General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Oxshott Village Pharmacy, 50 High Street, Oxshott, Leatherhead, Surrey, KT22 0JP

Pharmacy reference: 9011656

Type of pharmacy: Community

Date of inspection: 02/03/2022

Pharmacy context

This is an NHS community pharmacy set within a convenience store in the centre of Oxshott. The pharmacy opens six days a week. It sells some health and beauty products, including over-the-counter medicines. It dispenses people's prescriptions. And people can collect coronavirus (COVID-19) home-testing kits from its premises. The pharmacy offers travel and flu vaccinations. And it provides a health check service too. The pharmacy provides multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. And it delivers medicines to people who can't attend its premises in person. This inspection took place during the COVID-19 pandemic.

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

The pharmacy adequately manages its risks. It has introduced new ways of working to help protect people against COVID-19. And it has written procedures to help make sure its team works safely. Members of the pharmacy team know what they can and can't do, what they're responsible for and when they might seek help. They review the safety of the services they deliver. They understand their role in protecting vulnerable people. And they generally keep people's private information safe. People using the pharmacy can provide feedback to help improve its services. The pharmacy mostly keeps the records it needs to by law. And it has appropriate insurance to protect people if things do go wrong.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. And its team members were asked to read and sign the SOPs relevant to their roles to show they understood them and would follow them. The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it to try and stop the spread of the virus. And, as a result, it introduced new ways of working to protect people against COVID-19. The pharmacy had completed occupational COVID-19 risk assessments for its team members. Members of the pharmacy team were encouraged to self-test for COVID-19 regularly. They wore fluid resistant face masks to help reduce the risks associated with the virus. And they washed their hands and used hand sanitising gel when they needed to.

Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP). The pharmacy had systems to record and review dispensing errors and near misses. Members of the pharmacy team discussed and documented individual learning points when they identified a mistake. So, they could try to stop the same thing happening again. And, for example, they moved the different formulations of naproxen to keep them apart on the dispensary shelves to help reduce the chances of them picking the wrong one. The pharmacy team didn't routinely audit the mistakes it made. So, it could be missing opportunities to spot patterns or trends.

The pharmacy displayed a notice that told people who the RP was. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. But their responsibilities weren't always described within the SOPs. A team member explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't at the pharmacy. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints procedure. It had a notice next to its entrance that told people how they could provide feedback about it. It asked people for their views and suggestions on how it could do things better. And, for example, it tried to keep people's preferred makes of prescription-medicines in stock when its team was asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and when. The pharmacy kept an electronic controlled drug (CD) register. But the details of where a CD came from weren't always completed in full. The pharmacy team checked the stock levels recorded in the CD

register regularly. The pharmacy kept appropriate records for the supplies of unlicensed medicinal products it made. But it didn't always record when it had received one of these products, who it supplied it to or when. The pharmacy recorded the emergency supplies it made and the private prescriptions it supplied electronically. And most of these were in order. But the nature of the emergency wasn't always appropriately recorded in the emergency supply records. And the details of the prescriber were sometimes incomplete in the private prescription records.

People using the pharmacy couldn't see any other people's personal information. The pharmacy's owner was registered with the Information Commissioner's Office. The pharmacy had a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. And it had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always obliterated or removed from the unwanted medicines people returned to it before being disposed of as required by the SOPs. The RP had completed some safeguarding training. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. They used the NHS safeguarding mobile phone application to help them. And this provided them with the information and the contact details they needed if they wanted to raise a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. They generally work well together and 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 team consisted of a pharmacist (the RP), a dispensing assistant, two trainee dispensing assistants, a trainee medicines counter assistant and a delivery driver. The RP was responsible for managing the pharmacy and its team. The pharmacy relied upon its team members and team members from its sister branch to cover absences or provide additional support when needed. The RP, a dispensing assistant and a trainee dispensing assistant were working at the time of the inspection. And they were joined by the superintendent pharmacist.

Members of the pharmacy team generally worked well together. So, people were served promptly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for babies or young children, people who were pregnant or breastfeeding, people who were old and people with long-term health conditions to the pharmacist on duty.

