General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Norie's Pharmacy, 23 Oakhill Road, HORSHAM, West Sussex, RH13 5SD

Pharmacy reference: 1037354

Type of pharmacy: Community

Date of inspection: 14/11/2019

Pharmacy context

A community pharmacy set in a residential area of Horsham close to a railway station. The pharmacy opens six days a week. And most people who use it live nearby. The pharmacy sells a range of over-the-counter medicines. It dispenses NHS and private prescriptions. It offers a stop smoking service and blood pressure checks. The pharmacy provides multi-compartment compliance packs (blister packs) to help people take their medicines. It delivers medicines to people who can't attend its premises in person. And it also offers winter influenza (flu) vaccinations.

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	Good practice	2.4	Good practice	Staff work well together as a team and have a work culture of openness, honesty and learning. And they learn from their own and other people's mistakes.
3. Premises	Standards met	3.1	Good practice	The pharmacy is fitted out to a high standard. It provides a safe and a professional environment for people to receive healthcare.
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 mostly 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 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 usually 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 had written standard operating procedures (SOPs) in place. And these were scheduled to be reviewed to make sure they covered all the services the pharmacy provided. Staff were required to read, sign and follow the SOPs relevant to their roles. The team members responsible for making up people's prescriptions tried to keep 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 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 individual learning points when they identified a mistake. They also reviewed and discussed their mistakes periodically to help stop them happening again. But they didn't always document these reviews. They highlighted stocks of bisoprolol to raise their awareness of the risks of them selecting the wrong product following a succession of picking errors. The pharmacy team reviewed and strengthened its dispensing process following a review of a mistake where the wrong strength of medicine was recently supplied.

The pharmacy displayed a notice that identified the RP on duty. Its team members wore name badges which identified their roles within the pharmacy. And their roles and responsibilities were described within the SOPs. Members of the pharmacy team explained what they could and couldn't do, what they were responsible for and when they might seek help, for example, they referred repeated requests for the same or similar products to a pharmacist. A complaints procedure was in place and patient satisfaction surveys were undertaken each year. And the pharmacy team asked people for their views. The results of last year's patient satisfaction survey were available online. Staff tried to keep people's preferred makes of medicines in stock when they were asked to do so.

The pharmacy's records for its emergency supplies and its RP records were adequately maintained. A mistake in the pharmacy's controlled drug (CD) register about the quantity of a CD supplied to a patient was appropriately corrected during the inspection. The address from whom a CD was received from wasn't always included in the CD register. And most of the CD register's running balances, apart from methadone, were only checked after each transaction and not weekly as required by the pharmacy's SOPs. So, opportunities to spot mistakes or discrepancies within the CD register could be missed. The prescriber's details were sometimes incomplete or incorrect within the pharmacy's private prescription records. The date an unlicensed medicinal product was obtained wasn't routinely included in the

pharmacy's 'specials' records.

An information governance policy was in place. And staff were required to read and sign it. Arrangements were in place for confidential waste to be collected and destroyed securely by a third-party contractor. People's details were removed or obliterated 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. The pharmacy team removed confidential information stored in the consultation room during the inspection. So, people using a doctor video consultation service within the consultation room didn't have access to other people's personal details. Members of the pharmacy team could clearly explain what they would do and who they would make aware if they had a safeguarding concern about a child or a vulnerable person. The RP had completed level 2 safeguarding training. And the pharmacy had a list of key safeguarding contacts if its team needed to raise a safeguarding concern. But staff couldn't find the pharmacy's safeguarding policy or its procedures at the time of the inspection.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough suitably qualified team members to provide its services safely and effectively. And it encourages its team members to give feedback. They work well together as a team and have a work culture of openness, honesty and learning. And they learn from their own and other people's mistakes. The pharmacy team makes appropriate decisions about what is right for the people it cares for. Team members 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 46½ hours a week. It dispensed about 6,800 NHS prescription items a month. The pharmacy team consisted of a full-time pharmacist manager (the RP), a part-time pharmacy technician, a full-time dispensing assistant, two part-time dispensing assistants, a full-time medicines counter assistant (MCA) and a part-time delivery driver. The RP, three dispensing assistants and the MCA were working at the time of the inspection. The pharmacy relied upon its team, staff from one of the company's other branches and locums to cover absences.

The RP led by example. And the team worked well together and supported one another. So, prescriptions were processed efficiently, but safely, 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. A member of staff 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 or breastfeeding, elderly people or people with long-term health conditions.

