General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Haslemere Pharmacy, Haslemere Health Centre, Church Lane, HASLEMERE, Surrey, GU27 2BQ

**Pharmacy reference:** 1116395

**Type of pharmacy:** Community

**Date of inspection:** 15/01/2020

## Pharmacy context

A busy community pharmacy located within a health centre in Haslemere. The pharmacy opens seven days a week and most people who use it are patients of the health centre. The pharmacy sells a small range of over-the-counter medicines and dispenses NHS and private prescriptions. It provides multi-compartment compliance packs (compliance packs) to help people take their medicines. And it delivers medicines to people who can't attend its premises in person. It also offers winter influenza (flu) vaccinations.

## 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 | 4.1 | Good practice | The pharmacy makes sure that its services are accessible and meet the needs of the people it serves. |
| **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 review 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 keep people's private information safe.

### Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) for the services it provided. And these have been reviewed since the last inspection. The pharmacy's team members were required to read, sign and follow the SOPs relevant to their roles. The pharmacy's dispensary was small. But the pharmacy team tried to keep part of the dispensing bench clear. So, the pharmacist had a dedicated area to check people's prescriptions. Members of the pharmacy team highlighted some look-alike and sound-alike drugs to help reduce the risks of them picking the wrong medicine from the dispensary shelves. 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, near misses and patient safety incidents. Members of the pharmacy team discussed and recorded individual learning points when they identified a mistake. They also reviewed their mistakes periodically to help spot the cause of them. And they tried to stop them happening again; for example, they highlighted and separated stocks of amitriptyline and propranolol following a mistake when they selected the wrong product.

The pharmacy displayed a notice that identified the RP on duty. Members of the pharmacy team were required to wear name badges which identified their roles within the pharmacy. They explained what they could and couldn't do, what they were responsible for and when they might seek help. They also 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 pharmacist. But their roles and responsibilities weren't clearly defined within the SOPs. A complaints procedure was in place and patient satisfaction surveys were undertaken annually. The results of last year's patient satisfaction survey were available online. The pharmacy's practice leaflet told people how they could provide feedback about the pharmacy. The pharmacy team asked people for their views. People's feedback led to the pharmacy trying to keep people's preferred makes of prescription-medicines in stock.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, through the National Pharmacy Association (NPA). The pharmacy's electronic controlled drug (CD)

register and its RP records were adequately maintained. The CD register's running balance was checked regularly. The nature of the emergency within the records for emergency supplies made at the request of patients sometimes didn't provide enough detail for why a supply was made. The pharmacy's private prescription records were generally kept in order. But sometimes the prescriber's details were incomplete or incorrect. The pharmacy's records for the supplies of unlicensed medicinal products were sometimes incomplete; for example, they didn't always include the date the product was obtained, when it was supplied and to whom.

The pharmacy had a 'Data, Security and Protection' policy in place. And its team members were required to read and sign a confidentiality agreement. A privacy notice was displayed within the pharmacy to tell people how it and its team gathered, used and shared personal information. The pharmacy had arrangements to make sure its confidential waste was collected and then sent to a centralised point for secure destruction. Its team stored 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 and a list of key contacts if its team needed to raise a safeguarding concern. Members of the pharmacy team were required to complete safeguarding training relevant to their roles. And they 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 team members. Members of the pharmacy team keep their skills and knowledge up to date. So, they can deliver safe and effective care. They use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. They 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 100 hours a week. It dispensed about 13,500 NHS prescription items a month. The pharmacy team consisted of a full-time pharmacist manager, four part-time pharmacists, two full-time dispensing assistants, a part-time dispensing assistant, two part-time trainee dispensing assistants, a full-time medicines counter assistant and two part-time delivery drivers. One of the part-time pharmacists (the RP), three dispensing assistants and a trainee dispensing assistant were working at the time of the inspection. The pharmacy relied upon its team, relief team members and locum staff to cover absences.

The pharmacy's team members needed to complete mandatory training during their employment. And they were required to undertake accredited training relevant to their roles after completing a probationary period. But they sometimes found it difficult to complete this training especially when the pharmacy was busy. The team members were encouraged to ask questions, read newsletters and familiarise themselves with new products. They were also asked to complete online training and assessments to make sure their knowledge was up to date. But they sometimes did this in their own time.

Members of the pharmacy team supported each other. 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 followed. 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 or children, people who were pregnant or breastfeeding, elderly people or people with long-term health conditions.

