RP who also initialled the dispensing label. The pharmacy had systems to record and review dispensing errors and near misses. Members of the pharmacy team discussed and recorded the mistakes they made. But they didn't always review them to help reduce the chances of the same sort of errors happening again. The pharmacy team recently strengthened its dispensing process after it gave someone the wrong asthma inhaler and the incorrect strength of levothyroxine.

The pharmacy displayed a notice that told people who the RP was. Its SOPs described the roles and responsibilities of the pharmacy team. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. They explained that they wouldn'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 to the RP. The pharmacy had a complaints procedure. It displayed a notice that told people how they could provide feedback about the pharmacy. People were asked to take part in a satisfaction survey once a year. And the results of some recent surveys were available online. The pharmacy team tried to keep people's preferred makes of prescription-medicines in stock when asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy team generally kept the controlled drug (CD) register in order.

But the address from whom a CD was received from wasn't always recorded. And the CD running balance wasn't checked as often as the SOPs required. So, the pharmacy team could be missing opportunities to spot mistakes or discrepancies. The pharmacy kept a record to show which pharmacist was the RP and when. But the time the pharmacist stopped being the RP hadn't been recorded recently. The pharmacy kept records for the supplies of unlicensed medicinal products it made. But it didn't always record when a product was supplied and to whom. The pharmacy recorded the emergency supplies it made and the private prescriptions it supplied electronically. And while these records were mostly in order, the name and address of the prescriber were sometimes missing or entered incorrectly.

The pharmacy had an information governance policy. It had arrangements for confidential waste to be collected and destroyed by a third-party contractor. The pharmacy team tried to store prescriptions in such a way so people's names and addresses couldn't be seen by someone who shouldn't see them. The pharmacy had safeguarding procedures. It had the contacts it needed if a member of the team needed to raise a safeguarding concern. And team members 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 people in its team. Members of the pharmacy team undergo training for the jobs they do. So, they can deliver safe and effective care. They work well together and make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy and its services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets or incentives.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacy manager (the RP), a full-time accuracy-checking dispensing assistant, a full-time trainee dispensing assistant, a full-time trainee medicines counter assistant (MCA) and a part-time delivery driver. Some experienced team members, including the resident pharmacist, left the pharmacy earlier in the year. The remaining team members hadn't worked together for long. And the RP and the trainee MCA had only recently started at the pharmacy. The accuracy-checking dispensing assistant was leaving the pharmacy soon. But a pre-registration pharmacist trainee was due to start at the pharmacy. And the pharmacy's head office team was trying to recruit an additional team member for the pharmacy. The RP, the accuracy-checking dispensing assistant, the trainee dispensing assistant and the trainee MCA were working at the time of the inspection. The pharmacy relied upon its team, and team members from other branches or head office, to cover absences or provide support. Members of the pharmacy team occasionally struggled and felt under pressure to do all the things they were expected to do. But they were coping with the pharmacy's workload at the time of the inspection. And they worked well together and supported each other so prescriptions were processed quickly, but safely, and people were served promptly. The superintendent pharmacist promised that the pharmacy team would receive additional support, including a second pharmacist, over the coming weeks to make sure it could continue to deliver the pharmacy's services safely.

The RP supervised and oversaw the supply of medicines and advice given by staff. The pharmacy had a sales of medicines protocol which its team needed to follow. A team member described the questions they would ask when making OTC 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 the RP. Team members were required to undertake accredited training relevant to their roles. They discussed their performance and development needs with their line manager when they could. They were encouraged to ask questions and familiarise themselves with new products. They could train while they were at work when the pharmacy wasn't busy. But they often chose to train in their own time. The pharmacy held informal meetings to update its team and discuss concerns. The pharmacy's team members didn't feel their professional judgement or patient safety were affected by targets. The pharmacy had a whistleblowing policy. Its team members knew who they should raise a concern with if they had one. And they felt comfortable about making suggestions on how to improve the pharmacy and its services. The pharmacy team's feedback led to a change to the dispensary's layout.

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 had a retail area, a consulting room, a counter, a dispensary, a kitchenette, a stockroom and a toilet. The pharmacy was bright, clean, secure and adequately presented. But it didn't have air conditioning. So, its team took steps to try and control the temperature when it was hot or cold. The dispensary had the workspace and storage it needed for its current workload. But its dispensing worksurfaces could become cluttered when the pharmacy was busy. The flooring was worn in places. And some fixtures were dated too. The pharmacy was due to be refurbished sometime next year. People tried to socially distance themselves from one another when inside the pharmacy. And they wore face coverings too. Members of the pharmacy team used the consulting room if people needed to speak to them in private. The consulting room couldn't be locked when not in use. So, team members tried to make sure its contents were kept secure when it wasn't being used. The pharmacy had some sinks. But its hot water supply wasn't working at the time of the inspection. So, the pharmacy team used a kettle to heat water when needed. The superintendent pharmacist was notified of the matter. And an assurance was given that the hot water supply would be promptly fixed. Members of the pharmacy team were responsible for keeping the pharmacy's premises clean and tidy. They wiped and disinfected the surfaces they and other people touched. The pharmacy had handwash and alcoholic hand sanitiser for people to use. And its team members could wash or sanitise their hands regularly.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access. Its working practices are generally safe and effective. And its team is helpful. 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 stores most of them appropriately and securely. Members of the pharmacy team generally carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy team disposes of most people's unwanted medicines properly too.

