General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Harper's Pharmacy, 12 Hollingbury Place, BRIGHTON, East Sussex, BN1 7GE

Pharmacy reference: 1036123

Type of pharmacy: Community

Date of inspection: 13/08/2024

Pharmacy context

This is a community pharmacy in a parade of shops in a residential area of Brighton. It provides NHS dispensing services. It also offers the Pharmacy First service, needle exchange, and supervised administration of certain medicines. It supplies medicines in multi-compartment compliance packs to people who need this additional support. And it delivers medicines to some people's homes.

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 appropriately manages the risks associated with its services to help provide them safely. It generally keeps the records it needs to, and people using the pharmacy can provide feedback or raise concerns. The pharmacy adequately protects people's personal information. And team members know how to protect the welfare of a vulnerable person. The team discusses any dispensing mistakes, so that there is an opportunity to learn and make the pharmacy's services safer.

Inspector's evidence

The standard operating procedures (SOPs) had been reviewed recently and were accessible to staff. Team members had read through most of the SOPs relevant to their role and signed to confirm this. Some SOPs were new (for example, safeguarding), and staff were in the process of reading through them. A team member was able to explain what they could and could not do if the pharmacist had not turned up in the morning. And said that they would refer any repeated purchases of medicines liable to misuse to the pharmacist.

There was a sheet to record near misses, where a dispensing mistake happened but was identified before the medicine was handed out. Team members tried to record all the near misses, but the superintendent pharmacist (SI) said that not all of them had been recorded. Near misses were discussed at the time if possible, and the accuracy checking technician (ACT) said that they were discussed in the team meetings. She was able to show an agenda for one of these meetings, which included discussions about recent near misses. Following near misses, some medicines had been separated on the shelves, for example venlafaxine capsules and tablets. Dispensing errors, where a dispensing mistake happened and the medicine was handed to a person, were recorded. Examples of these records were seen, and they included an analysis of what had caused the error, and the action taken to prevent a recurrence.

People were able to give feedback or raise concerns with the pharmacy using several routes, including in person and via the pharmacy's website. There was a complaint procedure for staff to refer to and the SI was not aware of any recent formal complaints.

The pharmacy had current indemnity insurance, and the right responsible pharmacist (RP) notice was displayed. The RP record and records about emergency supplies seen complied with requirements. Most of the records in the private prescription register had the required information recorded, but a few records were missing the name of the prescriber. Team members had recorded the necessary information when supplies of unlicensed medicines had been made. Controlled drug (CD) registers seen complied with requirements, and the running balances were usually checked regularly. A check of a random CD found that the recorded balance matched the amount of physical stock.

No confidential material was visible from the shop area. A couple of labels on bags of dispensed medicines were potentially visible on the way to the consultation room, but this was immediately resolved when highlighted. Staff confirmed that they had done training about confidentiality, including the General Data Protection Regulation. Confidential waste was kept separate from general waste, and sent offsite for secure disposal.

The SI and ACT confirmed that they had completed level 3 safeguarding training, and contact details for

local safeguarding agencies were available in the dispensary. Other team members had also undertaken some safeguarding training. The SI was unsure if the delivery driver had done any but said she would check and ensure he did it if not. She explained that if the driver had any concerns, he would contact the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services and they do the right training for their roles. They feel comfortable about raising any concerns. They do some ongoing training to help keep their knowledge and skills up to date.

Inspector's evidence

During the inspection there was the SI, an accuracy checking technician (ACT), and a trainee dispenser. A trained dispenser came in towards the end of the inspection. A few team members were not currently in, but the team was coping well and was generally up to date with its workload. The SI confirmed that all team members were either undertaking or had completed accredited courses for their roles. Team members were observed referring queries to the SI as needed.

The ACT was aware of the continuing professional development requirements, and was undertaking additional training relating to the expansion of the role of pharmacy technicians. Team members were provided information about new services and did training packages as they came up, but they did not do regular ongoing training. They felt comfortable about raising any concerns, and the SI was the regular pharmacist in the pharmacy. Team members were not set any numerical targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally suitable for providing the pharmacy's services. They are kept secure from unauthorised access, and people can have a conversation with a team member in private. The premises are limited in size and cluttered in areas, but generally clean. The pharmacy team could do more to keep the dispensary floor free from potential tripping hazards.

