General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Addiscombe Pharmacy, 331 Lower Addiscombe Road, CROYDON, CR0 6RF

Pharmacy reference: 1121245

Type of pharmacy: Community

Date of inspection: 04/01/2023

Pharmacy context

This is an NHS community pharmacy on a row of shops in Addiscombe. The pharmacy opens six days a week. It sells over-the-counter medicines and some health and beauty products. It dispenses people's prescriptions. And it delivers medicines to people who can't attend its premises in person. The pharmacy provides 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. Its team can check a person's blood pressure. And people can get their coronavirus (COVID-19) vaccination and flu vaccination (jab) at 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	Good practice	3.1	Good practice	The pharmacy is well designed to meet the needs of the people who use it.
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 appropriately manages its risks. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has appropriate insurance 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 to each other about 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 people who may be at risk.

Inspector's evidence

The pharmacy had considered the risks of COVID-19. It completed an occupational risk assessment for each of its team members. And it had some plastic screens on its counter to try and stop the spread of the virus. Members of the pharmacy team knew that any work-related infections needed to be reported to the appropriate authority. They had the personal protective equipment they needed. And hand sanitising gel was available for people to use. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these have been reviewed since the last inspection. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. The team members responsible for making up people's prescriptions kept the dispensing and checking 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 responsible pharmacist (RP) 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 usually discussed the mistakes they made to learn from them and reduce the chances of them happening again. They didn't always record them or review them to help them spot patterns or trends. But they generally highlighted and separated medicines involved in dispensing mistakes or were similar in some way, such as medicines that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being picked.

The pharmacy had a notice that told people who the RP was at that time. Members of the pharmacy team 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 a pharmacist. Some people have shared their experiences of using the pharmacy and its services online. The pharmacy had a complaints procedure. It had leaflets which asked people to share their views and suggestions about how the pharmacy could do things better. And, for example, the pharmacy team tried to keep a person's preferred make of a prescription medicine in stock 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 a controlled drug (CD) register which was generally in order. But the stock levels recorded in the CD register weren't checked as often as the SOPs asked them to be. The pharmacy kept appropriate records to show which pharmacist was the RP and when. And it recorded the emergency supplies it made and the private prescriptions it supplied on its

computer. But the prescriber details were sometimes incomplete in the private prescription records. The pharmacy kept a record for the supplies of the unlicensed medicinal products it made. But its team sometimes forgot to record when it had received an unlicensed medicinal product.

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 it gathered, used and shared their personal information. It completed a self-assessment each year to provide assurance to the NHS that it was practising good data security and that personal information was handled correctly. And it also had arrangements to make sure confidential information was stored and disposed of securely. The pharmacy had safeguarding procedures. Its pharmacists had each completed level 2 safeguarding training. And it had an off-site safeguarding lead who was trained to level 3. 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 just enough people in its team to deliver safe and effective care. But team members are sometimes so busy they struggle to do all the things they are asked to do. Members of the pharmacy team do the right training for their roles. They work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy didn't set targets for its team. And it didn't incentivise its services. The pharmacy team consisted of two pharmacists, a full-time dispensing assistant, a full-time medicines counter assistant (MCA) and a part-time delivery driver. The RP was the superintendent pharmacist and one of the pharmacy's regular pharmacists. And they were responsible for managing the pharmacy and its team. The RP, the dispensing assistant and the MCA were working at the time of the inspection. The pharmacists tended to work together when the COVID-19 vaccination service was operating. And they were supported by additional and appropriately trained vaccination team members, including vaccinators, to deliver the service. The pharmacy had contingencies in place to support the pharmacy and its vaccination service if a pharmacy team member or a member of the vaccination team was absent for any reason. And team members from other nearby branches could cover these absences or provide additional support when needed. Members of the pharmacy team sometimes struggled to do all the things they were asked to do as they didn't always have enough time to do them as they were so busy. But they worked well together and helped each other to serve people and dispense prescriptions safely. They were up to date with their workload. And they felt they could make 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. People working at the pharmacy were required to do accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with their manager when they could. They could share learning from the mistakes they made and were usually kept up to date during one-to-one discussions or ad hoc meetings. And they were encouraged to complete training when they could. But they were often too busy to train when they were at work. 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 their feedback led to the layout of the retail area being changed so people could keep apart more easily.

