

Registered pharmacy inspection report

Pharmacy Name: Allcorn Chemists; T.A., 197 St. James Road,
CROYDON, Surrey, CR0 2BZ

Pharmacy reference: 1036503

Type of pharmacy: Community

Date of inspection: 15/07/2024

Pharmacy context

This NHS community pharmacy is set on a main road near a medical centre in Croydon. The pharmacy opens five and a half days a week. It sells medicines over the counter. It dispenses people's prescriptions. And it delivers medicines to a few local people who have difficulty in leaving their homes. The pharmacy provides a substance misuse treatment service. It supplies multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. It delivers the NHS Pharmacy First service to help people who have a minor illness or need an urgent supply of a medicine. And people can visit the pharmacy to have their blood pressure checked.

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 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 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 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. And they 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 also available for people to use. The pharmacy had a notice that told people who the responsible pharmacist (RP) was at that time. It had standard operating procedures (SOPs) for the services it provided. But it could do more to make sure these were reviewed more frequently. 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 though they were required to read the SOPs, they hadn't signed all of them to show they understood them and agreed to follow them. 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 a pharmacist.

The team members responsible for making up people's prescriptions tried to keep 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 by the RP who also initialled the dispensing label. The pharmacy had a process 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 the mistakes it made to learn from them and help stop the same sort of things happening again. And, for example, it separated a medicine used to treat high blood pressure and an antidepressant that looked alike and whose names sounded alike from one another on the shelves to help reduce the chances of the wrong one being picked. But more could be done to make sure near misses and any learning outcomes from them were routinely documented.

The pharmacy had a complaints procedure. People could share their views and make suggestions about how the pharmacy could do things better. They had left online reviews about their experiences of using the pharmacy and its services. 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. The pharmacy kept an electronic controlled drug (CD) register. And a written log showed which pharmacist was the RP and when. The RP had fallen slightly behind with making entries in the CD register and the RP log. But this was addressed before the end of the day to make sure the CD register and the RP log were up to date. The pharmacy adequately recorded the supplies of the unlicensed medicinal products it made.

And its team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But occasionally the wrong prescriber details were recorded in the private prescription records. The RP gave an assurance that the pharmacy records would be kept up to date and maintained as they should be.

The pharmacy was registered with the Information Commissioner's Office. And people using it couldn't see other people's personal information. The pharmacy had arrangements to make sure confidential information was stored and disposed of securely. And its team 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. The pharmacy had a safeguarding policy. 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 RP had done some safeguarding training too.

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 can make decisions to keep the people they care for safe. They are comfortable about giving feedback to help the pharmacy do things better. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy team consisted of the RP, a trainee pharmacy technician, a trainee dispensing assistant and an assistant. The pharmacy depended upon its team or locums to cover planned absences. But the pharmacist owner and a trained dispenser could provide support if needed. The people working at the pharmacy during the inspection included the RP, the trainee pharmacy technician, the trainee dispensing assistant and the assistant. The RP was the pharmacy's regular pharmacist. They were responsible for leading the pharmacy and its team. And they supervised and oversaw the supply of medicines.

A member of the pharmacy team 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 assistant had only just started to work at the pharmacy. And needed to complete a probationary period. Members of the pharmacy team were required to start an accredited training course relevant to their roles, if they hadn't done so already, within three months of starting at the pharmacy. They could discuss their development needs and any clinical governance issues with the RP when the pharmacy wasn't busy. And they were encouraged to learn from their mistakes too.

The pharmacy didn't set any targets or incentives for its team. Members of the pharmacy team felt able to make decisions that kept the people they cared for safe. They worked well together. They helped each other make sure people were seen to as quickly as possible. And they were up to date with their workload. 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, for example, an additional computer terminal was installed following a team member's suggestion.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver its services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was bright and secure. And its public-facing area was appropriately presented. But it wasn't air-conditioned. So, the pharmacy team took steps to make sure the pharmacy didn't get too hot. The pharmacy had a counter, a dispensary, a retail area and a small stockroom. It had just enough workspace and storage available for its current workload. But its appearance, fixtures and flooring were dated and worn. The pharmacy had a consulting room for the services it offered that required one or if someone needed to speak to a team member in private. But it was small and it could be difficult for some people to use. The pharmacy had a few sinks and a supply of hot and cold water. And a cleaner as well as its team were 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. And its team is friendly and helps people access the services they need. The pharmacy keeps adequate records to show it has delivered the right medicine to the right person. It 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. And its entrance wasn't level with the pavement. But it had a portable ramp that could be placed outside. And a member of the pharmacy team would open the door when necessary to help people who had trouble climbing stairs enter the building. The pharmacy had a notice that told people when it was open. And it had a seating area for people to use when 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 NHS Pharmacy First 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 some minor illnesses. Members of the pharmacy team were friendly and helpful. And they took the time to listen to people. So, they could help and advise them, and signpost them to another provider if a service wasn't available at the pharmacy.

The pharmacy provided a local delivery service to a few people who couldn't attend its premises in person. And its team kept a record to show 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 an assessment was completed to determine if a person needed one. The pharmacy provided a patient information leaflet and a brief description for each medicine contained within the compliance packs. And it kept an audit trail of the person who checked the accuracy of each assembled compliance pack. The pharmacy marked prescriptions to highlight when a pharmacist needed to speak to the person about the medicines they were collecting or if other items, such as a CD or a refrigerated product, needed to be added. But its team could do more to make sure assembled CD prescriptions were routinely 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 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 as well as products which were soon to expire. They checked the expiry dates of medicines when they dispensed

them and a few times each year. But they didn't always record when they had done a date check. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. It stored CDs, which weren't exempt from safe custody requirements, securely. And it kept out-of-date CDs separate from in-date stock. The pharmacy had procedures for handling 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 its team could use to dispose of 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 a team member described the actions they took when the pharmacy received an MHRA medicines recall. But the pharmacy team could do more to record what actions it took.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy generally 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 few glass measures to measure out liquids. And it had some plastic measures too. But an assurance was received that the plastic measures wouldn't be used. And the pharmacy team ordered a few more glass measures during the inspection. The pharmacy 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 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 had suitable equipment for the Pharmacy First service as well as for measuring a person's blood pressure. And this equipment appeared to be well maintained. 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 were stored securely 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.