General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Portslade Health Centre, Church Road, Portslade, BRIGHTON, East Sussex, BN41 1LA

Pharmacy reference: 1036110

Type of pharmacy: Community

Date of inspection: 09/03/2020

Pharmacy context

This is a community pharmacy in a medical centre, in a largely residential area just west of Hove. The medical centre has around ten GPs. The pharmacy dispenses NHS prescriptions, most of which it receives electronically. It provides a substance misuse service to a few people. And supplies medications in multi-compartment compliance packs to some people who need help managing their medicines. The pharmacy uses the services of a centralised dispensing hub and sends a proportion of its prescriptions to the hub for dispensing.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough staff to keep up-to-date with its workload. It is behind on dispensing and checking prescriptions, and other tasks such as date-checking are not up to date.
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 doesn't always manage its medicines properly. It stores some medicines in a very untidy way, which increases the risk of dispensing mistakes happening. It doesn't regularly date check its stock, and as a consequence doesn't always remove date-expired medicines from stock promptly. This could increase the risk that people are supplied a medicine which is past its use-by date.
		4.4	Standard not met	The pharmacy doesn't respond to drug alerts and recalls promptly. And this increases the risk that people are supplied a medicine or medical device which is not safe to use.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy adequately manages the risks associated with its services. But there are some issues with the pharmacy keeping up-to-date with its workload (see Principle 2). The pharmacy keeps the records it needs to by law to show that medicines are supplied safely and legally. People using the pharmacy can provide feedback about the pharmacy's services. And team members generally protect people's personal information well. They know how to protect vulnerable people. The team responds well when a dispensing mistake happens. But team members do not always record their mistakes. And this could mean that they are missing out on opportunities to learn and to make the pharmacy's services safer.

Inspector's evidence

The inspection was undertaken over two days (9 and 10 March 2020), due to how busy the pharmacy was. The report refers to evidence found as a whole over both days of the inspection unless otherwise specified.

Standard operating procedures (SOPs) were available electronically using the pharmacy's computers. One of the dispensers was able to show his training records which indicated that he had read and understood the SOPs relevant to his role. The other dispenser had not yet been through the relevant SOPs, and she had worked at the pharmacy for around three months. Team members said that the pharmacy was busy, and it was often hard to find the time to go through the SOPs and any ongoing training packages. They said that they would try and ensure they went through any SOPs they were not familiar with.

Near misses, where a dispensing mistake was found before people were handed the products, could be recorded on the pharmacy's 'Datix' system. Some records of near misses were found, but the record for December 2019 was blank. Team members said that not all the near misses had necessarily been recorded, as it was sometimes very busy, and the Datix system was not always available due to IT issues. They explained how they had separated two types of medicines with similar packs on the shelves following a near miss. They said that any dispensing errors, where the mistake had reached someone, were recorded on the Datix system. But they were unable to bring up any previous records.

The dispensers were clear about their own role and responsibilities, and what they could and couldn't do if the pharmacist had not turned up. Staff were observed referring queries to the pharmacist as appropriate.

The pharmacy undertook an annual patient survey, and the results from the latest published one were on the NHS website. The results were generally positive, with around 75% of respondents rating the pharmacy overall as very good or excellent. Staff were aware that the pharmacy's complaint procedure was available electronically. They said that they had received complaints from people when their prescriptions were not ready on time. And they were trying to work through the prescription backlog to help address this.

Indemnity insurance was arranged by the pharmacy's head office and there was current cover. The right responsible pharmacist (RP) notice was clearly displayed, and the RP log had largely been

completed correctly. Private prescription records and emergency supply records seen had the necessary information recorded. Controlled drug (CD) registers seen complied with requirements, and the CD running balances were checked regularly. A random check on a CD medicine showed that the recorded balance matched the amount of physical stock. Records seen for unlicensed medicines supplied had been completed correctly.

The regular pharmacist (present on the first day) was in the process of completing the level 2 safeguarding training. The locum pharmacist (present on the second day) confirmed that he had completed it. Both could describe what they would do if they had any concerns about a vulnerable person. The pharmacy technician confirmed she had completed safeguarding training online. But the dispensers did not recall doing any formal training on safeguarding, although they could describe what they would do if they had safeguarding concerns. Contact details for local safeguarding agencies were available online.

People using the pharmacy couldn't see other people's personal information. A designated sack was generally used to dispose of confidential waste, but two pieces of paper containing people's personal information were found in general waste. The pieces were immediately removed and the staff said that although they were usually very careful they would take more care in the future. Most staff had individual smartcards, but the regular pharmacist was in the process of sorting hers out. And on the first day of the inspection, the pharmacy technician's smartcard was in the computer when she was not present. The pharmacist said that she was due to visit the local NHS commissioner the next day to update her smartcard so that it could be used in this pharmacy. Staff were not aware of having done any training on the General Data Protection Regulation. One of the dispensers had completed training on confidentiality but the other had not.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not have enough staff to keep up-to-date with its workload. It is behind on dispensing and checking prescriptions, and other tasks such as date-checking are not up to date. However, the team members do the right training for their roles. They do some ongoing training to help keep their knowledge and skills up to date. They can raise concerns and they can take professional decisions.

