General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Swan Pharmacy, 119 South End, CROYDON, Surrey, CR0 1BJ

Pharmacy reference: 1036519

Type of pharmacy: Community

Date of inspection: 14/10/2020

Pharmacy context

A busy community pharmacy set on a row of shops in South Croydon. The pharmacy opens six days a week. And most people who use it live nearby. The pharmacy sells a range of over-the-counter (OTC) medicines. And it dispenses people's prescriptions and substance misuse treatments. The pharmacy offers winter influenza (flu) vaccinations. It supplies medicines in multi-compartment compliance packs (compliance packs) to help people take their medicines. And it delivers medicines to a few people who have difficulty in leaving their homes. This inspection took place during the coronavirus (COVID-19) pandemic.

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 generally manages its risks appropriately. And it has written procedures to help make sure its team works safely. The pharmacy keeps most of the records it needs to. And it has adequate insurance to help protect people if things do go wrong. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They review the mistakes they make. So, they can try to stop them happening again. They understand their role in protecting vulnerable people. And they keep people's private information safe.

Inspector's evidence

The pharmacy team had risk assessed the impact of COVID-19 on the pharmacy and its services. And, as a result, it had suspended providing some face-to-face services, such as Medicines Use Reviews and the NHS New Medicine Service. The pharmacy offered to undertake an occupational risk assessment for each team member to help identify and protect those at increased risk in relation to COVID-19. But some team members hadn't had their assessments yet. The pharmacy manager and the responsible pharmacist (RP) agreed that any outstanding risk assessments would be completed. The RP was aware of the need for community pharmacy employers to report instances of exposure to COVID-19 in the workplace. The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And most of the SOPs had been reviewed since the last inspection. Members of the pharmacy team were required to read, sign and follow the SOPs. But some team members hadn't read and signed them as they had only recently started at the pharmacy. The RP gave an assurance that any SOPs that needed to be reviewed would be. And the pharmacy team would read and sign them too.

The team members responsible for making up people's prescriptions kept look-alike and sound-alike drugs apart on the dispensary shelves to reduce the chances of them picking the wrong product. They used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. 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 systems to record and review dispensing errors and near misses. Members of the pharmacy team discussed and documented individual learning points when they identified a mistake. They reviewed their mistakes periodically to help spot the cause of them. And they shared any learning from these reviews with each other. So, they could try to stop the same types of mistakes happening again. The pharmacy strengthened its dispensing process after a mistake when someone was given the wrong medicine. And it highlighted the stock locations of the medicines involved to point out to its team the possibility of the error.

The pharmacy displayed a notice that identified the RP on duty. Its SOPs didn't fully describe the roles and responsibilities of the pharmacy team. But members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. They 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 to the RP. The pharmacy had a complaints procedure. It told people how they could provide feedback about it and the services it provided in its practice leaflet. People were asked to take part in a satisfaction survey once a year. And the results of a survey were available online. The pharmacy team tried to keep people's preferred makes of prescription-medicines in stock when 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. But the pharmacy team hadn't checked the CD running balance for some time. So, it could be missing opportunities to spot mistakes or discrepancies. The pharmacy kept a record to show which pharmacist was the RP and when. The pharmacy kept records for the supplies of unlicensed medicinal products it made. But it didn't always record when it received a product. The pharmacy recorded the emergency supplies it made and the private prescriptions it supplied. But the reason for an emergency supply made at a patient's request wasn't always recorded properly. And the name and address of the prescriber wasn't always recorded for some private prescriptions.

The pharmacy had an information governance policy. Members of the pharmacy team needed to read and sign a confidentiality agreement. The pharmacy made sure that its confidential waste was collected and destroyed securely by a third-party company. The pharmacy team stored prescriptions in such a way so people's names and addresses couldn't be seen by someone who shouldn't see them. The pharmacy had safeguarding procedures. It had the contacts it needed if a member of the team needed to raise a safeguarding concern. And team members could explain what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to deliver safe and effective care. Members of the pharmacy team don't always have time set aside so they can train while 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. They're comfortable about giving feedback on how to improve the pharmacy's services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacy manager, a full-time pharmacist (the RP), a part-time locum pharmacist, a full-time accuracy checking pharmacy technician, three full-time dispensing assistants, a part-time medicines counter assistant (MCA), a part-time trainee MCA and a part-time delivery driver. The team members responsible for making up people's prescriptions, including the RP, had only recently started to work at the pharmacy. The pharmacy manager, the RP, two dispensing assistants and a MCA were working at the time of the inspection. The pharmacy relied upon its team, its superintendent pharmacist and team members from one of the company's other pharmacies to cover absences.

