General Pharmaceutical Council

Registered pharmacy inspection report

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

Pharmacy reference: 9012365

Type of pharmacy: Community

Date of inspection: 13/09/2024

Pharmacy context

This is an NHS community pharmacy set on a main road in the centre of Oxshott. The pharmacy opens six days a week. It sells medicines over the counter. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy supplies multi-compartment compliance packs (compliance packs) to a few people who need help managing their medicines. And it delivers the NHS Pharmacy First service to help people who have a minor illness or need an urgent supply of a medicine. People can visit the pharmacy to have an NHS health check or their blood pressure measured. And they can also get their coronavirus booster, flu jab or travel vaccination.

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 manages its risks appropriately. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work at the pharmacy talk about the mistakes they make to try to stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy relocated to larger premises a few months ago. And it had more space to deliver its services from than it did before. People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had a notice that told people who the responsible pharmacist (RP) was at that time. It had standard operating procedures (SOPs) for the services it provided. And the superintendent (SI) pharmacist had recently reviewed these. But most members of the pharmacy team hadn't had chance to sign the SOPs to say they had read them and agreed to follow them. A team member explained they would refer repeated requests for the same or similar over-the-counter products, such as medicines liable to abuse, misuse or overuse, to the RP. And prescriptions couldn't be delivered and medicines weren't sold or supplied if a pharmacist wasn't present.

The team members who were responsible for making up people's prescriptions tried to keep the dispensing workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by an appropriately trained team member. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). The pharmacy team discussed the mistakes it made to learn from them and help stop the same sort of things happening again. But it could do more to make sure it routinely recorded and reviewed its mistakes to help improve the quality and the safety of its dispensing service.

The pharmacy had a complaints procedure. And it displayed a notice on its counter that gave people details of how they could provide feedback about its services. People could share their views and make suggestions about how the pharmacy could do things better. They had left online reviews about their experiences of using the pharmacy. And, for example, the pharmacy team tried to order a person's preferred make of a prescription medicine when it was asked to do so. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It kept a log to show which pharmacist was the RP and when. It had a controlled drug (CD) register. And the stock levels recorded in the register were checked regularly. The pharmacy kept a record of the unlicensed medicinal products (specials) it supplied. But it could do more to make sure the date it received one of these products was routinely recorded. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the details of the prescriber were sometimes incomplete in the private prescription records seen. The pharmacy

team gave an assurance that the pharmacy records would be maintained as they should be.

People using the pharmacy couldn't see other people's personal information. The pharmacy displayed a notice that told people how it gathered, used and shared their personal information. It had arrangements to make sure confidential information was stored and disposed of securely. And its team needed to complete a self-assessment each year and declare to the NHS that it was practising good data security and it was handling personal information correctly. The pharmacy had a safeguarding SOP. And the pharmacist and the pharmacy technician had completed safeguarding training. Members of the pharmacy team knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. Members of the pharmacy team can make decisions to keep the people they care for safe. They are comfortable about giving feedback to help the pharmacy do things better. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy team consisted of the pharmacist manager (the RP), a pharmacy technician, two dispensing assistants, two trainee medicines counter assistants (MCAs) and a delivery driver. The pharmacy depended upon its team, locum pharmacists and colleagues from a nearby branch to cover absences. The people working at the pharmacy during the inspection included the RP, the pharmacy technician and a trainee MCA. The RP was the pharmacy's regular pharmacist. They were responsible for managing the pharmacy and leading its team. And they supervised and oversaw the supply of medicines and advice given by the pharmacy team.

People who worked at the pharmacy were required to do accredited training relevant to their roles after completing a probationary period if they hadn't done so already. 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 animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist. Members of the pharmacy team discussed their performance and development needs with their manager when the pharmacy wasn't busy. They shared learning from the mistakes they made. And they were encouraged to complete training to keep their knowledge up to date.

People who worked at the pharmacy didn't feel that targets or incentives stopped them from making decisions that kept people safe. They worked well together. They helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they were up to date with their workload. Team members knew who they should raise a concern with if they had one. And they were comfortable about making suggestions on how to improve the pharmacy and its services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy had a consulting room, a counter, a dispensary, a retail area, a staffroom, a stockroom and a toilet. The pharmacy had enough workspace and storage available for its workload. The pharmacy's public-facing area was bright and professionally presented and had a seating area for people to use when they wanted to wait. But the pharmacy's air conditioning wasn't working properly. So, its team took steps to make sure its premises didn't get too hot. The consulting room could be used when people wanted to talk to a team member in private. It was locked when not in use to make sure the things in it were kept secure. And people's conversations in it couldn't be overheard outside of it. The pharmacy had the sinks it needed for the services it provided. It had a supply of hot and cold water as well as antibacterial hand wash and hand sanitisers. And its team was responsible for keeping its premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access. Its working practices are generally safe and effective. And it keeps adequate records for its vaccination service to show that it has given the right vaccine to the right person. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team are friendly and helpful. They dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy didn't have an automated door. And its entrance wasn't level with the pavement. But it had a portable ramp that could be placed outside. And a member of the pharmacy team would open the door when necessary to help people who had trouble climbing stairs enter the building. The pharmacy team asked people who were prescribed a new medicine if they wanted to speak to the pharmacist about it. The pharmacy dealt with NHS Pharmacy First referrals. People benefited from this service as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for some minor illnesses. Members of the pharmacy team were friendly and helpful. They asked people who were prescribed a new medicine if they wanted to speak to a pharmacist about it. And they took the time to listen to people. So, they could help and advise them, and signpost them 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. But people didn't routinely sign a log to say they had received their medicines safely despite the SOPs requiring the delivery person to ask them to do so. The pharmacy offered coronavirus boosters, flu jabs and travel vaccinations. It had the anaphylaxis resources and the patient group directions (PGDs) it needed for these services. And the pharmacists providing these services were appropriately trained. The pharmacy kept a record for each vaccination it made to show it had given the right vaccine to the right person. And the records included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacy also offered face-to-face weight management consultations, advice and treatments. But this service was only available when the company's pharmacist independent prescriber (PIP) was working at the pharmacy. So, the pharmacy was considering delivering the service through a PGD instead as it could be provided by the RP and not just the PIP. The superintendent (SI) pharmacist explained that the pharmacy's prescribing service was minimal and would be reviewed and strengthened following the inspection. But the SI gave assurance that it was indemnified and had been risk assessed. And its quality and safety, including consultation records and prescribing decisions, would be audited.

The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And its team assessed whether a person needed a compliance pack. The pharmacy team were reminded of the importance of providing people who received compliance packs with the information they needed so they could take 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. It used reminder stickers to alert the team when these items needed to be added or if extra counselling was

needed. But its team could do more to make sure assembled CD prescriptions awaiting collection were routinely marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully.

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. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. They were aware of the rules on dispensing valproate-containing medicines in the manufacturer's original full pack. And they had access to the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team usually marked the containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. And they marked products which were soon to expire. These things helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. It stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. The pharmacy had a process for dealing with the alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). But its team could do more to make sure it recorded the actions it took when it received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And its team makes sure the equipment it uses is suitable for what it's being used for.

Inspector's evidence

The pharmacy had some glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out or count medicines before they used it. 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 checked and recorded the refrigerator's maximum and minimum temperatures on the days the pharmacy was open. The pharmacy had suitable equipment for the Pharmacy First service as well as for measuring a person's blood pressure and for NHS health checks. And this equipment appeared to be well maintained. 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.