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: 16/04/2024

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 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 a flu jab or a travel vaccination or have their blood pressure checked.

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
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 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 log 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 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 superintendent pharmacist had reviewed the pharmacy's travel vaccination and childhood immunisation service since the last inspection. And the risks with this service had now been adequately assessed and its safety was now being monitored. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed periodically by the superintendent pharmacist. Members of the pharmacy team had to read and sign the SOPs relevant to their roles to say they understood them and would 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 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 a pharmacist. The team members responsible for making up people's prescriptions kept the dispensing workstations tidy. 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 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 the locations of a few medicines, which looked alike and whose names sounded alike, to help reduce the chances of them picking the wrong product. They talked to one another about the mistakes they made to try to stop the same things happening again. And they recorded and reviewed the mistakes they made to help them spot any patterns and strengthen their dispensing process further.

Some 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's refrigerators were replaced following feedback from the last inspection. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. It largely kept appropriate records for the supplies of the unlicensed medicinal products it made. It kept adequate records to show which pharmacist was the RP and when. And the entries seen in its controlled drug (CD) register were as they should be. The pharmacy team checked the stock levels

recorded in the CD register as often as the SOPs required them to be. And the emergency supplies it made and the private prescriptions it supplied were appropriately recorded on the pharmacy's computer. 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 policy. And its pharmacists 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 do the right training for their roles. And they work well together and 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 two pharmacists, an accuracy checking pharmacy technician (ACPT), a trainee pharmacist, two dispensing assistants, a trainee dispensing assistant, a medicines counter assistant (MCA) and a delivery driver. 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, the trainee pharmacist, a dispensing assistant and the MCA. Members of the pharmacy team 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 they were asked to do things that stopped them from making decisions that kept people safe. The RP was the superintendent pharmacist. And they were responsible for managing the pharmacy and its team. The trainee pharmacist confirmed that the superintendent pharmacist was their designated supervisor. And there was a training plan in place for their foundation training year. The trainee pharmacist felt supported. They were encouraged to improve their skills and attend training events. They had regular discussions and reviews with their supervisor. And they received time to study. 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. Team members could ask the pharmacists 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 following their feedback the assembly of compliance packs now took place in a separate room.

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.

Inspector's evidence

The pharmacy was air-conditioned, bright and secure. Its public-facing area was adequately presented. And its layout had changed since its last inspection to maximise its workspace and storage. 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 some sinks and a supply of hot and cold water. And its team members cleaned its premises as often as they could.

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 them appropriately and securely. Members of the pharmacy team usually 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 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 NHS Pharmacy First Service 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 a few 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 local delivery service to a few 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. And people were asked to sign the log to say they had received their medicines safely. The pharmacy offered winter flu jabs, childhood immunisations and travel vaccinations. It had the anaphylaxis resources and the patient group directions it needed for its vaccination service. And the pharmacist delivering the vaccination service was appropriately trained. The vaccinator asked the second pharmacist or the trainee pharmacist or the ACPT to check the right vaccine had been selected before they administered it. The pharmacy kept a record for each vaccination it made to show it had given the right vaccine to the right person. And the records 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 an assessment was done to determine if a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. It provided a brief description for each medicine contained within a compliance pack. And it generally provided patient information leaflets with people's compliance packs every four weeks. The pharmacy 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. And its team usually marked CD prescriptions awaiting collection 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 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 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. It 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 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 were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But a patient-returned medicine that had been put into a waste bin by mistake was removed during the inspection and stored securely. 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 a team member described the 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 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 Numark to ask for information and guidance. The pharmacy had the medical refrigerators it needed 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 pharmacy had suitable equipment for the NHS Pharmacy First Service as well as for other diagnostic tests such as 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.