Inspector's evidence

On the first day of inspection, there was the regular pharmacist and two trained dispensers. The pharmacist had started working at the pharmacy around two or three weeks ago. On the second day, there was a locum pharmacist, the same two dispensers, and a pharmacy technician. Team members explained that two experienced full-time staff had recently left and not yet been replaced, and one of the current dispensers was due to leave the following week. The dispenser due to leave dealt with the dispensing of multi-compartment compliance packs. The pharmacy did not have a regular team member to cover the chemist counter, and dispensers were frequently observed having to stop in the middle of dispensing to help people waiting at the counter. This could increase the chance of dispensing mistakes occurring. A new member of staff was due to start work at the pharmacy in the near future, and they would be covering the counter.

The pharmacy had been running on locum pharmacists before the regular pharmacist had started and had not had a regular manager. Most of the workspace in the dispensary was covered with baskets containing part-dispensed prescriptions, or prescription awaiting checking. Team members said that they were almost a week behind on dispensing, and this was seen when many prescriptions in baskets were found to be dated from 4 March 2020. Almost all the prescriptions seen in these baskets had been labelled. Due to the large number of part-dispensed prescriptions in baskets, it was seen that it took staff a relatively long time to find people's medicines. As they had to check through the piles of baskets to find them. Team members said that it sometimes took a while to send people's prescriptions to the hub for dispensing. As they were often dealing with queries from people coming into the pharmacy and people with walk-in prescriptions. It was observed that sometimes people had to wait several minutes at the counter before a team member came to help them. But the team member generally acknowledged the person as soon as they came into the pharmacy. The pharmacy's phone rang a lot during the inspection, and staff were sometimes too busy with other tasks to be able to answer it. Staff were attentive to people using the pharmacy and managed their own tasks well, but it was clearly apparent that they were under significant pressure.

Team members had access to the company's e-learning system, 'Eexpert', through the pharmacy computers. They said that they did not often get time to complete any ongoing training due to how busy the pharmacy was. But they had done some, with some staff having completed much more ongoing training than others. They said that they used to have regular staff 'huddles', but they no longer could find time to do these and discussed any issues between each other as they came up. Staff were observed communicating well with each other during the inspection. And although the pharmacy was busy, they appeared organised.

Team members felt comfortable about raising any concerns and were aware how to do this. One of the

team members had raised a concern about the items to be checked by the pharmacist piling up, and the potential safety impacts of this on dispensing due to the lack of space. But it was not clear what had been done to address this. Staff said that the delay in checking medicines meant that they could not put them on the shelves to await collection. And this caused a knock-on effect on the text reminder service, and they said that people as a result often came in to collect their prescription as they had not received a text. This was observed to cause further delays, as team members often had to look in several places for people's dispensed medicines.

The pharmacy had some targets, including around the New Medicine Service, text messaging signups, and Medicine Use reviews. Staff did not feel under any undue pressure to achieve them, but they were told when they were not meeting the targets. The regular pharmacist felt able to take any professional decisions.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally suitable for the pharmacy's services and they are secure from unauthorised access. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was accessed through the medical centre. Although the size of the pharmacy was adequate, the storage space was limited. However, most areas were clean and largely tidy. There were many baskets on the dispensary worktop, but there was a small clear space available for dispensing and another space available for the preparation of multi-compartment compliance packs. Despite the large number of baskets, they were stacked in an orderly manner. Some areas of paintwork were showing slight signs of wear. Lighting throughout was good. The room temperature was suitable for the storage of medicines and was maintained with air conditioning.

Staff had access to handwashing facilities. The consultation room was locked when not in use, and it was clean and tidy. The room allowed a conversation to take place inside which would not be overheard. The premises were secure from unauthorised access, and medical centre staff did not have access to the pharmacy when it was closed.

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

Summary findings

The pharmacy doesn't always manage its medicines properly. It stores some medicines in a very untidy way, which increases the risk of dispensing mistakes happening. It doesn't regularly date check its stock, and as a consequence doesn't always remove date-expired medicines from stock promptly. This could increase the risk that people are supplied a medicine which is past its use-by date. The pharmacy doesn't respond to drug alerts and recalls promptly. And this increases the risk that people are supplied a medicine or medical device which is not safe to use. However, the pharmacy gets its stock from reputable sources and otherwise stores it properly. People with a range of needs can access its services. The pharmacy doesn't routinely highlight prescriptions for higher-risk medicines. And this could mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

The pharmacy had step-free access through the medical centre via automatic doors. There was a portable hearing loop for use with people who had compatible hearing aids. The pharmacy offered a text messaging service to inform people when their medicines were ready. A list of the pharmacy's opening times was displayed outside the main building. A seating area was available for people who wanted to wait in the pharmacy, and this was set away from the pharmacy counter to help protect other people's personal information.

