General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Fernhurst Pharmacy, 1 Crossfield, Fernhurst, HASLEMERE, Surrey, GU27 3JL

Pharmacy reference: 1124905

Type of pharmacy: Community

Date of inspection: 31/10/2023

Pharmacy context

This NHS community pharmacy is set on a small row of shops in the centre of Fernhurst village. The pharmacy opens six days a week. It sells medicines over the counter. It dispenses people's prescriptions. It delivers medicines to people who have difficulty in leaving their homes. And it supplies multi-compartment compliance packs (compliance packs) to a few people who need help managing their medicines.

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 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 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 some plastic screens 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. But these hadn't been reviewed for a while. 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. 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 kept the dispensing workstations tidy. They 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). Its team members discussed the mistakes they made to learn from them and help them stop the same sort of things happening again. But they didn't always record them.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. It had a leaflet which asked people to share their views and make suggestions 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 an electronic controlled drug (CD) register. But the stock levels recorded in this register weren't checked as often as the SOPs asked them to be. The pharmacy kept appropriate records for the supplies of the unlicensed medicinal products it made. It kept records to show which pharmacist was the RP and when. But the time the pharmacist stopped being the RP wasn't always recorded. 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 easily see other people's personal information. The pharmacy had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always obliterated or removed from the unwanted medicines returned to it before being disposed of. The pharmacy had an information governance policy. And its team completed a self-assessment each year and made a declaration to the NHS that it was practising good data security and it was handling personal information correctly. The pharmacy had a safeguarding procedure. 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. 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 just 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, a part-time pharmacist and a full-time trainee dispensing assistant. The pharmacy depended upon its team, its director and locum pharmacists to cover absences. The people working at the pharmacy during the inspection included the trainee dispensing assistant and the director (the RP). The pharmacy didn't set any targets or incentives for its team. And it had seen an increase in its dispensing volume since its last inspection. But its team was 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 felt able to make decisions that kept people safe. The RP supervised and oversaw the supply of medicines and advice given by the team. The dispensing assistant 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 accredited training relevant to their roles. And they could ask the pharmacist questions, discuss their development needs, read pharmacy-related literature and familiarise themselves with products when they had the time to do so. The pharmacy had a whistleblowing policy. Team members 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 the pharmacy's delivery process being reviewed.

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 was bright, clean, secure and tidy. And its public-facing area was professionally presented. The pharmacy team and a cleaner were responsible for keeping the premises clean and tidy. The pharmacy generally had the workbench and storage space it needed for its workload. And 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.

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 usually 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 gets its medicines from reputable sources. And it stores them appropriately and securely.

Inspector's evidence

The pharmacy had a ramp leading to its entrance. But it didn't have an automated door. So, members of the pharmacy team remained alert to make sure they could help people enter the building and use the pharmacy's 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. And its team asked people who were prescribed a new medicine if they wanted to speak to the pharmacist about it. 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. But its team could do more to make sure a record was kept showing 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 the pharmacist assessed whether a person needed a compliance pack. The pharmacy 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. 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. But it 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 ensure 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 its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team removed some out-of-date medicines from the shelves during the inspection. They 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. 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 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 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. But its team could do more to make sure it recorded what actions it took when it 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. 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 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 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 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.