General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Frimley Pharmacy, 54 - 56 High Street, Frimley, CAMBERLEY, Surrey, GU16 7JF

Pharmacy reference: 1036414

Type of pharmacy: Community

Date of inspection: 17/11/2023

Pharmacy context

This NHS community pharmacy is set on a row of shops in Frimley. The pharmacy is part of a small chain of pharmacies. It 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 some people who need help managing their medicines. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. It provides a substance misuse treatment service. And people can get their covid boosters and flu jabs from the pharmacy too.

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 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 usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had changed its owner since its last inspection. 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 available too.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed within the last two years by the superintendent (SI) pharmacist. Members of the pharmacy team were required to read and sign the SOPs to show they understood them and agreed to 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 also described within the SOPs. And a notice in the pharmacy told people who the responsible pharmacist (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 the pharmacist.

The team members who were responsible for making up people's prescriptions used baskets to keep each person's prescription separate from other people's prescriptions. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out unless their clinical suitability had been assessed by a pharmacist and they had been checked by an appropriately trained checker 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 discussed the mistakes they made to learn from them and help them stop the same sort of things happening again. But they could do more to make sure they routinely recorded their mistakes and reviewed them more often to help them spot patterns or trends.

Some people have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. And some in-store leaflets 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 appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had a controlled drug (CD) register. And the stock levels recorded in the register were usually checked as often as the SOPs required them to be. But the details of where a CD came from weren't always completed in full. The pharmacy largely kept appropriate records to show which pharmacist was the RP and when. But the pharmacist occasionally forgot to record the time when they stopped being the RP. The pharmacy kept records for 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 team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the reason for making a supply of a prescription-only medicine to a person in an emergency wasn't always recorded properly. And the details of the prescriber were incomplete in some of the private prescription records seen. The pharmacy team gave an assurance that these records would be maintained as they should be.

The company that owned the pharmacy was registered with the Information Commissioner's Office. And people using the pharmacy couldn't see other people's personal information. The pharmacy had a confidentiality SOPs. And its owner completed a self-assessment each year and made a declaration to the NHS that the pharmacy was practising good data security and it was handling personal information correctly. The pharmacy had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always crossed out or removed from the unwanted medicines returned to it before being disposed of.

The pharmacy had a safeguarding procedure. And 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 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 an accuracy checking pharmacy technician (ACPT), three dispensing assistants, a counter assistant and a delivery driver. The pharmacy was managed by a regular pharmacist until recently. And it now largely relied upon a locum pharmacist to be its RP. But there were generally two pharmacists working alongside each other to make sure the pharmacy's vaccination service could be safely delivered without impacting upon the pharmacy's day-to-day activities. The pharmacy depended upon its team, locum pharmacists and colleagues from one of the company's other pharmacies to cover absences.

The people working at the pharmacy during the inspection included two locum pharmacists, the ACPT, three dispensing assistants and the counter assistant. They didn't feel the targets set for the pharmacy 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 nearly up to date with their workload. But they sometimes didn't have time to do all the things they were expected to do.

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 a pharmacist. The counter assistant had only just started to work at the pharmacy. And the pharmacy team was helping them learn.

People working at the pharmacy needed to complete accredited training relevant to their roles after completing a probationary period. They talked to one another about the mistakes they made to share learning. They were encouraged to ask each other questions and keep their knowledge up to date when the pharmacy wasn't busy. But they didn't always get time to train when they were at work or discuss their development needs since the regular pharmacist left.

The pharmacy had a whistleblowing policy. And its team was comfortable about making suggestions on how to improve the pharmacy and its services. Members of the pharmacy team knew who they should raise a concern with if they had one. They were comfortable about making suggestions on how to improve the pharmacy and its services. And, for example, their feedback led to an additional computer being installed at the pharmacy counter. This allowed them to check the patient medication record (PMR) system more easily.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver it services from. Its premises are secure and tidy. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy had a consulting room, a counter, a dispensary, an office, a retail area, a staffroom, a stockroom and a toilet. It was air-conditioned, bright and secure. And its public-facing area was adequately lit and presented. But its flooring and shop frontage were showing signs of wear. The pharmacy generally had the workbench and storage space it needed. But some dispensary drawers didn't shut properly because they were obstructed by stock that had fallen out. The consulting room was available for services that needed one or if someone needed to speak to a team member in private. It was 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 all the information they need to take their medicines safely with their compliance packs. 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 CPCS 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 minor illnesses. Members of the pharmacy team were friendly and 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 delivery service to people who couldn't attend its premises in person. It kept a log to show the right medicine had been delivered to the right person. But its team could do more to make sure the recipient signed the log to say they have received their medicines safely as required by the SOPs. The pharmacy offered covid boosters and flu jabs. And people generally booked an appointment for these to help the pharmacy manage its workload. The pharmacy had the anaphylaxis resources it needed for its vaccination service. 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, their consent and the details of the vaccine used.

The pharmacy provided substance misuse treatments and a needle exchange service. The pharmacist could supervise the consumption of a substance misuse client's treatment. And the pharmacy team asked needle exchange clients to return spent sharps within the containers provided and deposit these into a designated waste receptacle. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And most of these were assembled off-site at a hub pharmacy. But people could choose not to have their prescriptions dispensed there. Prescriptions dispensed at the hub pharmacy were returned to the pharmacy for people to collect or to be delivered. 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 kept an audit trail of the people involved in the assembly of each prescription. And a brief description or image of the medication contained within each compliance pack was usually provided. But patient information leaflets weren't routinely supplied with compliance packs, and

people were asked to download these instead. So, they didn't always have the information they needed to 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. The pharmacy highlighted prescriptions to alert its team when these items needed to be added or if extra counselling was needed. But the pharmacy could do more to make sure assembled CD prescriptions awaiting collection were 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 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 team had mistakenly put some pharmacy-only medicines on open shelving meaning that people could self-select them. But these medicines were removed once the matter was pointed out to the team.

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. Members of the pharmacy team checked the expiry dates of medicines as they dispensed them and at regular intervals. But they could do more to make sure they recorded when they had done a date check. And they sometimes forgot to write the date they opened a liquid medicine on the container. The pharmacy stored its stock, which needed to be refrigerated, at an 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 it kept these and out-of-date CDs separate from in-date stock. The pharmacy had procedures for managing 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. But the pharmacy didn't have a pharmaceutical waste bin for any hazardous waste that was returned to it. And some patient-returned medicines which had been put into a waste bin by mistake were removed during the inspection and stored securely.

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). And, for example, pholcodine-containing cough and cold medicines were removed following the receipt of an MHRA medicines recall earlier in the year. The pharmacy team described the actions it took and what records it made when an MHRA medicines recall was received.

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 data 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 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 Numark or the SI to ask for information and guidance. The pharmacy had a large 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 restricted access to its computers and PMR 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 weren't used 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.