Members of the pharmacy team discussed their performance and development needs with their line manager. Team meetings, one-to-one discussions and a 'WhatsApp' group were held to update staff and share learning from mistakes or concerns. The pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. The pharmacy had a whistleblowing policy in place. Staff knew how to raise a concern if they had one. And their feedback led to changes to the rostering of tasks. The pharmacy team felt the targets set for the pharmacy could be challenging at times. And occasionally team members felt under pressure to complete all the things they were

expected to do. But they didn’t feel their professional judgement or patient safety were affected by these. 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 has a room where people can have private conversations with members of the pharmacy team. And it provides an adequate and secure environment for people to receive healthcare. But it is small. So, its staff don't always have the space they need to work in.

### Inspector's evidence

The pharmacy shared a building with a health centre. It was located next to the health centre's entrance lobby. People attending the pharmacy could wait and sit in this area if they needed to. The pharmacy's premises were partly air-conditioned, bright, clean, secure and adequately presented. But the pharmacy was small. And it had limited storage. So, its worksurfaces often became cluttered when it was busy. The pharmacy had a consultation room for the services it offered and if people needed to speak to a team member in private. Conversations in the consultation room couldn't be overheard in the areas next to it. And it was kept locked when it wasn't being used to make sure its contents were kept secure. 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 too.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy makes sure that its services are accessible and meet the needs of the people it serves. The pharmacy's working practices are generally safe and effective. 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 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 fit for purpose. They mostly dispose of people's waste medicines properly. And they respond well to drug alerts or product recalls. So, people get medicines or devices which are safe.

### Inspector's evidence

The health centre's entrance was level with the outside pavement. It had automated doors leading to its lobby and the pharmacy. And a small section of the pharmacy's counter could be set at a lower level to the rest. So, people with mobility difficulties, such as wheelchair users, could access the pharmacy and its services. The pharmacy's services were advertised in-store and were included in its practice leaflet. 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 safely. The pharmacy was open most days of the year. And it opened early and stayed open later than usual six days a week. It provided a range of services tailored to the needs of the local community; for example, compliance pack dispensing, a delivery service and seasonal flu vaccinations. The pharmacy team worked closely with staff from the health centre to identify people who would benefit from these services.

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 safely. The pharmacy provided a winter flu vaccination service. It also offered a range of medicines for specific conditions without a prescription, such as the morning-after pill, a sore throat treatment, smoking cessation medication, erectile dysfunction treatments and malaria prevention medicines, through its paid-for patient group directions (PGDs). The pharmacy had valid, and up-to-date, PGDs and appropriate anaphylaxis resources in place for these services. It kept a record for each flu vaccination. 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 RP didn't always get another appropriately trained team member to check that the vaccine he selected was the correct one before administering it. The pharmacy team made sure the sharps bin was kept securely when not in use. Some people chose to be vaccinated at the pharmacy rather than their doctor's surgery for convenience or because they were not eligible for the NHS service. 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 repackaged into a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. Its team provided a brief description of each medicine contained within the compliance packs. But patient information leaflets

weren't always supplied. And cautionary and advisory warnings about the medicines contained within the compliance packs weren't included on the backing sheets. So, sometimes people didn't have all the information they needed to make sure they took their medicines safely. 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 staff when these items needed to be added or if extra counselling was required. But prescriptions for some CDs weren't always marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully. And some assembled CD prescriptions awaiting collection were found to be over the 28-day legal limit. 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 within their original manufacturer's packaging. Its stock was subject to date checks, which were documented, and short-dated products were marked. 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 some intact patient-returned pregabalin capsules were found in one of the pharmaceutical waste bins. 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 at the time of the inspection. The SOPs needed to be revised to reflect the changes FMD would bring to the pharmacy's processes. The pharmacy was scheduled to become FMD compliant over the coming months. The pharmacy had procedures 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. The pharmacy had suitable waste receptacles for the disposal of hazardous and non-hazardous waste. 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 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. It uses its equipment to make sure people's data is kept secure. 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 staff made sure the equipment they used to measure or count medicines was clean before using it. 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 recently suspended providing blood pressure (BP) checks as its team was unsure when the pharmacy's BP monitor was last replaced or calibrated. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the refrigerator's maximum and minimum temperatures. Access to the pharmacy's 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?

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| ✔ 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. |