General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Norbury Pharmacy, 1102 London Road, Norbury, LONDON, SW16 4DT

Pharmacy reference: 1041173

Type of pharmacy: Community

Date of inspection: 14/11/2023

Pharmacy context

This NHS community pharmacy is set on a main road in Norbury. The pharmacy 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 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. Its pharmacist can check a person's blood pressure. And people can get their flu jabs from the pharmacy too.

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 write down and review 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 plastic screen on its counter to help reduce the spread of airborne infections such as coronavirus. And hand sanitising gel was also available for people to use. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed recently by the superintendent (SI) pharmacist. Members of the pharmacy team were required to read and sign the SOPs 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. Their responsibilities were also described within the SOPs. And a notice in the pharmacy told people who the responsible pharmacist (RP) was at that time. 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 team members who were responsible for making up people's prescriptions used baskets to keep each person's prescription separate from other people's prescriptions. 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 processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). The pharmacy team discussed, reviewed and recorded the mistakes it made to learn from them, and help stop the same sort of things happening again. And, for example, antibiotics were separated from other medicines to help reduce the chances of the wrong one being picked.

People have left online reviews about their experiences of using the pharmacy and its services. And the pharmacy had a complaints procedure. 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 tried to order a person's preferred make of a prescription medicine 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 an appropriately maintained controlled drug (CD) register. But the stock levels recorded in this register weren't checked as often as the SOPs required them to be. The pharmacy kept adequate records to show which pharmacist was the RP and when. It recorded the supplies of the unlicensed medicinal products it made. But its team could do more to make sure it recorded when it received one of these products. The pharmacy team had to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the reason for making a supply of a prescription-only medicine to a person in an emergency wasn't always recorded properly.

And the details of the prescriber were incomplete or incorrect in some of the private prescription records seen. The RP gave an assurance that these records would be maintained as they should be.

The company that owned the pharmacy was registered with the Information Commissioner's Office. And people using the pharmacy couldn't see other people's personal information. The pharmacy team completed a self-assessment each year and made a declaration to the NHS that it was practising good data security and it was managing personal information correctly. The pharmacy 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 returned to it before being disposed of. The pharmacy had a safeguarding policy. And the RP had completed level 3 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. And the pharmacy's consulting room could be used by someone 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. Members of the pharmacy team work well together and use their judgement to make decisions about what is right for the people they care for. They know how to raise a concern if they have one. And they can give feedback to help the pharmacy do things better.

Inspector's evidence

The pharmacy team consisted of a regular locum pharmacist (the RP), a dispensing assistant, a medicines counter assistant, a delivery driver and an assistant. The pharmacy depended upon its team, locum pharmacists and colleagues from one of the company's other pharmacies to cover absences. The people working at the pharmacy during the inspection included the RP, the dispensing assistant and the assistant. They didn't feel the targets set for the pharmacy 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 nearly up to date with their workload. But they sometimes didn't have time 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. The dispensing assistant 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. People working at the pharmacy needed to complete accredited training relevant to their roles after completing a probationary period. And the assistant had been at the pharmacy for only a few weeks and had started some induction training. Members of the pharmacy team could ask the RP questions, discuss their development needs, read pharmacy-related literature and familiarise themselves with products when they had the time to do so. They knew 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 their feedback led to changes to the process they followed when making up people's compliance packs.

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 the pharmacy is busy.

Inspector's evidence

The pharmacy was air-conditioned, bright and secure. And its public-facing area was adequately lit and presented. The pharmacy had a basement, a consulting room, a counter, a dispensary, a retail area, a stockroom and a toilet. Its flooring was uneven and worn in places. And some of its fixtures were dated too. The dispensary had limited workspace and storage available. And its worksurfaces could become cluttered when the pharmacy was busy. The consulting room was available for services that needed one or if someone needed to speak to a team member in private. But it was small and couldn’t be locked. So, the pharmacy team needed to make sure its contents were kept secure when it wasn’t being used. The pharmacy had the sinks it needed for the services it provided. It had 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 safe and effective. Its team is friendly and helps people access the services they need. And it keeps appropriate 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 most of them appropriately and securely. Members of the pharmacy team usually dispose of people's unwanted medicines properly. And they largely carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy didn't have step-free access. So, members of the pharmacy team remained alert to make sure they could help people use the pharmacy and access its services. The pharmacy had notices that told people when it was open and what services it offered. And it had a seating area for people to use if 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 CPCS 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 minor illnesses. Members of the pharmacy team were friendly and 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. It kept a log to show the right medicine had been delivered to the right person. But its team could do more to make sure the recipient signed the log to say they have received their medicines safely as required by the SOPs. The pharmacy offered a winter flu jab service. It had the anaphylaxis resources it needed for its vaccination service. And the pharmacist providing the service was appropriately trained. 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. And the pharmacist assessed whether a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. And a brief description of each medicine contained within a compliance pack was provided. But sometimes patient information leaflets weren't supplied so people didn't always have all the information they needed to take their medicines safely. The pharmacy team highlighted prescriptions to show 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. 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 new rules on dispensing valproate-containing medicines in the manufacturer's original full pack. 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. 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 recorded 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 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 managing 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 the pharmacy didn't have a pharmaceutical waste bin for any hazardous waste that was returned to it. 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). The pharmacy team removed and returned pholcodine-containing cough and cold medicines following the receipt of an MHRA medicines recall earlier in the year. But it could do more to make sure it routinely recorded what actions it took when it received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally 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 equipment for counting loose tablets and capsules. Its team had ordered some glass measures to replace the ones which broke recently. And in the meantime, a plastic measure was used to measure out liquids. 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 Numark or the SI 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. The RP could check a person's blood pressure when asked. And the monitor used for this service was less than a year old. 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 weren't used 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.