

# 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:** 21/10/2024

## Pharmacy context

This is an NHS community pharmacy set in the centre of Crawley Down village. The pharmacy is part of a small chain of pharmacies. It 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 a few people who need help managing their medicines. And it delivers the NHS Pharmacy First service to help people who have a minor illness or need an urgent supply of a medicine. People can visit the pharmacy to have their blood pressure measured. And they can also get their coronavirus booster or flu jab.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	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 at the pharmacy log and 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 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 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. And these were reviewed by a team at the pharmacy's head office. People who worked at the pharmacy have read and signed the SOPs relevant to their roles to show they understood them and agreed to follow them. And they knew what they could and couldn't do, what they were responsible for and when they might seek help. 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 who were 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 and initialled by the RP. The pharmacy had reviewed its dispensing process. And most people's compliance packs were now assembled off-site at the company's hub pharmacy. This meant the pharmacy team could spend more time talking to people about their medicines and deliver other services. 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). And its team discussed and recorded the mistakes it made to learn from them and help stop the same sort of things happening again.

The pharmacy had a complaints procedure. And it had leaflets that told people how they could provide feedback about its services. People could share their views and make suggestions about how the pharmacy could do things better. Some people have left online reviews about their experiences of using the pharmacy. And, for example, the pharmacy recently employed a window cleaner following feedback that its windows were dirty. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It kept a log to show which pharmacist was the RP and when. But the pharmacist occasionally forgot to record when they stopped being the pharmacy's RP. The pharmacy generally kept an appropriate record of the unlicensed medicinal products (specials) it supplied. The pharmacy had a controlled drug (CD) register. And the stock levels recorded in the register were checked regularly. But the pharmacy team didn't always complete the details of where a CD came from in full. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the details of the prescriber were sometimes

incomplete in the private prescription records seen. And the pharmacy team was reminded that an appropriate record needed to be made when it supplied a prescription-only medicine (POM) to a person in an emergency including the reason for making a supply even for requests referred to it through the NHS Pharmacy First service. The pharmacy team was also reminded that in addition to standard labelling requirements the words 'Emergency supply' needed to be added to the dispensing label when it supplied a POM to a person in an emergency.

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 displayed a notice that told people how it gathered, used and shared their personal information. It had SOPs on information governance and data security. And it had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always crossed out or removed from the unwanted medicines that were returned to the pharmacy before being disposed of. The pharmacy had a safeguarding SOP. And the RP had completed safeguarding training. 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.

## 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 a locum pharmacist (the RP), three trainee dispensing assistants, two trainee medicines counter assistants and a delivery driver. The pharmacy depended upon its team, locum pharmacists and colleagues from another branch to cover absences. The people working at the pharmacy during the inspection included the RP, a second pharmacist, two trainee dispensing assistants and a medicines counter assistant. The RP was the pharmacy's regular pharmacist. They were responsible for managing the pharmacy and leading its team. And they 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. 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 who worked at the pharmacy were required to do accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with the RP when the pharmacy wasn't busy. They shared learning from the mistakes they made. And they were encouraged to ask questions and complete their training to make sure their knowledge was up to date.

People who worked at the pharmacy didn't feel that targets or incentives stopped them from making decisions that kept people safe. They worked well together. They helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they were up to date with their workload. Members of the pharmacy team knew the pharmacy had a whistleblowing policy and 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, the skills mix and work pattern of the pharmacy team was reviewed following staff feedback.

## 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. But members of the pharmacy team don't always have the space they need to work in when the pharmacy is busy.

### Inspector's evidence

The pharmacy was air-conditioned and appropriately lit. And its public-facing area was adequately presented. The pharmacy had a counter, a dispensary, a retail area, a small stockroom and a toilet. It had limited workbench and storage space available. And its worksurfaces could become cluttered when it was busy. The pharmacy had a small consulting room for the services it offered that required one or if someone needed to speak to a team member in private. And this was locked when not in use to make sure the things in it were kept secure. The pharmacy had a sink and a supply of hot and cold water. And its team was responsible for keeping its premises clean and tidy.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides services that people can access. Its working practices are generally safe and effective. And it keeps adequate records for its vaccination service to show that it has given the right vaccine to the right person. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team are friendly and helpful. They 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. And it didn't have an automated door. But the pharmacy team remained alert to make sure it could help people enter the building and use the pharmacy's services. The pharmacy had a notice that told people when it was open. And it had a couple of seats 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 a pharmacist about it. And the pharmacy dealt with NHS Pharmacy First referrals. People benefited from these services as they could access the advice and medication they needed when they needed to. 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 offered a local delivery service to people who couldn't attend its premises in person. It kept a log to show the right medicine had been delivered to the right person. But, apart from medicines that needed to be locked away, people weren't generally asked to sign the log to say they had received their medicines safely despite the SOPs asking the delivery person to do so. The pharmacy had the patient group directions (PGDs) and protocols it needed for the NHS Pharmacy First service. It provided coronavirus boosters and winter flu jabs. It had the anaphylaxis resources, trained vaccinators and PGDs it needed for its vaccination service. And, during peak times, it usually had two pharmacists working alongside each other so one pharmacist could concentrate on delivering the pharmacy's day-to-day services and the other its vaccination service. 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 hub pharmacy to assemble people's medicines into disposable compliance packs. The pharmacy team was responsible for the accuracy of the data entered into the computer for prescriptions dispensed at the hub pharmacy. And the pharmacist needed to make sure the prescription was clinically appropriate too. The pharmacy team told people that their prescription may be sent to another pharmacy to be made up. And the assembled compliance packs were returned to the pharmacy for the team to hand out or deliver. The pharmacy team checked whether a medicine was suitable to be re-packaged. And an assessment was done to decide if a person needed a compliance pack. An audit trail of the people involved in the assembly of each compliance pack was kept. And a brief description of each medicine was printed next to the medicine's name. This made it easier for people to tell what medicine they were taking. But patient information leaflets weren't routinely supplied with the compliance packs the hub pharmacy assembled. So, people didn't always have the information they needed to take their medicines safely. The pharmacy used clear bags for 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. The pharmacy used reminder stickers to alert its team when CDs or refrigerated products 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 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 access to the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team marked containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. And they marked products which were soon to expire. These things 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 an appropriate temperature. And it 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 were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. The pharmacy had a process for dealing with the alerts it received from the Medicines and Healthcare products Regulatory Agency (MHRA). And a team member described what actions they took and demonstrated what records they made when the pharmacy 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. And its team makes sure the equipment it uses is clean and is suitable for what it's being used for.

### Inspector's evidence

The pharmacy had some 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 a team at its head office to ask for information and guidance. The pharmacy had the medical refrigerators it needed to store pharmaceutical stock requiring refrigeration. And its team usually checked 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.