General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Crawley Chemists, 1st Floor, Crawley Health Centre, Cross Keys House, 14 Haslett Avenue, CRAWLEY, West Sussex, RH10 1HS

Pharmacy reference: 1106083

Type of pharmacy: Community

Date of inspection: 03/10/2023

Pharmacy context

This busy NHS community pharmacy is next to a GP surgery in Crawley town centre. 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 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. Its team can check a person's blood pressure. And people can get their flu jabs and travel vaccinations from the pharmacy too.

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	1.1	Standard not met	The pharmacy doesn't adequately identify and manage the risks associated with its vaccination service. It doesn't have written procedures to make sure this service is delivered consistently and safely. And it hasn't done enough to make this service safer when something has gone wrong.
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 not all met	4.3	Standard not met	The pharmacy cannot show that it stores all its medicines which it needs to keep in a refrigerator at the right temperature.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy doesn't adequately identify and manage the risks associated with its paid-for (private) vaccination service. It doesn't have written procedures to make sure this service is delivered consistently and safely. And it hasn't done enough to make this service safer when something has gone wrong. The pharmacy mostly keeps the records it needs to by law. 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 keep a log and talk to each other about the mistakes they make with people's prescriptions 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

The responsible pharmacist (RP) was a pharmacist independent prescriber (PIP). The pharmacy provided a PIP-led travel vaccination and childhood immunisation service (private vaccination service). And the RP was solely responsible for this service. The pharmacy had up-to-date standard operating procedures (SOPs) for some of the services it provided. But it didn't have SOPs or risk assessments for its private vaccination service. And there haven't been any audits, clinical or otherwise, of this service despite someone being given the wrong vaccine. The pharmacy did, however, keep a vaccination record for each person. And, with the person's consent, it shared information about the vaccination with the person's regular doctor.

Members of the pharmacy team knew what to do if the pharmacy needed to close. They understood what they should do to make sure people could access the care they needed if the pharmacy couldn't open. They were required to read and sign 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 a notice in the pharmacy told people who the 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 one of the pharmacists.

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 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 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 highlighted look-alike and sound-alike drugs to help reduce the risks of them picking the wrong product. They usually discussed and recorded the mistakes they made to learn from them and help them stop the same sort of things happening again. But they could review them more often to help them spot patterns or trends sooner.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. And it had a leaflet that told people how they could provide feedback about the pharmacy or its team. People could share their views and make suggestions to the

pharmacy team about how the pharmacy could do things better. And, for example, improvements were made to the pharmacy's waiting area following people's feedback.

The pharmacy didn't have professional indemnity insurance for any face-to-face PIP prescribing services it provided. But this was addressed once the oversight was identified. And appropriate insurance arrangements, including professional indemnity, were put in place for all the pharmacy services before the end of the inspection. The pharmacy had a controlled drug (CD) register. But the stock levels recorded in this register weren't checked as often as the SOPs asked them to be. And the details of where a CD came from weren't always completed in full. The pharmacy kept records to show which pharmacist was the RP and when. But the time when a pharmacist stopped being the RP wasn't routinely recorded. The pharmacy recorded the supplies of the unlicensed medicinal products it made. But it could do more to make sure its team always recorded when it received an unlicensed medicinal product. The pharmacy team was required 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 in some of the private prescription records seen. The pharmacists gave an assurance that these records would be maintained as they should be.

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 its website told people how their personal information was gathered, used and shared. The pharmacy required its team to complete training on information governance and the General Data Protection Regulation. It had a safeguarding procedure. And its 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 work well together. They make decisions about what is right for the people they care for and their professional judgement isn't affected by targets. 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 two pharmacists, an accuracy checking pharmacy technician (ACPT), a student pharmacist, two dispensing assistants, a team member who made up people's compliance packs, a medicines counter assistant (MCA) and two delivery drivers. The pharmacy depended upon its team and on some occasions a locum pharmacist to cover absences. The people working at the pharmacy during the inspection included the RP, a second pharmacist, the ACPT, a dispensing assistant, the team member who made up people's compliance packs and the MCA. They were up to date with their workload. They worked well together and 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 was the superintendent pharmacist. And they were responsible for managing the pharmacy team. The pharmacists supervised and oversaw the supply of medicines and advice given by the 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. Members of the pharmacy team needed to complete training relevant to their roles after completing a probationary period. The MCA had started at the pharmacy recently and needed to complete some induction training. The delivery drivers and the person responsible for making up people's compliance packs hadn't completed accredited training. So, they were each enrolled upon an appropriate training course shortly after the inspection. Team members 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 were comfortable about making suggestions on how to improve the pharmacy and its services. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback led to air conditioning being installed at the pharmacy.

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 its team members don’t always have the space they need to work in when it’s busy.

Inspector's evidence

The pharmacy was air-conditioned, bright and secure. Its public-facing area was adequately presented. But, despite being enlarged since its last inspection, it was small with limited workspace and storage available. And its worksurfaces could become cluttered when it was busy. 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. People’s conversations in the consulting room couldn’t be overheard outside of it. And it could be locked to make sure its contents were kept secure when it wasn’t being used. The pharmacy had a plastic screen on its counter to help reduce the spread of airborne infections such as coronavirus. It had some sinks and a supply of hot and cold water. Its team members cleaned its premises as often as they could. And hand sanitising gel was also available for people to use.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy cannot show that it stores all its medicines which it needs to keep in a refrigerator at the right temperature. But it manages, sources and stores its other medicines appropriately. Its working practices are generally safe and effective. And people can access its services easily. Members of the pharmacy team are friendly and helpful. And they usually dispose of people's unwanted medicines properly.

Inspector's evidence

The pharmacy was on the first floor of a shared building opposite a doctor's surgery. The building had an automated entrance which was level with the outside pavement. And people who had difficulty in climbing stairs, such as someone with a pushchair or a wheelchair, could use a lift to access the building's first floor. The pharmacy had a seating area people could 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 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. They took the time to listen to people. So, they could help and advise 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. And it needed to keep an audit trail to show when it delivered someone their medicines. The pharmacy couldn't provide childhood immunisations at the time of the inspection as the anaphylaxis treatment it used for children had expired. But it had the anaphylaxis resources and the patient group direction it needed to administer NHS flu jabs. And the RP was 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. But consideration should be given to asking an appropriately trained team member to check that the right vaccine had been selected before the pharmacist administered it.

The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And an assessment was made, usually by the doctor, 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. And it generally provided patient information leaflets every four weeks. 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 it could do more to make sure assembled CD prescriptions awaiting collection were routinely marked with the date the 28-day legal limit would be reached to ensure 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. Members of the pharmacy team usually 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 generally 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 CDs, which weren't exempt from safe custody requirements, securely. Its team recorded the destruction of the CDs that people returned to it. And it kept these separate from in-date stock. The pharmacy was required to store its stock, which needed to be refrigerated, at an appropriate temperature (between two and eight degrees Celsius). And it used two domestic refrigerators to do so. The pharmacy team monitored and recorded the maximum and minimum temperatures of the refrigerator in the dispensary. But it hadn't for the refrigerator in the consultation room, which was used to store vaccines, as the pharmacy didn't have an appropriate thermometer available. When asked, the pharmacy team said that the vaccines had been stored like this for a while.

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 pharmaceutical waste bin. But the pharmacy didn't have an appropriate waste bin for the hazardous waste medicines people brought back 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). 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 personal information 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. Members of the pharmacy team could check a person's blood pressure when asked. And the monitor they used was replaced each year. 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.