General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Selhurst Pharmacy, 8 Selhurst Road, South Norwood, LONDON, SE25 5QF

Pharmacy reference: 1040948

Type of pharmacy: Community

Date of inspection: 11/07/2024

Pharmacy context

This NHS community pharmacy is set on a main road in Selhurst. The pharmacy opens five 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 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 get their flu jab or have their blood pressure checked.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.6	Standard not met	The pharmacy doesn’t do enough to make sure it keeps records in the way the law requires it to do so. And, for example, it can't show which pharmacist is its responsible pharmacist at any given time.
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 not all met**

Summary findings

The pharmacy manages its risks appropriately. And it has written instructions to help its team members work safely. But it doesn't do enough to make sure it keeps records in the way the law requires it to do so. The pharmacy 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. 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. But it could do more to make sure the responsibilities of the pharmacy team were clearly described in these SOPs. 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 any incidents. This included dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). The pharmacy team discussed and usually logged 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.

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 adequate insurance arrangements in place, including professional indemnity, for the services it provided. But it didn't keep appropriate records to show which pharmacist was the RP and when. The pharmacy had a controlled drug (CD) register. But its team didn't always complete the details of where a CD came from in full. And the CD register's running balance wasn't checked as often as the RP wanted it to be. The pharmacy kept a record of the supplies of the unlicensed medicinal products (specials) it made. But more could be done to make sure its team recorded when it received one of these products as well as who it was

supplied to and when. 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 and the date of prescribing were incorrect in the private prescription records seen. And the pharmacy team was reminded that it needed to make an appropriate record when it supplied a prescription-only medicine 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.

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 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 SOP. 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 pharmacy technician and a part-time assistant. The RP was considering recruiting another team member. The pharmacy depended upon its team or locums to cover absences. The people working at the pharmacy during the inspection included the RP and the pharmacy technician. The RP was the superintendent pharmacist and a director of the company that owned the pharmacy. They were responsible for leading the pharmacy and its team. And they supervised and oversaw the supply of medicines.

The pharmacy technician 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.

Team members could discuss their development needs and any clinical governance issues with each other. And the pharmacy professionals working at the pharmacy were required to keep their professional skills and knowledge up to date as part of their annual revalidation process. 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. And they were comfortable about making suggestions on how to improve the pharmacy and its services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver it 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 toilet. And it had enough storage and workspace for its current workload. 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. And this was locked when not in use to make sure the things in it were kept secure. The pharmacy had some sinks 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 has working practices that are generally safe and effective. And its team is friendly and helps people access the services they need. The pharmacy gets its medicines from reputable sources. And it stores most of them appropriately and securely. Members of the pharmacy team largely dispose of people's unwanted medicines properly. And they usually 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 offered a local delivery service to people who couldn't attend its premises in person. And its team made a note on a person's patient medication record (PMR) when it delivered their medicines. The pharmacy provided winter flu jabs. And its team was already thinking about how to prepare for the upcoming season. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And an assessment was done to determine if a person needed a compliance pack. The pharmacy usually provided a brief description for each medicine contained within a compliance pack. But an audit trail of the person who had assembled and checked each complaince pack wasn't routinely kept. And patient information leaflets weren't always supplied. The pharmacy 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 access to 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 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. And some expired medicines were removed from the shelves during the inspection. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. It stored its CDs, which weren't exempt from safe

custody requirements, securely. And its team were required to record the destruction of the CDs that people returned to it. 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 a pharmaceutical waste bin for hazardous medicines wasn't available. 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 the team described the actions it took and what records it 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 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 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 the refrigerator's maximum and minimum temperatures on the days the pharmacy was open. But it could do more to make sure it routinely recorded these. 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 PMR 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.