The superintendent pharmacist confirmed that each pharmacy team member had completed or was undertaking accredited training relevant to their role. Members of the pharmacy team discussed their performance and development needs with their manager or the superintendent pharmacist when they could. They shared learning and were kept up to date during one-to-one discussions or informal meetings. They also used a mobile phone messenger application to send and receive messages to each other and the superintendent pharmacist. They were encouraged to ask questions and familiarise themselves with new products. They were also asked to complete training to make sure their knowledge was up to date. And they could train while they were at work when the pharmacy wasn't busy.

The pharmacy didn't set targets for its team. And it didn't incentivise its services. Members of the pharmacy team felt able to make professional decisions to ensure people were kept safe. And they didn't feel under pressure to do the things they were expected to do. Team members were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And their feedback led to a heater being installed at the premises.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate and secure environment to deliver it services from. And people can receive services in private when they need to. But its team don’t always have the space they need to work in when it’s busy.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure. But they were small. The dispensary had limited workspace and storage available. So, items were sometimes stored on the floor. And worksurfaces could become cluttered when the pharmacy was busy. Members of the pharmacy team were responsible for keeping the premises clean and tidy. And they took steps to make sure they and the pharmacy didn’t get too cold or hot. The pharmacy had a consulting room for the services it offered. And this could be used if people needed to speak to a team member in private. People’s conversations in the consulting room couldn’t be overheard outside of it. And it was locked when it wasn’t being used. So, its contents were kept secure. The pharmacy had the sinks it needed for the services it provided. And it had a supply of hot and cold water.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are safe and effective. Its team members are helpful. And they make sure that people have the information they need. So, they can use their medicines safely. The pharmacy offers flu and travel vaccinations and keeps appropriate records to show that it has given the right vaccine to the right person. It gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team generally dispose of people's unwanted medicines properly. And they carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The convenience store had a ramp leading to its automated entrance. And this helped people who had trouble climbing stairs enter its premises. The pharmacy had a notice that told people when it was open. And it advertised some of its services in-store. The pharmacy had a seat someone could use if they wanted to wait. Members of the pharmacy team were helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a local delivery service to people who couldn't attend its premises in person. And it kept an audit trail for each delivery to show when a person's prescription was delivered. The pharmacy supplied COVID-19 tests that people could use at home. And these tests were used to help find cases in people who may have no symptoms but were still infectious and could give the virus to others. The pharmacy had the anaphylaxis resources and the patient group directions it needed for its flu and travel vaccination services. And the pharmacy team members who vaccinated people were appropriately trained. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated and their consent, an audit trail of who vaccinated them and the details of the vaccine used. But the pharmacist didn't always ask one of the dispensing assistants to check the vaccine they selected was the correct one before administering it. The pharmacy team made sure the sharps bins were kept securely when not in use. 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 re-packaged. And it generally assessed each request for the service to make sure compliance packs were appropriate for the patient. The pharmacy provided a brief description of each medicine contained within the compliance packs as well as patient information leaflets. And an audit trail of the people who had assembled and checked each compliance pack was routinely kept. The pharmacy used clear bags for some dispensed items, such as CDs and insulin, 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. The pharmacy team marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items, such as a refrigerated product, needed to be added. Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. And they knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The pharmacy had the resources it needed for when it dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and

medical devices tidily within the dispensary within their original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines at regular intervals. It recorded when it had done these checks. And it marked products which were soon to expire to reduce the chances of it giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy team needed to keep a record of the destruction of CDs people returned to it. And these and out-of-date CDs were kept separate from in-date stock. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they took and demonstrated what records they made when they received a drug alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to protect people's privacy. And its team makes sure the equipment it uses is clean.

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 to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure out, or count, medicines before it was used. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of this refrigerator. The pharmacy provided blood pressure (BP) checks on request. And its BP monitor was replaced recently. The pharmacy needed to make sure the diagnostic equipment its team used in the health check service was calibrated regularly. And the accuracy of its monitors to measure blood cholesterol and sugar levels needed to be checked regularly too. The pharmacy team made sure that any equipment stored in the consultation room was kept secure. The pharmacy had a shredder. 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 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.