Inspector's evidence

The pharmacy had step-free access. But it didn't have an automated door. So, the pharmacy team opened the door when needed. This meant that people with mobility difficulties, such as wheelchair users, could enter the building easily. The pharmacy listed the services it could provide in-store and online. Members of the pharmacy team were 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 people who couldn't attend its premises in person. It kept an audit trail for each delivery to show that the right medicine was delivered to the right person. But it had adapted its delivery process because of the pandemic. And people no longer needed to sign a delivery record to say they had received their medicines. This meant that the delivery person and the people they were delivering to could socially distance from each other.

The pharmacy had appropriate resources, including an up-to-date patient group direction, for its flu vaccination service. And people were encouraged to book an appointment for their flu vaccination. The pharmacy kept a record of the vaccinations it made. And this included the details of the person vaccinated and their consent, an audit trail of who vaccinated them and the details of the vaccine used. The pharmacy team made sure the sharps bin was kept securely when not in use. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked whether a medicine was suitable to be re-packaged. It provided a brief description of each medicine contained within the compliance packs. It kept an audit trail of the person who had assembled and checked each prescription. But the date of dispensing wasn't always included on the compliance pack. And sometimes patient information leaflets weren't supplied. The pharmacy team marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting, for example a high-risk medicine, or if other items, such as CDs and refrigerated products, needed to be added. 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. The pharmacy had some valproate educational materials available.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices tidily within their original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines when it dispensed them and at regular intervals. It recorded when it had done these checks. It marked products which were soon to expire. And it marked containers of liquid medicines with the date they were opened. This helped the team reduce the chances of it giving people out-of-date medicines by mistake. The pharmacy was required to store its

stock, which needed to be refrigerated, between two and eight degrees Celsius. But the pharmacy team hadn't been monitoring or recording the pharmacy's refrigerator's maximum and minimum temperatures as often as it should. The pharmacy refrigerator had three thermometers. And they indicated that the refrigerator's maximum and minimum temperatures were out of range. But all of them showed that the current temperature in the refrigerator was within the nominal range. The matter was reported to and investigated by the superintendent pharmacist. The superintendent pharmacist sought guidance and decided that the stock within the refrigerator shouldn't be supplied and should be quarantined. The pharmacy team postponed people's flu vaccination appointments. But the superintendent pharmacist and the RP were satisfied that the flu vaccines had been stored and administered appropriately. The pharmacy team was shown how to use the thermometers properly. And the pharmacy's process for the storage of refrigerated products was reviewed and strengthened. The refrigerator's temperature was regularly monitored during and after the inspection and was found to be stable and within range. The pharmacy stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy kept a record of the destruction of patient-returned CDs. The pharmacy team needed to keep patient-returned and out-of-date CDs separate from in-date stock. But these had been allowed to build up and needed to be destroyed. Members of the pharmacy team 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. And they were unsure when the pharmacy would become FMD compliant. The superintendent pharmacist confirmed that the pharmacy had the FMD equipment and software it needed. And the pharmacy should become FMD compliant by the end of the following month once the pharmacy's processes had been updated and its team trained. The pharmacy had procedures for handling unwanted medicines people returned to it. And its team checked if these included any CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. The pharmacy had suitable pharmaceutical waste bins for the disposal of hazardous and non-hazardous waste. But some intact patient-returned gabapentin capsules were found in a pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they would take when they received a drug alert. But they didn't always record these actions.

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 reviewed the equipment its team needed as a result of the pandemic. It had hung a plastic screen from the ceiling above its counter. And markings on its floor were there to help people keep two metres apart and restrict the number of people in the pharmacy at any one time. The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment, including face masks, its team members needed when they couldn't socially distance from people or each other. The pharmacy had a range of clean glass measures. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure the equipment they used to measure, or count, medicines was clean 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 medical refrigerator to store pharmaceutical stock requiring refrigeration. 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. The pharmacy had a cordless telephone system. So, its team could have confidential conversations with people when necessary. Most of the team members responsible for the dispensing process 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.