General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Oatlands Park Pharmacy, 126 Oatlands Drive, Oatlands Park, WEYBRIDGE, Surrey, KT13 9HL

**Pharmacy reference:** 1036860

**Type of pharmacy:** Community

**Date of inspection:** 23/11/2023

## Pharmacy context

This NHS community pharmacy is set on a row of businesses in a residential area on the outskirts of Weybridge. 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 | 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 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

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 a plastic screen 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 regularly. 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 the pharmacist.

The team members who were responsible for making up people's prescriptions 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 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). 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 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 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 the emergency supply record looked at during the inspection were found to be in order. But the details of the prescriber were incomplete or incorrect in a few of the private prescription records seen.

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 SOP. 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 RP had completed a level 2 safeguarding training course.

## 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 a pharmacist, two dispensing assistants, two trainee dispensing assistants, a trainee medicines counter assistant (MCA), two delivery drivers 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, two dispensing assistants, a trainee dispensing assistant and a trainee MCA.

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 up to date with the 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 was the superintendent pharmacist. They managed the pharmacy and its team. And they supervised and oversaw the supply of medicines and advice given by the team. The trainee MCA 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.

People working at the pharmacy needed to complete accredited training relevant to their roles. And the RP gave an assurance that this included team members who delivered people's prescriptions. Members of the pharmacy team discussed their development needs with the RP when they could. They were encouraged to ask questions and keep their knowledge up to date. They could train while they were at work when the pharmacy wasn't busy. But they could choose to train in their own time too.

The pharmacy held meetings and one-to-one discussions to update its team and share learning from mistakes or concerns. The pharmacy had a whistleblowing policy. And its team was comfortable about making suggestions on how to improve the pharmacy and its services. Team members knew who they should raise a concern with if they had one. And their feedback led to a wipeable noticeboard being installed to help them better manage their workload.

## 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 had a website. But it didn't sell or supply medicines online. And the website told people about the pharmacy, who its superintendent pharmacist was and what services it offered. The pharmacy was tidy and secure. Its public-facing area was adequately lit and presented. And a portable air-conditioning unit and some window blinds were used to make sure the pharmacy, and its team, didn't get too hot. The pharmacy had a retail area, a counter, a dispensary, a small storeroom, a toilet, a consulting room and some other rooms upstairs. But some of its fixtures were dated. And the plaster on one of the walls had some large cracks in it that required some attention. The dispensary was enlarged following a previous inspection. So, the pharmacy had the workbench and storage space it needed for its current workload. The consulting room could be used when people wanted to talk to a team member in private. And it was at the rear of the property and it had its own entrance. 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. And it keeps a log to show that it has given 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 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. But it had a portable ramp its team could use to help people who had trouble climbing stairs, such as someone who used a wheelchair, enter the building. And the entrance used to access the consulting room was almost level with the outside pavement. The pharmacy had notices that told people when it was open and what services it offered. And it had a small 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 the pharmacist about it. The pharmacy dealt with a few 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 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. But its team could do more to make sure the recipient signed the log to say they have received their medicines safely as required by the SOPs.

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 circled the date on CD prescriptions awaiting collection 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 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. It stored its CDs, which weren't exempt from safe custody requirements, securely. And its 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 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 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 team could check a person's blood pressure when asked. And the monitor it used for this service was new. 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. |