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:** 08/10/2020

## 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. And it offers a flu vaccination service. 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. This inspection was undertaken during the Covid-19 pandemic.

## 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 adequately identifies and manages the risks associated with its services. Staff have clear roles and responsibilities. And they know how to protect vulnerable people. People using the pharmacy can provide feedback to help improve the pharmacy's services. The pharmacy keeps the records it needs to by law to show that medicines are supplied safely and legally. And it protects people's personal information well. When a dispensing mistake happens, the team members generally respond well. But they don't always record any actions that they took to prevent a recurrence. So, they may not be able to make full use of these opportunities to learn and make the pharmacy's services safer.

### Inspector's evidence

Standard operating procedures (SOPs) were available electronically using the pharmacy's computers. The trainee dispenser was able to show her training records which indicated that she had read and understood the SOPs relevant to her role. The records could only be accessed by each individual team member and a summary was not available. Other team members present said that they were familiar with the SOPs.

Dispensing mistakes that were identified before the medicine was handed to a person (near misses) were recorded on the pharmacy computer using the 'Datix' system. Records of previous near misses were seen, but the ones examined did not include a record of any actions taken to prevent a recurrence. This could mean that team members may not be able to make full use of any opportunities to learn and make the pharmacy's services safer. The trainee dispenser said that there had been a near miss between two medicines that sounded and looked alike. And said that as a result the medicines had been separated on the shelves. Dispensing mistakes where the medicine was handed to a person (dispensing errors) were also recorded on Datix. The trainee dispenser said that the team discussed any near misses or dispensing errors at the time so that staff were aware.

Staff had received Covid-19 risk assessments, and these had been completed electronically. Staff were clear on how they would report any work-related infections to the pharmacy's head office. Team members were observed wearing personal protective equipment (PPE) and maintaining social distancing where possible.

The trainee dispenser was clear about what she could and could not do if the pharmacist had not turned up in the morning, or if the pharmacist was absent from the premises. Staff were observed referring queries to the pharmacist as appropriate. The pharmacy usually undertook an annual patient survey, but the trainee dispenser did not recall one being done in 2020, possibly due to the pandemic. The results from the 2018 to 2019 survey were on the NHS website, and around 76% of people who responded had rated the pharmacy as very good or excellent overall. The people who had responded had rated the staff highly, but some people had expressed dissatisfaction about the waiting times. People could find out how to make a complaint or provide feedback from the sign in the public area. And the pharmacy had a complaints procedure. The trainee dispenser showed cards people had sent to the pharmacy to express thanks for way the pharmacy provided its services.

The pharmacy had current indemnity insurance which was arranged by head office. The right responsible pharmacist (RP) notice was displayed and the RP record had been generally been filled in

properly. Records seen for private prescriptions, emergency supplies, and unlicensed medicines complied with requirements. Controlled drug (CD) registers had been completed correctly and the CD running balances were checked regularly. A random check of a CD medicine showed that the recorded balance matched the amount of physical stock.

People using the pharmacy could not see any other people's personal information. Confidential waste was separated into designated bags and sent offsite for secure disposal. Computer terminal screens were turned away from the public area and the terminals were password protected. The trainee dispenser had a working NHS smartcard, but the other two staff did not. They said that they would contact their area manager to resolve this. The trainee dispenser said that team members had completed training about information governance and data protection, as well as safeguarding vulnerable groups. The pharmacist confirmed he had completed the level 2 safeguarding training and could explain what he would do if he had any concerns. The trainee dispenser gave an example of a safeguarding incident that had occurred in the pharmacy, and what the team had done to help protect the welfare of the person involved.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff to provide its services safely, and they do the right training for their roles. They keep the pharmacy's workload up to date. They do some ongoing training to help keep their knowledge and skills up to date. And they feel comfortable about raising any concerns. Team members can take professional decisions to help ensure people are kept safe.

### Inspector's evidence

On the day of inspection there was one locum pharmacist, one trainee dispenser (relief store manager), and one pharmacy degree student. The pharmacy was currently running on locum pharmacists and did not have a regular pharmacist, but most of the locums worked at the pharmacy frequently. The trainee dispenser was due to finish working at the pharmacy soon. The student usually worked at another pharmacy branch but was covering at this pharmacy for the time being.

The team was up to date with its workload and there was a clear workflow through the dispensary. On the previous inspection the dispensing had been around week behind, and staff had clearly worked since then to keep up to date. The pharmacist said that a new area manager started just before the pandemic and he had come in regularly to help support the team.