Baskets were used through the dispensing process to prevent different people's medicines becoming mixed up. This was especially important given the amount of prescriptions that were part-dispensed.

People were assessed for the multi-compartment compliance pack service by their GP. Packs seen were labelled with a description of the medicine inside, but this was only as 'tablet' or 'capsules', with no indicate as to the colour or shape. This could make it harder for people or their carers to identify the medicines in the packs. The packs were labelled with an audit trail to show who had dispensed and checked the packs. And patient information leaflets that came with the medicines were routinely supplied. One of the dispensers showed how records were made of when people's medicines were stopped or changed. But the records seen only sometimes had a date and did not have who had initiated the change. This could make it harder for the pharmacy to find out this information if there was a query.

The pharmacy sent off a proportion of people's prescriptions to an offsite dispensing hub. The hub dispensed the prescriptions and returned the medicines to the pharmacy for handing out. The dispenser showed a handheld device that was used to find out where people's prescriptions were. She showed how the bag labels had QR codes on them which were scanned on handout, which helped provide an audit trail for this process. The device could also identify if someone's medicines were at the hub, in the process of dispensing, or dispensed. If a person's medicines had been dispensed the device indicated on which shelf staff could find it. And it flagged when a person's medicines could be found in the fridge rather than on the shelf.

Prescriptions for higher-risk items such as warfarin or methotrexate were not routinely highlighted. This could mean that staff miss out on opportunities to speak with these people when they collect their medicines. Prescriptions for CDs were also not routinely highlighted. And this could increase the chance

that the CD was handed out after the prescription was no longer valid. Team members said that it was sometimes hard to get time to highlight prescriptions but said that they would try to ensure this was done in future. They were aware of the additional guidance around pregnancy prevention to be given to some people taking valproate medicines. They confirmed that the pharmacy currently did not have any people in the at-risk group. They showed the additional informational literature they had for valproate, such as cards, leaflets, and stickers.

The pharmacy obtained its stock from licensed wholesale dealers and specials suppliers. It had the equipment to comply with the Falsified Medicines Directive, but the equipment was not currently being used and staff were waiting for guidance from head office. Bulk liquids were marked with the date of opening to help staff know if the medicine was still suitable to use. Medicines for destruction were separated into designated destruction bins and sent offsite for secure disposal.

Some of the medicines in the dispensary were stored in a disorganised and untidy fashion. Some shelves had stock piled up in a haphazard fashion, with different medicines and strengths mixed up. This could increase the change of mistakes being made when the stock was picked. Staff said that they were actively trying to reduce the amount of stock the pharmacy held, as the introduction of the offsite hub had meant that they needed less stock in. Date-checking was meant to be done regularly, but the records on the computer showed that this had not happened since November 2019. Five date-expired medicines were found in with stock, and these were removed. One of the items of stock had expired in 2018. Team members said that it was often hard to find the time to date-check the stock, but they showed two large boxes which they had started to fill with date-expired stock.

CDs were kept securely. Medicines requiring cold storage were stored in a suitable fridge and the temperatures were monitored and recorded daily. Records seen showed that the temperatures had remained within the appropriate range.

The pharmacy received drug alerts and recalls via the company's intranet. Staff explained that they usually printed off the information for their records, but the only records found were from around July 2019. A team member showed the alerts and recalls on the intranet, and the system indicated whether the alerts or recalls had ben actioned or were outstanding. The most recent actioned alert was from 15 January 2020, and no evidence was found that the ones issued after this had been dealt with.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. It uses its equipment to help protect people's personal information adequately.

Inspector's evidence

The pharmacy had a range of clean calibrated glass measures for use with liquids, with separate marked ones for use with certain liquids. There was one measure for use with water, but this could not accurately measure quantities less than ten millilitres. The technician said that she would order another smaller measure in that day. Tablet counting triangles were clean, and a separate marked triangle was used for methotrexate to help avoid cross-contamination.

Staff had access to up-to-date information resources including the internet. The phone was cordless and could easily be moved to a more private area to help protect other people's personal information. Computer terminal screens were turned away from people using the pharmacy and were password protected. One of the handheld devices was briefly left unattended on the pharmacy counter before being removed by a team member. Staff said that they were usually very careful about this and gave assurances that it would not happen again.

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.