General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Crawley Down Pharmacy, 14 Old Station Close, Crawley Down, CRAWLEY, West Sussex, RH10 4TX

Pharmacy reference: 1037303

Type of pharmacy: Community

Date of inspection: 22/11/2022

Pharmacy context

This is an NHS community pharmacy on a parade of shops in the centre of Crawley Down village. The pharmacy is part of a small chain of pharmacies. It opens six days a week. And most people who use it live nearby. The pharmacy sells over-the-counter medicines and some health and beauty products. It dispenses people's prescriptions. And it delivers medicines to people who can't attend its premises in person. The pharmacy supplies multi-compartment compliance packs to some 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 people can get their flu vaccination (jab) from the pharmacy.

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 appropriately manages its risks. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has appropriate insurance 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 can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. They understand their role in protecting vulnerable people. And they talk to each other about the mistakes they make. So, they can learn from them.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were kept on the computer and were recently 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. Team members responsible for making up people's prescriptions used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP). The pharmacy had processes to deal with dispensing mistakes that were found before reaching a person (near misses) and those which hadn't (dispensing errors). Team members generally highlighted and separated medicines involved in dispensing mistakes or were similar in some way, such as medicines that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being picked. They discussed the mistakes they made to learn from them and to reduce the chances of them happening again. But they didn't always record the near misses they made nor the lessons they learnt from them. So, they may have missed opportunities to spot patterns or trends in the mistakes they made.

The pharmacy displayed 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. And their roles and responsibilities were described within the SOPs. 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. People shared their views about using the pharmacy and its services online. The pharmacy had a complaints process. It had leaflets which asked people for their suggestions on how it could do things better. And, for example, its 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 appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had a controlled drug (CD) register. And the stock levels in the register were usually checked as often as the SOPs required. But a few entries hadn't been made when they should have been. Some headers were incomplete. And the details of where a CD came from weren't always completed in full. The pharmacy generally kept appropriate records of the supplies of the unlicensed medicinal products it made. It had a record to show which pharmacist was the RP and when. But the time at which a pharmacist stopped being the RP wasn't always recorded. The pharmacy recorded the emergency supplies it made and the private prescriptions it supplied on its computer. But the prescriber details were sometimes incorrect or incomplete in the private prescription records. 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 had arrangements to make sure confidential information was stored and disposed of securely. And it had an information governance policy which its team needed to read. The pharmacy had a safeguarding policy. Members of the pharmacy team had the contacts they needed if they wanted to raise a safeguarding concern. And they knew 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 generally don't 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. And they're comfortable about giving feedback on how to improve the pharmacy's services. The pharmacy team knows how to raise a concern if it has one. And its professional judgement and patient safety are not affected by targets.

Inspector's evidence

The regular pharmacy team consisted of a full-time pharmacist manager, a part-time dispensing assistant, two full-time trainee dispensing assistants, a part-time trainee medicines counter assistant, a full-time team member who recently started at the pharmacy and a part-time delivery driver. The pharmacist manager (the RP), two trainee dispensing assistants and the team member who recently started at the pharmacy were working at the time of the inspection. The pharmacy relied upon its team, locum pharmacists and team members from one of the company's other pharmacies to cover absences. Members of the pharmacy team were up to date with their workload and helped each other to serve people and dispense prescriptions safely. But they sometimes struggled to do all the things they were expected to do.

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. 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 on duty. People working at the pharmacy were required to do accredited training relevant to their roles after completing a probationary period. And the superintendent pharmacist provided evidence of this following the inspection. Members of the pharmacy team discussed their development needs with their manager when they could. They talked to one another about the mistakes they made to share learning. And they were encouraged to ask each other questions and keep their knowledge up to date when the pharmacy wasn't busy. But they didn't always get time set aside to train when they were at work. The pharmacy had a whistleblowing policy. Its team members were 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 them strengthening the way they processed partly dispensed prescriptions. The pharmacy team felt the targets set for the pharmacy were challenging. But it didn't feel these stopped it from making decisions that kept people safe.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate environment to deliver it services from. And people can receive services in private when they need to. But members of the pharmacy team don’t always have the space they need to work in when it’s busy.

Inspector's evidence

The pharmacy premises had a small consulting room if people needed to speak to a team member in private. The pharmacy was air-conditioned, bright, clean and appropriately presented. But its dispensary was small. It had limited workbench and storage space available. And its dispensing worksurfaces could become cluttered when the pharmacy was busy. 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 the surfaces they and other people touched.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are generally safe and effective. And it offers flu jabs and keeps appropriate records to show that it has given the right vaccine to the right person. The pharmacy gets its medicines from reputable sources. It stores most of them appropriately and securely. And its team is friendly and tries to help people access its services. Members of the pharmacy team 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.

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 notices that told people about its services and when it was open. And it had a small seating area for people to 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 the pressure on local surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses was reduced too. Members of the pharmacy team were friendly and helpful. 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 an audit trail to show when it delivered someone their medicines. But its team didn't routinely ask people to sign to say they had received their medicines as required by the SOPs. The pharmacy had the anaphylaxis resources and the patient group directions it needed for its flu jab service. And the RP was appropriately trained to vaccinate people. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. It used a hub pharmacy to assemble most of its compliance packs. People could choose not to have their prescriptions dispensed at the hub pharmacy. Prescriptions assembled at the hub pharmacy were returned to the pharmacy for people to collect or to be delivered. The pharmacy team checked if a medicine was suitable to be re-packaged. The pharmacist assessed whether a person needed a compliance pack. And an audit trail was kept of the people involved in the assembly of each compliance pack from clinically assessing the prescription through to checking its accuracy. A brief description or image of the medication contained within each compliance pack was provided. But patient information leaflets weren't routinely supplied. And people were asked to download these instead. So, they didn't always have the information they needed to take their medicines safely. The pharmacy team marked some 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 assembled CD prescriptions awaiting collection weren't 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. 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. Team members checked the expiry dates of medicines at regular intervals and recorded when they had done these. And they marked products which were soon to expire. These steps helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at the appropriate temperature. And it generally 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. But it didn't always record when it received these medicines as required by the SOPs. The pharmacy kept patient-returned CDs and out-of-date CDs separate from in-date stock. But these had been allowed to build up. 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 an appropriate pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team usually kept a record of what action it took when a drug alert was received.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy mostly 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 made sure they 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 a team at head office or Numark to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team checked and recorded each refrigerator's maximum and minimum temperatures most 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 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.