General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chertsey Pharmacy, 1 Weir Road, CHERTSEY, Surrey, KT16 8NF

Pharmacy reference: 1036443

Type of pharmacy: Community

Date of inspection: 03/01/2024

Pharmacy context

This NHS community pharmacy is set on a busy road close to Chertsey Health Centre. 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 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. Its team can check a person's blood pressure. And people can get their flu jabs and travel medicines or vaccinations 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 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 log and review 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

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 standard operating procedures (SOPs) for the services it provided. And these were reviewed regularly. 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 until they were checked and initialled by the RP. 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 and recorded the mistakes it made to learn from them. It reviewed its mistakes periodically to help stop the same sort of things happening again. And, for example, it moved some look-alike and sound-alike drugs to keep them apart on the dispensary shelves to help reduce the risks of the wrong product being picked.

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 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 kept appropriate records for the supplies of the unlicensed medicinal products it made. It largely kept adequate records to show which pharmacist was the RP and when. But the pharmacist sometimes forgot to record the time when they stopped being the RP. 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.

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 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. People working at the pharmacy needed to read and sign an agreement saying that they would keep people's private information safe. Members of the pharmacy team had access to safeguarding guidance and resources through the 'NHS Safeguarding' mobile phone application. 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. And the RP had completed a level 2 safeguarding training course.

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 do the right training for their roles. And they work well together and use their judgement to make decisions about what is right for the people they care for. The pharmacy team is comfortable about giving feedback to help the pharmacy do things better. And it knows how to raise a concern if it has one.

Inspector's evidence

The pharmacy team consisted of two pharmacists, seven dispensing assistants and a delivery driver. The pharmacy depended upon its team and the directors to cover absences. The people working at the pharmacy during the inspection included the RP and four dispensing assistants. The pharmacy didn't set any targets or incentives for its team. It had seen an increase in its dispensing volume since the ownership of the pharmacy changed last year. Members of the pharmacy team were up to date with the workload. They helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they felt able to make decisions that kept people safe. One of the dispensing assistants was the pharmacy's supervisor. And they helped manage the pharmacy and its team. The RP supervised and oversaw the supply of medicines and advice given by the 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. People working at the pharmacy needed to complete accredited training relevant to their roles. And an assurance was given that this included team members who delivered people's prescriptions. Members of the pharmacy team discussed their development needs with the directors when they could. They were encouraged to ask questions and keep their knowledge up to date. They could train while they were at work when the pharmacy wasn't busy. But they could choose to train in their own time too. The pharmacy had ad-hoc meetings as well as one-to-one discussions to update its team and share learning from mistakes or concerns. 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 changes to the pharmacy's layout.

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.

Inspector's evidence

The pharmacy was air-conditioned, bright and secure. And its public-facing area was adequately presented. The pharmacy had a consulting room, a counter, a dispensary, a kitchenette, a retail area, a stockroom and a toilet. Its flooring was worn in places. And some of its fixtures were dated too. The pharmacy had the workbench and storage space it needed and its dispensary had been enlarged since the last inspection. The consulting room was available for services that needed one or if someone needed to speak to a team member in private. But it was narrow and couldn’t be locked. So, the pharmacy team needed to make sure its contents were kept secure when it wasn’t being used. 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 has working practices that are safe and effective. Its team is friendly and helps people access the services they need. And it keeps appropriate 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 usually 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 step-free access. But it had a portable ramp its team could use to help people who had trouble climbing stairs, such as someone who used a wheelchair, enter its premises. The pharmacy had notices that told people when it was open and what services it offered. And it had a seating area for people to use if they wanted to wait. 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 record for each delivery. And this showed it had delivered the right medicine to the right person. The pharmacy offered winter flu jabs and a travel clinic. It had the anaphylaxis resources and the patient group directions it needed for its vaccination services. And the pharmacists providing these services 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. And an assessment was done to determine if a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. And a patient information leaflet and a brief description for each medicine contained within a compliance pack were routinely provided. 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. And its team marked CD prescriptions awaiting collection 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 used recognised wholesalers to obtain its pharmaceutical stock. And it kept most of its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team 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 steps 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. 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 and demonstrated what records they made when the pharmacy 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 clean and suitable for what it's being used for.

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 Numark to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team checked and recorded each refrigerator's maximum and minimum temperatures on the days the pharmacy was open. The pharmacy team could check a person's blood pressure when asked. And the monitor it used for this service was new. 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. But it could do more to make sure people's NHS smartcards were stored securely when they weren't working at the pharmacy.

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.