General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Village Pharmacy, 9 Belsize Terrace, LONDON, NW3 4AX

Pharmacy reference: 1040569

Type of pharmacy: Community

Date of inspection: 10/05/2023

Pharmacy context

The pharmacy is in a parade of businesses in a mostly residential area of northwest London. It dispenses NHS and private prescriptions and provides health advice. Services offered by the pharmacy include delivery, Community Pharmacist Consultation Service (CPCS), new medicines service (NMS), blood pressure case-finding and seasonal flu vaccinations. The pharmacy supplies medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. And it provides palliative care services to people in a hospice and the local community.

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	1.1	Good practice	The pharmacy identifies and manages risk well so its services are safe and effective
		1.2	Good practice	The pharmacy monitors the safety and quality of its services by carrying out planned reviews and audits.
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	4.2	Good practice	The pharmacy team manages its services effectively so they are provided safely to the people who use the pharmacy
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. The pharmacy team members follow suitable written procedures, which are reviewed regularly to make sure they are up to date and reflect current practice. Members of the pharmacy team make sure people have the information they need to help them use their medicines safely. They keep the records they need to, to show medicines are supplied safely and legally. The pharmacy team understands how to protect people's private information. And its members know how to raise a concern to safeguard vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The superintendent pharmacist (SI), who was also responsible pharmacist (RP), discussed mistakes with members of the pharmacy team to leam from them and reduce the chances of them happening again. Medicines involved in incidents, or were similar in some way, such as lansoprazole tablets and capsules, were generally separated from each other in the dispensary. The SI reviewed near miss records to spot patterns or trends and compiled a monthly patient safety review. And discussed incidents with a colleague to plan continuing professional development (CPD) to further learn and reflect. The pharmacy reported incidents via the NHS 'Learning from patient safety events' service.

During the visit, the SI was working alone but used baskets when making up people's prescriptions to separate each person's medication and to help prioritise the workload. He referred to prescriptions when labelling and picking products. The SI referred to the summary of product characteristics (SPC) when checking interactions between medicines prescribed for the same person such as erythromycin and apixaban. And explained that interventions were noted on the patient medication record (PMR). He took a mental break before completing checks of assembled prescriptions ready to be handed out. Regarding the hospice supplies on prescription, the SI checked that hospice prescriptions (FP10PCDs) included certain information which authorised the prescriber to issue the prescription. The SI could also verify the identity of doctors who prescribed from information which was maintained for each new doctor. The pharmacy had a policy for checking controlled drug prescriptions at the pharmacy and at transfer to the patient.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these were due to be reviewed. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. They knew what they could and could not do, what they were responsible for and when they might seek help. And their roles and responsibilities were described in the SOPs. A team member explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar products, such as medicines liable to misuse to a pharmacist. The SI was providing training for the delivery driver so he could also help with other pharmacy tasks such as putting away the medicines order. The pharmacy had a complaints procedure and an annual community pharmacy patient questionnaire which asked people for their views and suggestions on how it could do things better.

The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it.

Members of the pharmacy team had access to fluid resistant face masks and used hand sanitising gel when needed to help reduce the risks associated with the virus. Other infection control measures such as screens at the medicines counter and restricting the number of people in the pharmacy had been removed. The SI regularly completed and updated risk assessments for the pharmacy including security, fire security, pest control, medicines storage and new services. The pharmacy's services were monitored via audits and the most recent audit was of people taking a valproate. And the SI audited the services provided to the hospice.

The pharmacy displayed a notice that told people who the RP was, and it kept a record to show which pharmacist was the RP and when. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The SI had a current Home Office licence and Medicines and Healthcare products Regulatory Agency (MHRA) wholesale distribution authorisation (WDA) to supply medicines to the hospice. The pharmacy had controlled drug (CD) registers. And the stock levels recorded in the CD register were audited weekly. So, the SI could spot mistakes quickly. The pharmacy kept records for the supplies of the unlicensed medicinal products it made and the private prescriptions it supplied and these generally were in order. And retained all CD related paperwork for two years which was in line with Home Office requirements. Records were retained relating to the flu vaccination service.

The pharmacy was registered with the Information Commissioner's Office. The notice that told people how their personal information was gathered, used and shared by the pharmacy and its team required re-printing. The pharmacy team tried to make sure people's personal information could not be seen by other people and was disposed of securely. Team members had trained in general data protection regulation (GDPR) and signed confidentiality agreements. The pharmacy had a safeguarding SOP. And the SI had completed a level 2 safeguarding training course and the pharmacy team members were due to re-train in safeguarding. Members of the pharmacy team described what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. The SI was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team works well together to manage the workload. Team members are well supported in undertaking ongoing training to keep their knowledge and skills up to date. They are comfortable about providing feedback about services to the pharmacist and they know how to raise concerns.

