General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chobham Pharmacy, 32 Chertsey Road, Chobham, Woking, Surrey, GU24 8PQ

Pharmacy reference: 9011946

Type of pharmacy: Community

Date of inspection: 05/07/2023

Pharmacy context

This NHS community pharmacy is set on a small parade of shops in Chobham. 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 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 at the pharmacy too.

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 generally review the mistakes they make 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 usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. And people who worked at the pharmacy were required to read the SOPs relevant to their roles and agree to follow them. 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 responsible pharmacist (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 had separated some medicines, which looked alike and whose names sounded alike, from one another to help reduce the risks of the wrong product being selected. They discussed and reviewed the mistakes they made. So, they could learn from them. And, for example, they reviewed their dispensing process following a mistake when a medicine used to treat high blood cholesterol was dispensed instead of a medicine used to treat low moods and panic attacks. But they didn't always record the near misses they made. And they may have missed opportunities to strengthen their processes further by spotting patterns in the mistakes they made.

The pharmacy had a notice that told people who the RP was at that time. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. But the pharmacy could do more to make sure their roles and responsibilities were described within the SOPs. A team member explained that they wouldn'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 pharmacy had a process to deal with people's complaints. People have left online reviews about their experiences of using the pharmacy and its services. They could share their views and make suggestions about how the pharmacy could do things better. And, for example, the pharmacy team tried to keep a person's preferred make of a prescription medicine in stock when it was asked to do so. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. It had a controlled drug (CD) register. But the stock levels recorded in the register weren't checked as often as the SOPs asked them to be. And the address from where a CD came from wasn't included in the sample of entries seen. The pharmacy had an electronic record to show which pharmacist was the RP and when. It kept records for the supplies of the unlicensed medicinal products it made. But when the pharmacy received an unlicensed medicinal product, when it supplied it and who it supplied it to weren'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 RP gave an assurance that all the pharmacy 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 needed to complete a self-assessment each year and declare to the NHS that it was practising good data security and it was handling personal information correctly. It 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 people returned to it before being disposed of. Members of the pharmacy team were made aware of the NHS safeguarding mobile phone application during the inspection. 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 level 2 safeguarding training. But the pharmacy could do more to make sure it had a safeguarding policy or guidance available for its team to refer to.

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 don’t always get time to train when they’re at work. But they work well together and use their judgement to make decisions about what is right for the people they care for. And they know how to raise a concern if they have one or give feedback to help the pharmacy do things better.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist (the RP), a full-time trainee dispensing assistant and a delivery driver. The pharmacy relied upon colleagues from a nearby branch or locums to cover absences. The people working at the pharmacy during the inspection included the RP, the trainee dispensing assistant and a locum dispenser. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. Members of the pharmacy team were up to date with their workload. They worked well together and helped each other to serve people and make sure prescriptions were dispensed safely. And they didn’t feel the targets set for the pharmacy stopped them from making decisions that kept people safe. 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 the pharmacist. People working at the pharmacy were required to do accredited training relevant to their roles. But they had fallen behind as they were sometimes too busy to train whilst they were at work. Members of the pharmacy team could share learning about the mistakes they made, ask the pharmacist questions and familiarise themselves with products when they had the time to do so. They could make suggestions to the pharmacy owner and each other on how to improve the pharmacy and its services. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback led to changes in the way they processed private prescriptions.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an appropriate and modern 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 modern. And its public-facing area was professionally presented. The pharmacy had the workbench and storage space it needed for its current 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. People’s conversations in the consulting room couldn’t be overheard outside of it. The consulting room 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 its team delivered. And the premises had a supply of hot and cold water. Members of the pharmacy team were responsible for keeping the premises clean and tidy. And they wiped and disinfected the surfaces they and other people touched.

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 generally 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. 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. So, people who couldn't open the door easily, such as people with pushchairs or wheelchairs, relied upon the pharmacy team to help them access the pharmacy. The pharmacy had a notice that told people when it was open. And it had a chair next to its entrance for people to use when 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. And it kept a record to show that people had received their medicines safely. 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 kept an audit trail of the person who had assembled and checked each prescription. It provided a brief description of each medicine contained within the compliance packs. But patient information leaflets weren't always supplied. And cautionary and advisory warnings about the medicines contained within the compliance packs weren't included on the backing sheets. So, people didn't always have the information they needed to take their medicines safely. The pharmacy used clear bags for dispensed 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. It used reminder stickers to alert the team when these items needed to be added or if extra counselling was needed. But assembled CD prescriptions awaiting collection weren't routinely marked with the date the 28-day legal limit would be reached. And this meant there was a greater risk of its team making supplies that were unlawful. 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. And the pharmacy had the resources it needed when its team 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. But a few medicines weren't. Members of the pharmacy team marked products which were soon to expire. They checked the expiry dates of medicines as they dispensed them or when they got chance to. But they didn't

record when they had done so. And they didn't always mark containers of liquid medicines with the date they opened them. 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. 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 an appropriate waste bin for the hazardous waste people brought back to it. The pharmacy had removed and returned its pholcodine-containing cough and cold medicines following a medicines recall issued by the Medicines and Healthcare products Regulatory Agency (MHRA) explaining that these products were to be withdrawn. The RP described the process they followed when dealing with a recall issued by the MHRA. But the pharmacy hadn't kept a record of the actions it took in response to any recent recalls.

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 personal information 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 usually 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 a 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. And the monitor they used to do this was obtained within the last year. 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 its team members stored their NHS smartcards securely when they weren't working or using them.

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.