Members of the pharmacy team needed to undertake accredited training relevant to their roles. They regularly discussed their performance and development needs with the RP or one of the company's senior managers. And they helped each other learn. They were encouraged to ask questions and familiarise themselves with new products. They were also encouraged to complete training or attend training events to make sure their knowledge was up to date. And staff could train while they were at work when the pharmacy wasn't busy or during their own time. They were comfortable talking about their own mistakes and weaknesses with their colleagues. And team meetings were held to update them and share learning from mistakes or concerns. The pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. Staff knew how to raise a concern if they had one. And their feedback led to blister packs being assembled in a room separate to the dispensary. The pharmacy team was encouraged to promote the pharmacy's services. And staff didn't feel the company set inappropriate targets. Medicines Use Reviews and New Medicine Service 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 is fitted out to a high standard. It provides a safe and a professional environment for people to receive healthcare. It has a room where people can have private conversations with members of the pharmacy team. But, the room's contents aren't always kept securely when it isn't being used.

Inspector's evidence

The pharmacy was air-conditioned, bright, clean and modern. It was well laid out and organised. It was professionally presented throughout. And its fixtures and fittings were of a high standard. The dispensary had ample dispensing workbench and storage space available for the pharmacy's current workload. People's blister packs were dispensed in a room separate to the main dispensary. So, distractions and interruptions to the team members assembling them were minimised. The pharmacy had a spacious and well-equipped consultation room for the services it offered and if people needed to speak to a team member in private. But the consultation room's contents couldn't be appropriately secured when it wasn't being used. Conversations in the consultation room couldn't be overheard in the areas next to it. The pharmacy team was responsible for keeping the registered pharmacy premises clean and tidy. 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. It provides services that people can access easily. 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 stores them appropriately and securely. The pharmacy team is helpful. And it makes sure that people have all the information they need. So, they can use their medicines safely. Members of the pharmacy team 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 had a step-free entrance and an automated door. So, people with mobility difficulties, such as wheelchair users, could access the pharmacy and its services. The pharmacy's services were advertised in-store. Staff knew where to signpost people to if a service wasn't provided. And they were helpful and routinely provided advice to people on how to take their medicines. 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 used a disposable and tamper-evident system for people who received their medicines in blister packs. The pharmacy team checked whether a medicine was suitable to be repackaged into a blister pack. And it had a process to assess if a person was eligible for the service. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. The pharmacy team provided a brief description of each medicine contained within the blister packs. And staff made sure patient information leaflets were routinely supplied. So, people had the information they needed to make sure they took their medicines safely.

The pharmacy offered a stop smoking service. And its pharmacist could supply the morning-after pill to certain people through a locally commissioned patient group direction (PGD). Some members of the pharmacy team have completed training in readiness for the pharmacy to provide NHS health checks. The pharmacy offered a winter flu vaccination service. Its team promoted the benefits of flu vaccinations to people within the at-risk groups, carers and other people attending its premises. Some people chose to be vaccinated at the pharmacy rather than their doctor's surgery for convenience or because they weren't eligible for the NHS service. The pharmacy had valid, and up-to-date, PGDs and appropriate anaphylaxis resources in place for the services it provided. It kept a record for each vaccination it made. And this included the details of the person vaccinated and their written consent, an audit trail of who vaccinated them and the details of the vaccine used. But the pharmacy team didn't always make sure the pharmacy's sharps bin was kept securely when not in use. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. Prescriptions were highlighted to alert the team member handing the medication over that these items had to be added or if extra counselling was required. 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, Day Lewis Medical Ltd.,

Phoenix and Sigma, to obtain its pharmaceutical stock. It kept its medicines and medical devices in an organised fashion within their original manufacturer's packaging. Its stock was subject to date checks which were documented. But date checks haven't always been regularly done. So, the pharmacy team checked the expiry date of products when assembling people's prescriptions. 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 an out-of-date CD was found amongst in-date stock. 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. And they didn't know if the pharmacy had the appropriate equipment or software to do so. The pharmacy's SOPs hadn't been revised to reflect the changes FMD would bring to the pharmacy's processes. And the pharmacy team didn't know when the pharmacy would become FMD compliant. Procedures were in place for the handling of patient-returned medicines and medical devices. Patient-returned waste was checked for CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. Suitable receptacles for hazardous and non-hazardous pharmaceutical waste were available and in use. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And staff described the actions they would take and demonstrated what records they kept when the pharmacy received a concern about a product.

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, its team makes sure its equipment is kept clean.

Inspector's evidence

The pharmacy had a range of clean glass measures. It had equipment for counting loose tablets and capsules too. And this equipment was cleaned after each use. 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 medical refrigerator and a domestic refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the refrigerators' maximum and minimum temperatures. But, ice could quickly build up in the domestic refrigerator. So, the team defrosted it when this happened and temporarily relocated its stock to the other refrigerator. The pharmacy provided blood pressure (BP) checks on request. And the pharmacy team needed to replace the BP monitor regularly. The pharmacy team reported that the monitor used in the stop smoking service was recently replaced. 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.