General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Knights Weedon Pharmacy, 1 Bridge Street, Weedon, NORTHAMPTON, Northamptonshire, NN7 4PN

Pharmacy reference: 1092864

Type of pharmacy: Community

Date of inspection: 04/10/2022

Pharmacy context

This is a community pharmacy that is situated in the village centre. Most of its activity is dispensing NHS prescriptions and selling medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own homes. Other services that the pharmacy provides include delivering medicines to people's homes and the seasonal flu vaccination service.

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

Overall, the pharmacy identifies and manages the risks associated with the provision of its services. The pharmacy routinely records, reviews, and learns from its mistakes. Its team members have defined roles and accountabilities. And the pharmacy manages people's electronic personal information safely but some information in paper format is not always as well protected.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Parts of the SOPs were left blank to allow local teams to add information that reflected the situation in the local branch. These parts had not been completed by the pharmacist. She said that she would do so. Staff understood and mainly followed SOPs and were seen dispensing medicines and handing medicines out to people safely. Staff understood how to sell medicines safely and knew the advice to give during a sale. Staff knew that prescriptions were valid for six months apart from some controlled drugs (CDs) which were valid for 28 days. The pharmacy had processes in place to make sure medicines that were no longer valid were not handed out to people.

The pharmacy had processes for recording dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes where they had reached the person (errors). Near misses were discussed with the member of staff at the time and were then recorded in the near miss log. The pharmacist completed a monthly patient safety review which she discussed with the team. The safety review highlighted key issues that had caused problems and action to be taken going forward. For example, there had been a problem with staffing numbers, but this had been resolved and had led to a reduction in the number of near misses made.

The pharmacy maintained the necessary records to support the safe delivery of pharmacy services. These included the responsible pharmacist (RP) record, the CD registers, and the private prescription book. At the start of the inspection the RP notice from the previous day was on display. The RP had signed in on the RP log at the beginning of the day. She changed the RP notice displayed to the correct person. The pharmacy had an electronic CD register. The pharmacist carried out regular checks of CDs to make sure the balance matched the quantity in the register. A random check of the recorded running balance of a CD reconciled with the actual stock in the CD cabinet. The pharmacy managed patient-returned and out-of-date CDs appropriately.

The pharmacy had a complaints procedure and an information governance policy. Access to the electronic patient medication record (PMR) was password protected. Some confidential paperwork was stored in the consultation room on open shelves. This increased the risk that it could be viewed by other people using pharmacy services. Confidential information was destroyed securely. Professional indemnity insurance was in place. The pharmacy understood safeguarding requirements and could explain the actions they would take to safeguard a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members adequately manage the day-to-day workload within the pharmacy. They are suitably trained for the roles they undertake. And they can raise concerns if needed.

Inspector's evidence

During the inspection the pharmacy team adequately managed the day-to-day dispensing workload. There were two pharmacists, two qualified dispensers (one was providing support from another store) and a counter assistant. Staff said they felt supported by the pharmacist, and they discussed any issues informally on a daily basis and felt able to raise concerns if necessary. The pharmacy team had ad hoc informal training from the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. And it has made changes to help keep its team members and people using the pharmacy safe and keeps the pharmacy clean.

Inspector's evidence

Both the public and private areas of the pharmacy were a little small for the services provided. But they were well managed. There were separate areas for the assembly and checking of medicines. Air conditioning kept the pharmacy at a reasonable temperature; lighting was suitable and hot and cold water was available. A small-sized consultation room was available for people to have a private conversation with pharmacy staff. The pharmacy had a small clear plastic screen at the pharmacy counter which provided re-assurance to both the staff and the customers. There was hand sanitiser available. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's healthcare services are suitably managed and are accessible to people. The pharmacy team showed care and concern for people using its services. The pharmacy gets its medicines and medical devices from reputable sources. It stores them safely and it knows the right actions to take if medicines or devices are not safe to use to protect people's health and wellbeing. But the pharmacy doesn't always make a record of action it has taken in response to an alert. This makes it harder for the pharmacy to demonstrate how it has protected people.

Inspector's evidence

The pharmacy had a push-pull door and a small step which made it a little more difficult for people with a disability to get into the pharmacy. The pharmacist said that if necessary, they served people at the door. The pharmacist was easily accessible and engaged with people visiting the pharmacy. All of the pharmacy team members showed a people focus and were heard engaging with people, looking to answer questions and resolve problems they had. The pharmacy was providing a flu vaccination service. Staff had been trained and had the required patient group directions in place.

The pharmacist understood the signposting process and used local knowledge to direct people to local health services. The pharmacist knew the advice about pregnancy prevention that should be given to people in the at-risk group who took sodium valproate. She highlighted the records of a recent conversation and the advice that had been given. The pharmacist gave a range of advice to people using the pharmacy's services. This included advice when they had a new medicine or if their dose changed. The pharmacist recorded the interventions she made, for example suggestions to the local surgery about changes to prescribing intervals, but did not make records when she spoke to people who took warfarin or methotrexate.

The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label to help identify who had done each task. Baskets were used to keep medicines and prescriptions for different people separate to reduce the risk of error. The pharmacy supplied medicines in multi-compartment compliance packs to people living in the community who needed help managing their medicines. It had processes to make sure people got their medicines in a timely manner. Weekly compliance packs were dispensed at the pharmacy and monthly compliance packs from a hub for the whole pharmacy group. The compliance packs seen recorded the colour and shape of the medicines to make it easier for people to identify the medicine. The pharmacy sent patient information leaflets (PILs) every month. But people who got their packs from the hub received PILs when a medicine was provided for the first time or when they requested one. This might mean that people do not always have the information they need to take their medicine safely.

Medicines were stored tidily on shelves in their original containers. Opened bottles of liquid medications were marked with the date of opening so that the team would know if they were still suitable for use. The pharmacy team had a process for date checking medicines. A check of a small number of medicines didn't find any that were out of date. CDs were stored appropriately. A record of invoices showed that medication was obtained from licensed wholesalers. The pharmacist explained the process for managing drug alerts but didn't always make a record of the action taken. She said that she would start making a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. The pharmacy had up-to-date reference sources. Records showed that the fridge was in working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacy had the necessary equipment for the flu vaccination service. The pharmacy's portable electronic appliances had been last tested to make sure they were safe in September 2020. The portable electronic appliances looked in reasonable condition.

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.