General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Binscombe Pharmacy, 106 Binscombe Lane, GODALMING, Surrey, GU7 3PR

Pharmacy reference: 1092961

Type of pharmacy: Community

Date of inspection: 31/07/2023

Pharmacy context

This busy NHS community pharmacy is in a GP surgery in a residential area of Godalming. The pharmacy opens seven 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 Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. And its team can check a person's blood pressure.

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 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 in the pharmacy talk to each other about the mistakes they make and write them down 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

Members of the pharmacy team knew what to do if the pharmacy needed to close in an emergency. And they also understood what they should do to make sure people could access the care they needed if the pharmacy was closed. The pharmacy had some plastic screens on its counter to try and stop 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 reviewed by a team at the pharmacy's head office. 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. They knew what they could and couldn't do, what they were responsible for and when they might seek help. Their roles and responsibilities were described within the SOPs. And the pharmacy displayed a notice that 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 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 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). Members of the pharmacy team were required to discuss and record the mistakes they made to learn from them and help them stop the same sort of things happening again. And, for example, they separated some look-alike and sound-alike drugs from one another in the dispensary to help reduce the risks of them picking the wrong product. But they didn't always get time to review their mistakes. So, they may have missed opportunities to strengthen their processes further by spotting patterns in the mistakes they made.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. 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 computerised controlled drug (CD) register. And the stock levels recorded in this register were generally checked as often as the SOPs asked them to be. The pharmacy kept adequate records to show which pharmacist was the RP and when. And it also kept appropriate records for the supplies of the unlicensed medicinal products it made. 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.

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 SOPs on patient confidentiality and safeguarding.

Members of the pharmacy team were required to complete training on data protection and safeguarding. 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 pharmacy's consulting room could be used by someone if they felt they were in danger.

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 a regular pharmacist (the RP), a trainee pharmacy technician, two trainee dispensing assistants, a medicines counter assistant (MCA), a trainee MCA and a delivery driver. The pharmacy depended upon its team, colleagues from other branches or locum pharmacists to cover absences.

The people working at the pharmacy during the inspection included the RP, the trainee technician, the trainee dispensing assistants and the trainee MCA. The pharmacy had seen a recent increase in its dispensing volume following the closure of a nearby pharmacy. But its team was generally up to date with its workload. Members of the pharmacy team helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they didn’t feel the targets set for the pharmacy stopped them from making decisions that kept people safe. The RP led by example. And they were helping the superintendent pharmacist manage the pharmacy team until a new manager was in post.

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. And 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 mandatory training during their employment. And they were required to do accredited training relevant to their roles after completing a probationary period. But they were sometimes too busy to train whilst they were at work as they were doing all the other things they needed to do.

Members of the pharmacy team could ask the pharmacist questions, discuss their development needs and familiarise themselves with products when they had the time to do so. They 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 their feedback led to changes in the way they processed NHS prescriptions that people didn’t need to pay for.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy shared a building with a GP surgery. But it had its own separate entrance. The pharmacy was air-conditioned, bright, clean and tidy. Its public-facing area was professionally presented. And its team members were responsible for keeping its premises tidy. The pharmacy generally had the workbench and storage space it needed for its workload. It had a consulting room for the services it offered that required one. Or if someone 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 had some sinks and a supply of hot and cold water. And its team members cleaned the pharmacy as often as they could when it wasn't busy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are safe and effective. And its team is friendly and helps people access the services they need. Members of the pharmacy team dispose of people's unwanted medicines properly. And they generally carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources. And it usually 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 members of the pharmacy team helped people who couldn't open the door easily, such as someone with a pushchair or a wheelchair, access the building. The pharmacy had a seating area people could use if they wanted to wait in the pharmacy. 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 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. 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 an electronic audit trail for each delivery. And this showed it had delivered the right medicine to the right person. 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 generally kept an audit trail of the person who had assembled and checked each prescription. And patient information leaflets and a brief description of each medicine contained within a compliance pack were usually provided. So, people had the information they needed to make sure they took their medicines safely. Members of the pharmacy team 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. They 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. 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 routinely marked the containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and when they got chance to. But they could do more to make sure they did these checks more frequently and recorded when they had done them. And they could do more to make sure products which were soon to expire were appropriately marked. These steps would help them 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. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy kept out-of-date CDs separate from in-date stock. It 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 suitable 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). And, for example, the pharmacy team had removed and returned pholcodine-containing cough and cold medicines following the receipt of an MHRA medicines recall. One of the team members described the actions they took and showed what records they made when they 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 the National Pharmacy Association 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. Members of the pharmacy team could check a person's blood pressure when asked. But they haven't had the monitor they used to do this for very long.

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.