General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Norie's Pharmacy, 23 Oakhill Road, HORSHAM, West Sussex, RH13 5SD

Pharmacy reference: 1037354

Type of pharmacy: Community

Date of inspection: 24/07/2023

Pharmacy context

This busy NHS community pharmacy is set in a residential area of Horsham close to a mainline railway station. 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. 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 its team can check a person's blood pressure.

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 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 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 keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had written instructions for its team to follow if it needed to close due to an emergency. This told its team members what they should do to make sure people could access the care they needed if the pharmacy was closed. The pharmacy had some plastic screens on its counter to try and stop the spread of airborne infections such as coronavirus. And hand sanitising gel was also available for people to use. The pharmacy had computerised standard operating procedures (SOPs) for the services it provided. And these were reviewed by a team at the pharmacy's head office. Members of the pharmacy team were required to read and complete training on the SOPs relevant to their roles to show they understood them and agreed to follow them. They 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 the pharmacist. The pharmacy displayed a notice that told people who the responsible pharmacist (RP) was at that time. And it stored its pharmaceutical stock in alphabetical order. The team members who were responsible for making up people's prescriptions tried to keep the dispensing workstations tidy. They used plastic containers 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 unless their clinical suitability had been assessed by a pharmacist and they had been checked by an appropriately trained checker who also initialled the dispensing label. The pharmacy used an off-site dispensing hub (hub pharmacy) to make up most people's repeat prescriptions and compliance packs. The hub pharmacy assembled these prescriptions and returned the medicines to the pharmacy for its team to hand out or deliver to the person. People were told that their medicines would be dispensed at a different location to the pharmacy before being asked if they wanted to use the service. 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 were required to discuss, review and record the mistakes they made to learn from them, and help them stop the same sort of things happening again. And, for example, they highlighted some look-alike and sound-alike drugs to help reduce the risks of them picking the wrong product.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. And people could share their views and make suggestions to the pharmacy team about how the pharmacy could do things better. And, for example, the pharmacy team made sure it assembled people's repeat prescriptions when these people didn't want the hub pharmacy to do this. The pharmacy had appropriate insurance arrangements in place, including professional

indemnity, for the services it provided. It had a computerised controlled drug (CD) register. And the stock levels recorded in this register were usually checked more often than what the SOPs asked them to be. The pharmacy kept records to show which pharmacist was the RP and when. And these were mostly in order. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. But it didn't always record when it had received an unlicensed medicinal product. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on the computer. And the emergency supply records looked at during the inspection were generally in order. But the details of the prescriber were incorrect or incomplete in some of the private prescription records seen.

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 their personal information was gathered, used and shared by the pharmacy and its team. It had arrangements to make sure confidential information was stored and disposed of securely. And it had policies on information governance and safeguarding. Members of the pharmacy team were required to complete training on data protection and safeguarding. 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 pharmacy's consulting room could be used by someone as a 'safe space' if they felt they were in danger.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. But its team doesn't always start the training they need to do for their roles on time. Members of the pharmacy team work well together. And they use their judgement to make decisions about what is right for the people they care for. The pharmacy team is comfortable about giving feedback to help the pharmacy do things better. And it knows how to raise a concern if it has one.

Inspector's evidence

The pharmacy team consisted of a pharmacist manager (the RP), a trainee pharmacist, an accuracy-checking pharmacy technician (ACPT), two dispensing assistants, a medicines counter assistant (MCA), two counter assistants and a delivery driver. The pharmacy depended upon its team, colleagues from other branches or locum pharmacists to cover absences. The people working at the pharmacy during the inspection included the RP, the trainee pharmacist, the ACPT, the dispensing assistants and the MCA. The pharmacy was busy throughout the inspection. And its dispensing volume had recently increased since the closure of a nearby pharmacy. But its team was up to date with its workload. Members of the pharmacy team helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. The RP led by example. 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. The trainee pharmacist had just started at the pharmacy and was due to begin their induction training. The RP was their designated supervisor. And a training plan was in place for their foundation training year. The RP and the trainee pharmacist planned to have regular discussions and complete reviews when they needed to. People working at the pharmacy during the inspection had completed accredited training. But the counter assistants, who have worked at the pharmacy for some time, and the delivery driver hadn't. The superintendent pharmacist gave an assurance that these team members would be enrolled upon accredited training relevant to their roles following the inspection. This was to make sure all team members did the right training for the jobs they did. Team members discussed their performance and development needs with their manager when they could. They could share learning from the mistakes they made and were kept up to date during unplanned team meetings. They were encouraged to complete training. But they were often too busy doing all the other things they needed to do while they were at work so, they chose to train in their own time. Members of the pharmacy team 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, following their feedback, a folding table was purchased to give them additional space to store assembled prescriptions in the dispensary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver it services from. Its premises are clean and tidy. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was air-conditioned, bright, clean and tidy. Its public-facing area was professionally presented. And its team members were responsible for keeping its premises tidy. The pharmacy generally had the workbench and storage space it needed for its current workload. It had a separate room its team could use to assemble people's compliance packs in. But the lock to this room was broken. So, the pharmacy team needed to make sure the contents of this room were kept secure when it wasn't being used. The pharmacy had a good-sized consulting room for the services it offered that required one and if someone needed to speak to a team member in private. The consulting room was locked when it wasn't being used. So, its contents were kept secure. And people's conversations in it couldn't be overheard outside of it. The pharmacy had some sinks and a supply of hot and cold water. And its team members cleaned the pharmacy as often as they could when it wasn't busy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are generally safe and effective. And it delivers medicines to people's homes. But its team doesn't keep the records it should do to show it has delivered the right medicine 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 an automated door. And its entrance was level with the outside pavement. This made it simpler for people who couldn't open doors easily, such as people with pushchairs or wheelchairs, to access the pharmacy. The pharmacy had a notice that told people when it was open. It had another notice that told people about some of the services it delivered. And it had a seating area 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 some CPCS referrals. And people benefited from the CPCS as they could access the advice and medication they needed when they needed to. 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. It kept a record of the deliveries its driver needed to make. But it could do more to make sure its team followed its delivery SOP to show the right medicine had been delivered to the right person.

The pharmacy team was responsible for the accuracy of the data, including dosage instructions, they uploaded onto the hub pharmacy's system through the pharmacy computer. And the pharmacist was responsible for making sure the prescription was clinically appropriate. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And most of these were assembled at the hub pharmacy. The pharmacy team usually assessed whether a person needed a compliance pack. The pharmacy mostly kept an audit trail of the people involved in the assembly of each compliance pack. It routinely provided patient information leaflets. And a brief description or image of the medication contained within a compliance pack was provided. But 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 properly. The pharmacy team marked 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 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. They checked the expiry

dates of medicines as they dispensed them and at regular intervals which they were required to record to show they had done so. 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 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. And it kept these and 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 medicines were kept separate from the pharmacy's stock and were placed in a suitable pharmaceutical waste bin. 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, for example, the pharmacy team had removed and returned pholcodine-containing cough and cold medicines following the receipt of an MHRA medicines recall. One of the team members described the actions they took and showed what records they made when they 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. 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 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 two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team checked and recorded each 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 had recently been calibrated. 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.