Inspector's evidence

The shop area was small but was generally clean and tidy. The dispensary was also small, a little cluttered, and had limited storage space but the space available had generally been used well. Workspace in the dispensary was limited, but there was just enough clear space to dispense and check medicines. There were some baskets on the floor in the dispensary which had been moved to one side, but they could represent a potential tripping hazard.

The consultation room was set away from the shop floor and was accessed through a narrow walkway. The room allowed a conversation to take place inside at a normal level of volume and not be overheard. A portable air conditioning unit was available, and was usually used upstairs where the multi-compartment compliance packs were assembled. Lighting throughout was suitable, and the premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely, and people with different needs can access them. It gets its medicines from reputable suppliers and generally stores them properly. It responds appropriately to safety alerts and recalls to help ensure that people get medicines and medical devices that are safe to use. The pharmacy does not routinely highlight prescriptions for higher-risk medicines. So, it may be missing out on opportunities to provide additional information to people collecting these medicines.

Inspector's evidence

The pharmacy had a manual door, and there was a small ramp from street level. Team members said that people with wheelchairs and pushchairs were usually able to get into the pharmacy without difficultly. The pharmacy computers could generate large-print labels as required. The SI explained that sometimes she undertook consultations for emergency hormonal contraception by telephone for people who wanted this additional privacy.

Dispensing baskets were used to help stop different people's prescriptions becoming mixed up. There was a designated checking area in the dispensary which was kept clear. Team members were aware of the guidance about pregnancy prevention for people taking valproate who could become pregnant. The SI confirmed that the pharmacy currently had no people taking the medicine who were in the at-risk group. And the medicine was only supplied in its original manufacturer's pack. The SI said that she asked people taking warfarin about their latest blood test results. But prescriptions for higher-risk medicines such as warfarin or methotrexate were not routinely highlighted. So, this could mean that opportunities are missed to provide people with additional information about these medicines. Prescriptions for Schedule 4 CDs were not highlighted, and some examples were seen in the prescription retrieval system. As these prescriptions have a shorter validity date, this could make it harder for staff to know if the prescriptions were still valid.

Dispensed multi-compartment compliance packs were labelled with a description of the medicines inside, to help people and their carers identify them. And packs had the required warnings for particular medicines. Patient information leaflets were supplied regularly with the packs. Some of the packs had an audit trail to show who had dispensed them, but this was not done consistently. People were usually assessed to see if they needed the packs by their GP. The pharmacy maintained a record of when people's medicines had changed or stopped. Although the records seen were dated, it was not always clear who had requested a medicine be stopped.

The pharmacy provided the NHS Pharmacy First service, and the SI said that it was going well. There were printed in-date copies of the patient group directions available, and the SI had signed them.

The pharmacy delivered medicines out to some people's homes and kept an audit trail to indicate when the delivery had been made. The SI explained that signatures were obtained from people when CDs were delivered. If person was not in, the medicines were returned back to the pharmacy,

The pharmacy obtained its medicines from licensed suppliers and stored them in a generally orderly way. It had two fridges for storing medicines requiring cold storage, 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 so that staff knew if they were still suitable to use. Stock was date checked regularly, and this activity was recorded. Short-dated items were marked, and no date-expired medicines were found during a random check of the stock. Medicines people had returned were kept separate from current stock until they were taken offsite for secure disposal.

Drug alerts and recalls were received via email, and the SI described the action the pharmacy took in response. They were then printed and archived, with a note made of the action taken. This made it easier for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The current blood pressure meter had been labelled with a date when it was due for replacement, and there was an otoscope in the consultation room. Clean calibrated glass measures were used for measuring liquids, with some marked for use with certain liquids only. This helped avoid any cross-contamination. The sink in the dispensary was clean, but there was a little clutter on the draining board.

People using the pharmacy were unable to see the computer screens from the shop area. Staff had individual smartcards to access the NHS electronic systems and the cards were not shared. The phone was cordless and could be moved into a more private area to help protect people's personal information.

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.