General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Buckley Pharmacy, 224 Barnett Wood Lane, ASHTEAD, Surrey, KT21 2DB

Pharmacy reference: 1036398

Type of pharmacy: Community

Date of inspection: 07/12/2022

Pharmacy context

This is an NHS community pharmacy on a small row of shops in a residential area of Ashtead. The pharmacy opens six days a week. It sells over-the-counter medicines and some health and beauty products. It dispenses people's prescriptions. And it delivers medicines to people who can't attend its premises in person. The pharmacy supplies medicines to people who live at some local care homes. It provides multi-compartment compliance packs (compliance packs) to a few people who need help managing their medicines. And it delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. The pharmacy has a paid-for travel clinic. Its team can check a person's blood pressure. And people can get their flu vaccination (jab) at the pharmacy too.

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 appropriately manages its risks. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has appropriate insurance 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 in the pharmacy review the mistakes they make and learn from them to try and 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 had standard operating procedures (SOPs) for the services it provided. And the responsible pharmacist (RP) gave an assurance that the SOPs would be reviewed following the inspection as they hadn't been for a while. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and agreed to follow them. Members of the pharmacy team responsible for making up people's prescriptions kept 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 usually initialled each dispensing label. And assembled prescriptions weren't handed out until they were checked by the RP. The pharmacy had processes to deal with dispensing mistakes that were found before reaching a person (near misses) and those which hadn't (dispensing errors). Members of the pharmacy team generally highlighted and separated medicines involved in dispensing mistakes or were similar in some way, such as medicines that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being picked. They discussed, documented and reviewed the mistakes they made to learn from them and reduce the chances of them happening again.

The pharmacy had a notice that told people who the RP was at that time. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. A team member explained that they couldn'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, such as medicines liable to abuse, misuse or overuse, to a pharmacist. People could share their experiences of using the pharmacy and its services online. The pharmacy had a complaints procedure. It had leaflets which asked people to share their views and suggestions about how the pharmacy could do things better. And, for example, the pharmacy team tried to keep a person's preferred make of a prescription medicine in stock when it was asked to do so. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had a computerised controlled drug (CD) register. But recently the stock levels recorded in this register weren't checked as often as they once were. The pharmacy kept records of the supplies of the unlicensed medicinal products it made. But its team didn't always record when an unlicensed medicinal product was received. The pharmacy had an appropriate record to show which pharmacist was the RP and when. And it recorded the emergency supplies it made and the private prescriptions it supplied on its computer. But the prescriber details were sometimes incomplete in the private prescription records and the reason for making an emergency supply wasn't always recorded properly.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. It had arrangements to make sure confidential information was stored and disposed of securely. And it had an information governance policy which its team needed to read and sign. The pharmacy had a safeguarding procedure. And its pharmacists were required to complete a level 2 safeguarding training course. Members of the pharmacy team had the contacts they needed if they wanted to raise a safeguarding concern. And they knew 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 to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. They work well together and make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the services they provide. 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 regular pharmacy team consisted of two part-time pharmacists, a full-time accuracy checking dispensing assistant, two full-time dispensing assistants, a part-time delivery driver and a part-time member of staff who recently started at the pharmacy. One of the part-time pharmacists (the RP) and two dispensing assistants were working at the time of the inspection. And they were joined part way through the inspection by a dispensing assistant from a neighbouring branch. The pharmacy relied upon its team, team members from one of the company's neighbouring branches or locum pharmacists to cover absences or provide additional support when the pharmacy was busy. Members of the pharmacy team were up to date with their workload. And they 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 animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to the pharmacist on duty.

People working at the pharmacy were required to do accredited training relevant to their roles after completing a probationary period. They discussed how they were doing and their development needs with the superintendent pharmacist or one of the regular pharmacists. And they helped each other to learn. Members of the pharmacy team were encouraged to ask questions, complete training and familiarise themselves with new products to keep their knowledge up to date when the pharmacy wasn't busy. They could share learning from the mistakes they made and were kept up to date during regular team meetings or on a group messaging mobile phone application. The pharmacy didn't set targets for its team. It didn't incentivise its services. Its team members felt able to make decisions to keep people safe. And they didn't feel under pressure to do all the things they were expected to do. The pharmacy had a whistleblowing policy. And team members knew who they should raise a concern with if they had one. Members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. And, for example, they recently signposted one another to an NHS mobile phone application so they could access safeguarding contacts more quickly.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had a small consulting room for the services it offered and if people needed to speak to a team member in private. The consulting room was locked when it wasn’t being used. So, its contents were kept secure. And people’s conversations in it couldn’t be overheard outside of it. The pharmacy was air-conditioned, bright and appropriately presented. But its dispensary was small. It had limited workbench and storage space available. Its dispensing worksurfaces could become cluttered when the pharmacy was busy. And excess stock and some bulky prescriptions were often stored on the floor. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water. Members of the pharmacy team were responsible for keeping the premises clean and tidy. They wiped and disinfected the surfaces they and other people touched. And hand sanitising gel was available for them to use too.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are generally safe and effective. And its team is friendly and tries to help people access its services. Members of the pharmacy team dispose of most people's unwanted medicines properly. And they usually carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy offers flu jabs 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.

Inspector's evidence

The pharmacy didn't have an automated door. But its entrance was level with the outside pavement. And a member of the pharmacy team opened the door when necessary to help people with pushchairs or who used wheelchairs or mobility scooters enter the building. The pharmacy had some notices and a digital display that told people about its products and the services it offered. And it had a small seating area for people to use if they wanted to wait. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. The pharmacy dealt with CPCS referrals. People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And the pressure on local surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses was reduced too. Members of the pharmacy team were friendly and helpful. They took the time to listen to people. So, they could help and advise them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. And it kept an audit trail to show when it delivered someone their medicines. But its team didn't routinely ask people to sign to say they had received their medication, unless it was a CD, as required by the SOPs. The pharmacy had the anaphylaxis resources and the patient group directions it needed for its vaccination service, including flu jabs. And the RP was appropriately trained to vaccinate people. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked if a medicine was suitable to be re-packaged. And the pharmacist assessed whether a person needed a compliance pack. The pharmacy provided a brief description of each medicine contained within the compliance packs. And patient information leaflets were usually supplied. But the pharmacy didn't keep an audit trail of the person who had assembled and checked each compliance pack. The pharmacy used clear bags for dispensed CDs and insulin products 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 used reminder stickers to alert its team when these items needed to be added or if extra counselling was needed. And assembled CD prescriptions awaiting collection were generally marked to help the team member make sure supplies were made lawfully. But the pharmacy team could do more to make sure dispensed CD prescriptions were still valid. 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 had the resources they needed when they dispensed a valproate. And they knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications.

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 checked the expiry dates of medicines at regular intervals. They recorded when they did these. But the last recorded date check was a while back. And an out-of-date medicine was found on a shelf amongst in-date stock. This was removed during the inspection. And the pharmacy team gave an assurance that it would review and strengthen its date checking process. The pharmacy stored its stock, which needed to be refrigerated, at the appropriate temperature. And it also stored its CDs, which weren’t exempt from safe custody requirements, securely. The pharmacy team recorded the destruction of the CDs that people returned to it. And out-of-date and patient-returned CDs were kept separate from in-date stock. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy’s stock and were placed in a pharmaceutical waste bin. But the pharmacy team could do more to make sure the hazardous waste people brought back to it was appropriately disposed of. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And one of 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 make sure people's personal information is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of 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 they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association for information and guidance too. The pharmacy had a monitor its team could use to measure a person's blood pressure. And this was replaced earlier this year. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded each refrigerator's maximum and minimum temperatures. 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.