General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Severn Pharmacy, 44 Severn Road, Oadby, Leicester, Leicestershire, LE2 4FY

Pharmacy reference: 9011273

Type of pharmacy: Community

Date of inspection: 05/12/2024

Pharmacy context

This is a community pharmacy situated in an Oadby suburb. Most of its activity is dispensing NHS and private prescriptions and selling medicines over the counter. It provides NHS services such as the 'Pharmacy First' service, the hypertension case-finding service and flu vaccinations. It also provides private travel and weight loss services.

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	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 identifies and manages the risks associated with the provision of its services. And the pharmacy keeps the records it needs to by law. Its team members have defined roles and accountabilities. The pharmacy manages people's electronic personal information safely. And it has procedures to learn from its mistakes.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which required review. The pharmacist said that he would review them. They had been read and signed by most of the pharmacy team members. The pharmacist said that he would get the two newest members, who had read the SOPs to sign them. Team members could explain their roles and responsibilities. Staff were seen following the SOPs for dispensing medicines and handing medicines out to people 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 for learning from 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 they were found and were then recorded in the near miss log. The pharmacist completed a review and they then fed back the learning points to the whole team at the team meetings. And, when asked, the pharmacy team members were able to recall the actions from the latest review and how these reduced the risk of a mistake being made.

The Responsible Pharmacist (RP) notice was visible to members of the public but identified the previous pharmacist on duty. A member of staff changed the notice to the correct RP when this was pointed out to them. The pharmacy maintained the necessary records to support the safe delivery of pharmacy services. These included the RP record, the private prescription book, and the CD register. The entries for two CD items checked at random during the inspection agreed with the physical stock held. Regular balance checks of CDs were completed. Patient-returned CDs and date-expired CDs were separated from stock CDs to prevent dispensing errors.

The pharmacy had a complaints procedure and an information governance policy. Access to the electronic patient medication record (PMR) was password protected. Confidential waste was stored and destroyed appropriately. Professional indemnity insurance was in place. The pharmacy team had completed safeguarding training relevant to their role and they knew what to do if someone 'asked for Ani.'

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to manage the pharmacy’s workload. And they have the appropriate range of experience and skills. They are able to raise concerns if needed.

Inspector's evidence

During the inspection, the pharmacy team managed the day-to-day workload of the pharmacy effectively. There was one pharmacist, who was also the superintendent pharmacist, one trainee pharmacist, one accuracy checking pharmacy technician, one trained and one trainee dispenser. A team member asked said they discussed any issues informally and felt able to raise concerns if necessary. The trainee pharmacist had protected study time. Staff were given informal training by the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. And people visiting the pharmacy can have a conversation with a team member in private.

Inspector's evidence

The pharmacy had a bright modern appearance and the public area was a reasonable size for people using the pharmacy. The dispensary was an adequate size for the services provided with a clear work flow for dispensing and accuracy checking. It was clean and tidy. There was suitable heating and lighting, and hot and cold running water was available. One reasonable sized consultation room was available for people to have a private conversation with pharmacy staff. 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 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.

Inspector's evidence

The pharmacy had flat access with an automatic door which provided suitable access for people with a disability or a pushchair to get into the pharmacy. The pharmacy team understood the signposting process and used local knowledge to direct people to local health services. Pharmacy medicines were stored out of reach of the public and staff were aware of higher-risk, over-the-counter medicines such as painkillers containing codeine. The pharmacy team knew the advice about pregnancy prevention that should be given to people in the at-risk group who took sodium valproate but had not seen the latest guidance that should be given to men. The trainee pharmacist said he would look at the guidance and then discuss it at their team meeting. 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 pharmacy was providing the NHS ‘Pharmacy First’ service. This allowed the pharmacy to treat seven common conditions including supplying prescription-only medicines. The pharmacy was also offering the NHS hypertension case-finding service. The pharmacy also provided an NHS flu vaccination service. The pharmacy was also providing a private travel service and a weight loss service. The pharmacy had appropriate patient group directions (PGDs) for all the services provided and the pharmacist had completed the appropriate training.

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. The accuracy checking pharmacy technician knew that she could only complete the final check after the pharmacist had completed a clinical check. 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 to help them take their medicines at the right time. A sample of compliance packs were checked, they were seen to have accurate descriptions of the medicines inside and included the appropriate patient information leaflets.

Medicines were stored on shelves or in cupboards 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 did not 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 which included a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use.

Inspector's evidence

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use. The pharmacy had a service agreement for its dispensing robot. The pharmacy used suitable measures for measuring liquids. The pharmacy had up-to-date reference sources. Records showed that the fridges were in working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacy had appropriate equipment for the vaccination services. The pharmacy's portable electronic appliances looked in a reasonable condition, but they had not been safety tested. The pharmacist said he would look into portable appliance testing.

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.