General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Victoria Chemist, 80 High Street, BANSTEAD, Surrey, SM7 2NN

Pharmacy reference: 1036404

Type of pharmacy: Community

Date of inspection: 15/02/2024

Pharmacy context

This NHS community pharmacy is set on a shopping parade in Banstead. 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. It delivers the NHS Pharmacy First service to help people who have a minor illness or need an urgent supply of a medicine. And people can visit the pharmacy to get their flu jab or travel vaccination or have their blood pressure checked.

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 generally manages its risks appropriately. It has written instructions to help its team members work safely. It largely 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 in the pharmacy talk to each other 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

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 plastic screen on its counter to help reduce the spread of airborne infections such as coronavirus. And hand sanitising gel was also available for people to use. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were being reviewed by the responsible pharmacist (RP) and the superintendent (SI) pharmacist at the time of the inspection. Members of the pharmacy team had to read and sign the SOPs relevant to their roles to say they understood them and would follow them. They knew what they could and couldn't do, what they were responsible for and when they might seek help. Their responsibilities were described within the SOPs. And a notice in the pharmacy told people who the RP was at that time. 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. The team members responsible for making up people's prescriptions tried to keep the dispensing workstations tidy. 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 by a pharmacist who also initialled the dispensing label. 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). Members of the pharmacy team highlighted the locations of a few medicines, which looked alike and whose names sounded alike, to help reduce the chances of them picking the wrong product. They talked to one another about the mistakes they made to try to stop the same things happening again. But they could do more to make sure they always recorded and reviewed their near misses to help them spot patterns in the mistakes they made so they could strengthen their dispensing process further.

Some people have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. And it had a notice that told people how they could provide feedback about the pharmacy or its team. People could share their views and make suggestions to the pharmacy team about how the pharmacy could do things better. 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 insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept adequate records to show which pharmacist was the RP and when. It had a CD register which was largely maintained as it should be. And its team checked the stock levels in the CD register as often as the SOPs asked them to be. The pharmacy recorded the supplies of the unlicensed medicinal products it made. But its team could do more to make sure it recorded when it

received one of these products. The pharmacy required its team to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the details of the prescriber were incomplete in a few of the private prescription records seen. And the pharmacy team was reminded that it needed to make an appropriate record when a prescription-only medicine was supplied to a person in an emergency including requests referred to it by NHS 111. The pharmacy team gave an assurance that these records would be kept as they should be.

People using the pharmacy couldn't see other people's personal information. The pharmacy was registered with the Information Commissioner's Office. It had an information governance policy. 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 managing personal information correctly. And there were arrangements in place to make sure confidential information was stored and disposed of securely. The pharmacy had a safeguarding procedure. And the pharmacists had completed safeguarding training. Members of the pharmacy team had access to safeguarding guidance and resources through the 'NHS Safeguarding' mobile phone application. And they 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 work well together and use their judgement to make decisions about what is right for the people they care for. They know how to raise a concern if they have one. And they can give feedback to help the pharmacy do things better.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist (the RP), a part-time pharmacist (the SI), two dispensing assistants, a trainee medicines counter assistant and a delivery driver. And there were three assistants who had started at the pharmacy recently. The SI gave an assurance that people working at the pharmacy who needed to complete accredited training relevant to their roles were enrolled upon a suitable course after they had completed a probationary period. The pharmacy depended upon its team and another pharmacist to cover absences. The people working at the pharmacy during the inspection included the RP, a dispensing assistant and two of the assistants. And the SI and another pharmacist arrived part way through the inspection. The SI helped the RP with the day-to-day management of the pharmacy and its team. The pharmacy had seen an increase in its workload, including its dispensing volume, since the last inspection. But the pharmacy team was up to date with the workload. Members of the pharmacy team worked well together. They helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they didn't feel they were asked to do things that stopped them from making decisions that kept people safe. 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 development needs with their manager when they could. They were encouraged to ask questions and keep their knowledge up to date by completing training. They were sometimes too busy to train while they were at work. But they could choose to train in their own time. The pharmacy had meetings as well as one-to-one discussions to update its team and share learning. The pharmacy team was comfortable about making suggestions on how to improve the pharmacy and its services. Team members knew who they should raise a concern with if they had one. And their feedback led to brighter and more energy efficient lights being fitted in the premises.

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 the pharmacy team doesn’t always have the space it needs to work in when the pharmacy is busy.

Inspector's evidence

The pharmacy was bright and secure. And its public-facing area was adequately presented. But it wasn’t air-conditioned. So, its team took steps to make sure it didn’t get too hot. The pharmacy had a consulting room, a beauty counter, a healthcare counter, a dispensary, a large retail area, a storeroom and a toilet. The dispensary had limited storage available. Its worksurfaces could become cluttered when the pharmacy was busy. And some items were stored in boxes on the floor behind the counters. The consulting room could be used when people wanted to talk to a team member in private. It could be locked when it wasn’t being used to make sure its contents 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. And its team was responsible for keeping its premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are generally safe and effective. Its team is friendly and helps people access the services they need. And it keeps adequate records for its vaccination service to show that it has given the right vaccine to the right person. But it doesn't always give people who use compliance packs all the information they need to take their medicines safely. The pharmacy gets its medicines from reputable sources. And it stores most of them appropriately and securely. Members of the pharmacy team usually dispose of people's unwanted medicines properly. And they largely 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. But its entrance was level with the outside pavement. And its team helped people who had difficulty in opening the door enter the premises and use its services. The pharmacy had some leaflets and a notice that told people when it was open and what services it offered. It had a small seating area for people to use if they wanted to wait in the pharmacy. 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 Pharmacy First referrals. And its team helped the RP in triaging people requesting this service. People benefited from the 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. People were occasionally referred to the pharmacy by mistake. But members of the pharmacy team were friendly and helpful. And they took the time to listen to them. 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 delivery service to a few people who couldn't attend its premises in person. And it usually kept a log to show the right medicine had been delivered to the right person. The pharmacy offered flu jabs and travel vaccinations. It provided some childhood vaccinations too. It had the anaphylaxis resources and patient group directions it needed for its vaccination service. And the pharmacists providing the service were appropriately trained. 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. Its team checked if a medicine was suitable to be re-packaged. And an assessment was done to decide if a person needed a compliance pack. But the compliance packs seen didn't have the date they were dispensed on or an audit trail of the people who had assembled them. And a patient information leaflet, a brief description and cautionary and advisory warnings of each medicine contained within them weren't provided. So, people didn't always have the information they needed to take their medicines safely. The pharmacy marked 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 CD or 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. 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 new rules on dispensing valproate-containing medicines in the manufacturer's original full pack. And they had the resources they needed when they dispensed a valproate.

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. But some medicines found during the inspection, which weren't in their original packaging, were quarantined and disposed of by the pharmacy team. Members of the pharmacy team checked the expiry dates of medicines as they dispensed them and at regular intervals which they usually recorded to show they had done so. And they marked products which were soon to expire. But they didn't always mark the containers of liquid medicines with the date they opened them. The pharmacy stored its stock, which needed to be refrigerated, at the right temperature. It stored its CDs, which weren't exempt from safe custody requirements, securely. And its team recorded the destruction of the CDs that people returned to it. 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 didn't have a pharmaceutical waste bin for any hazardous waste that was returned to it. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And a team member described the actions they took when the pharmacy received an MHRA medicines recall. But the pharmacy hadn't kept a record of any recent recalls or the actions it took in response to these.

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 clean and 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 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 and new equipment for the Pharmacy First service as well as for measuring a person's blood pressure. 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.