Principle 3 - Premises ✔ Good practice

Summary findings

The pharmacy is bright, clean, modern and tidy. It provides a safe, secure and professional environment for people to receive healthcare in. It's well designed to meet the needs of the people who use it, and to make sure they can receive services in private when they need to.

Inspector's evidence

The pharmacy premises were air-conditioned, bright, clean, modern, secure and tidy. They were well laid out and organised. They were professionally presented throughout. And their fixtures and fittings were of a high standard. The pharmacy had the workbench and storage space it needed for its workload. People's compliance packs were dispensed in a quieter area of the pharmacy. So, distractions and interruptions to the team members assembling them were minimised. The pharmacy had two well-equipped consulting rooms for the services it offered and if people needed to speak to a team member in private. The consulting rooms were locked when they weren't being used. So, their contents were kept secure. And people's conversations in them couldn't be overheard outside of them. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water too. Members of the pharmacy team were responsible for keeping the premises clean and tidy. And they regularly wiped and disinfected the surfaces they and other people touched.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are safe and effective. 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 are friendly and helpful. They 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 had an automated entrance that was level with the outside pavement. It had a seating area for people who wanted to wait in the pharmacy. And this was set away from the counter to help people keep apart. The pharmacy had wide aisles and the doorways into each of its consulting rooms were wide. These things made access to the pharmacy and its services easier for people with pushchairs or who used wheelchairs. 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 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. And it kept an audit trail to show when it delivered someone their medicines. But its team didn't routinely ask people to sign to say they had received their medication as required by the SOPs. The pharmacy provided COVID-19 vaccinations and flu jabs. People aged 16 or over, who were eligible for a COVID-19 vaccination, could book an appointment to attend the pharmacy online through the NHS website. This helped the pharmacy better manage its workload and make sure it had the people it needed to deliver the vaccination service safely. People attending the pharmacy to be vaccinated were booked in at a reception desk situated next to the consulting rooms. The vaccinators administered a COVID-19 vaccination and/or a flu jab under the relevant national protocols. And the RP confirmed that a registered healthcare professional completed the stages of the national protocol they needed to. The national protocols afforded the pharmacy some flexibility in arranging vaccinators to be on-site to deliver the service if needed. But the appropriate patient group directions were sometimes used if the vaccination service was solely provided by one of the pharmacists. The pharmacy had the anaphylaxis resources it needed for its vaccination service. And the vaccinators were appropriately 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. The RP was considering reviewing the vaccination service so that another appropriately trained team member checked that the correct vaccine had been selected before the vaccinator administered it. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked if a medicine was suitable to be re-packaged. And the pharmacist sometimes assessed whether a person needed a compliance pack. The pharmacy usually kept an audit trail of the person who had assembled and checked each prescription. It generally provided a brief description of each medicine contained within the compliance packs. And patient

information leaflets were routinely supplied. So, people had the information they needed to make sure they took their medicines safely. The pharmacy team marked some 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. 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. But a few medicines weren't. And this made it difficult for the pharmacy team to tell if it had all the information it needed if a particular make of medicine was recalled. Members of the pharmacy team marked containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines before they dispensed them and when they cleaned the dispensary shelves. But they hadn't recorded when they did a date-check for a while. And they didn't routinely mark products which were soon to expire. The pharmacy stored its stock, which needed to be refrigerated, at the 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 out-of-date and patient-returned CDs were kept 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 pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And one of its team members described the actions they took and demonstrated what records they made when they received a drug alert.

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 it uses its equipment to help protect people's personal information.

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 made sure they 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 two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded each refrigerator's maximum and minimum temperatures. The pharmacy team could check a person's BP when asked. And the monitor it used to do this was recently changed. 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 put 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.