Staff had access to ongoing online training via the pharmacy computer. A recent package had been about over-the-counter laxatives. Staff did not get protected training time but said that they managed to keep relatively up to date with the training by doing it when the business was quieter. The pharmacy degree student said that she had an online training portfolio through her university. This included training packages and submitting learning logs which her academic advisers checked every term.

Team members felt comfortable about raising concerns and could explain how they would do this. They were seen communicating well with each other during the inspection. The pharmacist felt able to take professional decisions to help ensure people were kept safe. Staff had some targets such as numbers of Medicines Use Reviews and the New Medicine Service checks but did not feel under any undue pressure to achieve them.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The premises are suitable for the pharmacy's services and they are maintained appropriately. The pharmacy is secure from unauthorised access. And people can have a conversation with a team member in a private area.

### Inspector's evidence

The pharmacy was accessed through the medical centre. The size of the pharmacy was adequate and although the storage space was limited it had been used well and was tidy. Dispensary counter tops were largely clear and tidy, and the pharmacy appeared to be clean. The pharmacy was cleaned each evening and surfaces and handles were cleaned at lunchtime. The pharmacist said that the pharmacy received a deep clean once or twice a week.

Lighting throughout was good, and 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 met

### Summary findings

The pharmacy provides its services safely and manages them well. People with a range of needs can access its services. The pharmacy gets its medicines from reputable suppliers and generally manages them properly. It takes the right action in response to safety alerts to help ensure that people get medicines and devices that are safe to use.

### 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.

Dispensing baskets were used to help isolate individual people's medicines. Staff said that the flu vaccines were hard to get hold of and the pharmacy had run out of vaccination for people under 65 years old. But were hoping to obtain some more at the end of October.

The pharmacist explained how stickers were used to identify dispensed 'higher-risk' medicines, such as warfarin and methotrexate. This was done so that there was an opportunity for people collecting these medicines to receive further information about them. No dispensed prescriptions for higher-risk medicines were found on the shelves during the inspection. The pharmacist was observed counselling a person during the inspection about a medicine which required extra care when taken on a long-term basis. The team was aware of the additional guidance to be given about pregnancy prevention to some people taking valproate medicines. And the pharmacy had the relevant information cards and leaflets. The pharmacist said that he had counselled one person in the at-risk group who was taking valproate.

Dispensed multi-compartment compliance packs were labelled with a description of the medicines inside to help people or their carers identify the medicines. An audit trail was present on the packs to show who had dispensed and checked them. Patient information leaflets were supplied to people monthly. Any changes to people's medicines were recorded on the individual person's paper record.

Deliveries of medicines to people's homes were done from the pharmacy itself or from a central location. The pharmacy previously obtained people's signatures when the medicines were delivered, but this had stopped since the start of the pandemic to help with infection control. The pharmacy kept a record of the people it had delivered medicines to, and the pharmacist explained that they phoned people before delivering to make sure they would be at home.

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 or delivered them directly to the person. The pharmacist showed a handheld device that was used to find out where people's prescriptions were. He 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 this system was also linked to the text reminder service so that people knew their medicines were ready.

Medicines were obtained from licensed wholesale dealers and specials suppliers. The medicines were stored in an orderly manner, and significantly tidier than on the previous inspection. Team members said that they were trying to reduce any excess stock so that they had more storage space. And the increasing use of the off-site hub helped them reduce the amount of medicines they needed to keep. One bottle of medicines was found which was not labelled with information about the batch number or expiry date. And this could make it harder for staff to respond to safety alerts or date check the stock properly. This was discussed with the team during the inspection and the bottle was removed.

Medicines requiring cold storage were kept in a fridge and the temperatures were monitored and recorded daily. Temperature records seen were within the appropriate range. Bulk liquids were marked with the date of opening to help staff know if they were still suitable to use. Stock was routinely date checked and this was supported with records. Some of the date checks were a month or two behind, but a random check of stock found no date-expired medicines. The trainee dispenser said that the date checking would be brought up to date. She showed that the medical centre had given the pharmacy a separate bin to put in used face masks for destruction. Medicines that people had returned were kept separate from stock and placed into a designated bin for offsite disposal. CDs were kept securely. Drug alerts and recalls were received electronically, and a copy was printed out which included a record of who had taken action in response.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

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

### Inspector's evidence

The pharmacy had a range of clean glass measures for use with liquids, and some were marked for use only with certain liquids. Staff had access to PPE and were seen using the sanitising gel in the dispensary. Pens had been removed from the front counter to help with infection control, and team members signed on people's behalf when requested. The phone was cordless and could be moved to a more private area to help protect people's personal information.

There was an in-date anaphylaxis kit which was easily accessible when doing vaccinations. A plastic screen with a square hole in it had been set up in the consultation room to help provide additional protection to the person and team member during vaccinations.

## 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. |