Inspector's evidence

The pharmacy team consisted of the superintendent pharmacist (the RP), two full-time and two part-time medicines counter assistants and a part-time delivery driver. The pharmacy relied upon its team to cover absences. The SI was supported at the time of the visit by four team members. They were all accredited or enrolled on accredited training including the delivery person who was training as a medicines counter assistant.

The SI collaborated with a colleague who was a pharmacist to discuss safety incidents and plan CPD. This meant there was an opportunity to benefit from peer review. The pharmacy team included two regular locum pharmacists not present during the visit but they were familiar with the patterns of prescribing and the nature of the medicines supplied to the hospice. The SI was also a qualified doctor but never prescribed in this setting due to the conflict of interest. And he set aside time annually to catch up on administrative tasks such as renewing professional memberships. Members of the team had ongoing weekly training to complete via eLearning for healthcare (eLfh) which was managed by one team member.

Members of the pharmacy team worked well together. So, people were served quickly, and their prescriptions were processed safely. The SI supervised and oversaw the supply of medicines and advice given by the pharmacy team. And frequently went out to people to counsel them on how best to use their medicines. The pharmacy had an over-the-counter (OTC) sales and self-care SOP which its team needed to follow. This described the questions the team member needed to ask people when making OTC recommendations. And when they should refer requests to a SI. Performance development reviews were due but all the team met regularly and the SI encouraged an open policy so they felt able to make suggestions on how to improve the pharmacy and its services. They knew how to raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, bright and secure. The pharmacy protects people’s private information and keeps its medicines safe when it is closed.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure. And steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a large retail area, medicines counters, a small dispensary and a storeroom. The SI planned a re-fit to optimise the space available for the services the pharmacy provided. The pharmacy had signposted the consultation room. So, people knew where they could have a private conversation with a team member. The dispensary had limited workspace and storage available. The SI explained that storage issues were due to ordering excess stock to manage shortages in medical stock. So, items were sometimes stored on the floor behind the pharmacy counter. And worksurfaces in the dispensary could become cluttered when the pharmacy was busy. The pharmacy sink area in the dispensary was clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are easily accessible to people with different needs and its working practices are safe and effective. It gets its medicines from reputable sources and stores them securely at the right temperature to make sure they are fit for purpose and safe to use. The pharmacy team knows what to do when medicines have to be returned to the suppliers. Members of the team give suitable advice to people about where they can get other support. They make sure that people have all the information they need so that they can use their medicines safely

Inspector's evidence

The pharmacy entrance was level with the outside pavement. This made it easier for people who used a wheelchair, to enter the building. The pharmacy team tried to make sure people could use the pharmacy's services. The pharmacy had a notice that told people when it was open. Members of the pharmacy team were helpful and tried to advise and help them. And they signposted people to another provider if a service was not available at the pharmacy. They could speak or understand Italian and French which was helpful to some people whose first language was not English.

The pharmacy provided a delivery service to people who could not attend its premises in person. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The pharmacy used a disposable pack for people who received their medicines in multi-compartment compliance aids. The pharmacy team checked whether a medicine was suitable to be re-packaged. It provided a brief description of each medicine contained in the compliance aids and patient information leaflets. So, people had the information they needed to make sure they took their medicines safely. Members of the pharmacy team initialled dispensing labels so they could identify which of them prepared a prescription. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added. The pharmacy had warning cards to give to people which had additional information for some medicines which required therapeutic monitoring. And the SI was observed counselling the majority of people who visited the pharmacy to collect their medicines. The pharmacy received low levels of referrals from the community pharmacy consultation service. The SI was aware of the valproate pregnancy prevention programme. And he knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed. The pharmacy had provided the seasonal flu vaccination service and planned to introduce another new vaccination service.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer’s packaging. The pharmacy team checked the expiry dates of medicines when it dispensed them and a few times a year. And it generally recorded when it had done a date-check. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs securely in line with requirements. Uncollected prescriptions were removed from retrieval regularly. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock or were placed in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took 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 equipment and facilities it needs for the services it offers. The pharmacy keeps people's private information safe.

Inspector's evidence

The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had a few glass measures for use with liquids, and some were used only with certain liquids. The pharmacy team had access to up-to-date reference sources. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the refrigerator. The pharmacy collected paper for shredding. So, its team could dispose of confidential waste appropriately. 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 were not 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.