Members of the pharmacy team worked well together. So, people were served promptly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the team. The pharmacy had a sales of medicines protocol which its team needed to follow. One of the team members described the questions they would ask when making OTC recommendations. They referred requests for treatments for babies and young children, people with long-term health conditions and people who were pregnant or breastfeeding to a pharmacist. Members of the pharmacy team, including the pharmacy manager, needed to undertake accredited training relevant to their roles. Team members could talk to the RP, pharmacy manager or the superintendent pharmacist about their development needs. They could ask questions and familiarise themselves with new products. But they didn't always get time to train while they were at work as the pharmacy was busy. The pharmacy held informal meetings to update its team and to share learning from mistakes or concerns. The pharmacy didn't set any targets or have incentives for its staff. And its team didn't feel under pressure to complete the tasks it was expected to do. Members of the pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And their feedback led to a change in the way the pharmacy's dispensary was organised.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable and secure environment for people to receive healthcare. And its premises are generally clean and tidy. The pharmacy has a room where people can have private conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy had a small retail area, a consulting room, a counter, a narrow and long dispensary, a toilet and a stockroom in its basement. The basement had flooded recently. But several dehumidifiers were being used to dry it out. And the remainder of the pharmacy's premises were unaffected. The pharmacy was air-conditioned, bright, clean, secure and adequately presented. The dispensary generally had the workspace and storage it needed for its current workload. Members of the pharmacy team tried to socially distance themselves from each other and people using the pharmacy. But they each wore a face mask or visor just in case they couldn't. The pharmacy had a consulting room for the services it offered and if people needed to speak to a team member in private. But it was behind the pharmacy's counter and next to the dispensary's entrance. So, people had to be shown into it and the pharmacy team needed to make sure its contents were secure when it wasn't being used. The pharmacy had a few sinks. And it had a supply of running hot and cold water. Members of the pharmacy team were responsible for keeping the pharmacy's premises clean and tidy. They cleaned the pharmacy the days it was open. And they regularly wiped and disinfected the surfaces they and other people touched. The pharmacy had handwash and alcoholic hand gel for people to use. So, its team members could wash or sanitise their hands regularly.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are generally safe and effective. The pharmacy offers flu vaccinations and keeps appropriate records to show that it has given the right vaccine 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 generally carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose. And they dispose of most people's waste medicines properly too.

Inspector's evidence

The pharmacy had automated doors and its entrance was level with the outside pavement. So, people with mobility difficulties, such as wheelchair users, could access its premises easily. The pharmacy displayed information about COVID-19, how people should wear their face coverings and some of the services it provided. Members of the pharmacy team were 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. The pharmacy had appropriate resources, including an up-to-date patient group direction, for its flu vaccination service. The pharmacy kept a record of the vaccinations it made. And this included the details of the person vaccinated, an audit trail of who vaccinated them and the details of the vaccine used. The pharmacy team needed to make sure the sharps bins were kept securely when not in use. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked whether a medicine was suitable to be re-packaged. It provided a brief description of each medicine contained within the compliance packs. It kept an audit trail of the person who had assembled and checked each prescription. But sometimes patient information leaflets weren't supplied. The pharmacy team marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting, for example a high-risk medicine, or if other items, such as CDs and refrigerated products, needed to be added. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The pharmacy had some valproate educational materials available.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices tidily on the shelves within their original manufacturer's packaging. The pharmacy team were required to check the expiry dates of medicines at regular intervals. But it didn't always record when these were done. It marked products which were soon to expire to reduce the chances of it giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy team needed to keep patient-returned and out-of-date CDs separate from in-date stock. But these had been allowed to build up and needed to be destroyed. Members of the pharmacy team were aware of the Falsified Medicines Directive (FMD). They could check the anti-tampering device on each medicine was intact during the dispensing process. But they weren't decommissioning stock despite the pharmacy having the FMD equipment and software it needed. The pharmacy was aiming to become FMD compliant by the end of the year once its processes had been updated and its team trained. The pharmacy had procedures for

handling unwanted medicines people returned to it. And its team checked if these included any CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. The pharmacy had a pharmaceutical waste bin. But it didn't have an appropriate bin for the disposal of hazardous waste. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they would take. But they didn't routinely record these actions.

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 reviewed the equipment its team needed as a result of the pandemic. It had put some large plastic screens on its counter. And markings on its floor were there to help people keep two metres apart and restrict the number of people in the pharmacy at any one time. The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment, including face masks and visors, its team members needed. The pharmacy had a range of clean glass measures. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure the equipment they used to measure, or count, medicines was clean 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 two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded each refrigerator's maximum and minimum temperatures. 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. The pharmacy had a cordless telephone system. So, its team could have confidential conversations with people when necessary. Most of the team members responsible for the dispensing process had their own NHS smartcard. And they made sure it was 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.