General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Patcham Pharmacy, 37 Ladies Mile Road, Patcham, BRIGHTON, East Sussex, BN1 8TA

Pharmacy reference: 1036130

Type of pharmacy: Community

Date of inspection: 09/05/2019

Pharmacy context

This is a community pharmacy in a village within the boundaries of Brighton and Hove. It is opposite a high school. It dispenses NHS prescriptions, and offers medication deliveries and blood pressure checks. It provides multi-compartment compliance packs to help people take their medicines.

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	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 generally manages the risks associated with its services. This helps people receive services that are safe. The pharmacy largely keeps the records it needs to by law. Its team members know how to protect vulnerable people. And it mostly protects people's personal information well. But it could do more to make sure that its confidential waste is always destroyed properly.

Inspector's evidence

Near misses were recorded on an ongoing basis using a sheet in the dispensary. Not many were on the sheet, and the responsible pharmacist (RP) accepted that they may not all have been recorded. He explained that they had a weekly team meeting where they discussed any incidents that occurred. The meetings also included any updates, and he explained how the team had labelled the valproate shelves following a discussion. He gave an example of a near miss that had occurred between allopurinol and atenolol and showed that they had separated the medicines.

The pharmacist showed how they recorded dispensing errors using a standardised form from the National Reporting and Learning System. He said that an error had occurred between amitriptyline and amlodipine, and he had since separated the medicines. He said that he highlighted prescriptions for these medicines to help avoid a repetition.

A range of standard operating procedures (SOPs) was in place. Team members had signed to indicate that they had read and understood them. The pharmacist showed how the superintendent (SI) had done assessments of the potential risks in the pharmacy. These were written on a list, which was periodically updated when a new potential risk was identified. The list included items such as receiving short dated stock, and what to do if the pharmacist did not turn up in the morning. The dispenser was clear about her own role and responsibilities. And she could explain what she would do if the pharmacist failed to turn up for work.

The pharmacy did an annual patient survey. Results from the latest one were very positive, with 100% of respondents rating the pharmacy as very good or excellent overall. A record was made of people's complaints. The RP said that they had received feedback about the smoking cessation service, but this was not a service the NHS commissioned locally. Details of how to make a complaint or provide feedback was in the practice leaflet, but the leaflet was not easily accessible to people.

A current indemnity insurance certificate was displayed. The RP notice was wrong, and the RP had not signed into the log. These were immediately rectified. Private prescription records, emergency supply records, and controlled drug (CD) registers examined complied with requirements. CD running balances were checked regularly. A random stock-check of a CD medicine matched the amount shown in the register. Records of 'specials' medicines were maintained properly.

People's personal information was not visible to other people using the pharmacy. The RP explained that the shredder had just broken and a new one had been ordered in. Two items containing people's personal information were found in general waste, and they were immediately removed. Team members had been through and signed the confidentiality procedure. Computer terminal screens were turned away from people and access was restricted with a password. Team members had individual

smartcards to access the NHS services. But a team member who was not working on the day of inspection had left their card in a computer. This was removed, and the RP said that he would discuss this with the team member.

Team members had signed the safeguarding SOP, and the dispenser could describe what she would do if she had any concerns. The RP and SI said that they had completed the Level 1 safeguarding training and were in the process of doing the Level 2. They said that they had also been to an external training event on safeguarding and could explain what they would do with a concern. They were not aware of any recent concerns they had had.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained staff to provide its services safely. Its team members can make suggestions, and the pharmacy uses these ideas to help make improvements. The staff receive ongoing training and updates. This helps keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection there were two pharmacists (one RP and one SI), and a dispenser. The dispenser showed the certificate she had received when completing her accredited training course. The pharmacy employed another dispenser (who mainly worked on the counter) for three days a week, and a part-time pharmacy technician. Dispensing was up to date, and the RP felt that the level of staffing was appropriate.

The RP felt able to take any professional decisions. He gave an example of a child who had been prescribed penicillin V, and he felt the dose was too high. He contacted the prescriber and the dose was lowered.

Team members did not have formal ongoing training but they explained that they were kept up-to-date with new information through the weekly team meetings. The RP kept a brief note of what they had discussed in the meetings. He said that representatives from manufacturers came into the pharmacy from time to time to discuss their products, and team members confirmed this. Although it was not recorded when this happened.

The team felt able to raise any concerns and make suggestions. The RP said that he had made a suggestion that one person be responsible for dispensing the multi-compartment compliance packs. As a result, one of the dispensers had now taken responsibility for this. The SI was easily contactable and often worked at the pharmacy. Team members were not set any targets for the services. The RP felt that he was able to offer services to people when they were clinically appropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are secure and suitable for the pharmacy's services.

Inspector's evidence

The pharmacy was clean and tidy, with good lighting. There was a large amount of clear workspace available for dispensing. The consultation room was relatively small but adequate. It was clean and tidy. And it allowed a conversation to happen inside which would not be overheard. The premises were secure from unauthorised access.

Handwashing facilities were available. The room temperature was suitable for the storage of medicines. The pharmacy did not have air conditioning, but the SI said that the pharmacy remained quite cool through the summer months.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely. It obtains medicines from reputable sources and mostly manages them well. It takes the right action when safety alerts are received. This helps it make sure that people get medicines that are safe to use.

Inspector's evidence

The pharmacy had a wide entrance, and large open areas inside. There was a small step, and the SI showed a portable ramp he had made to help people get into the pharmacy. He thought that the pharmacy had a hearing loop but was unable to locate it. The RP said that he delivered urgent medicines to people if they needed them after the delivery driver had finished.

Baskets were used during the dispensing process to isolate individual people's medicines. And help prevent them becoming mixed-up. Dispensed multi-compartment compliance packs were labelled with a description of the tablets and capsules to help people identify their medicines. They were also marked with an audit trail to show who had dispensed and checked the pack. Patient information leaflets were not routinely supplied. This may mean that people do not always get the information they need to take their medicines safely. The RP said that the leaflets would be supplied in the future. He showed how they recorded changes in people's medicines on the patient medication record.

Team members were aware of the additional guidance to be provided to women taking valproate. Additional resources such as cards and leaflets were available. The SI had not yet done an audit to see if they had any people in the at-risk category but said that this would be done. The RP said that they used stickers to highlight dispensed high-risk medicines such as methotrexate or warfarin. But a bag containing dispensed warfarin was found on the shelf. This may make it harder for the team member handing out the medicine to know if they needed to speak with the pharmacist. The RP said that they asked people for the INR reading when they handed in prescriptions for warfarin. CD prescriptions were marked with a sticker to highlight that the prescriptions had a shorter expiry date.

The RP gave an example of person who had a Medicine Use Review, who was complaining of constant coughing when taking ramipril. The RP spoke with the person and referred them to their GP who changed the medicine.

The pharmacy had equipment for the Falsified Medicines Directive. The SI was waiting for their supplier to merge the data from the patient medication record before they could use it fully. Barcodes on packets of medicines could be scanned in using a mobile phone or tablet.

The pharmacy obtained medicines from licenced suppliers, and they were stored very tidily on the shelves. Stock was date checked regularly and this was recorded. No date-expired medicines were found in with stock. Liquids were marked with the date of opening, as some had limited shelf lives when the seal was split. Waste medicines were separated from stock and placed into designated destruction bins and sacks. One was in the toilet area, but this was moved to the dispensary when it was highlighted.

Medicines that needed cold-storage were kept in a suitable fridge. The temperatures were recorded

daily and were mostly within range, but on one or two days the temperature had reached 8.9 degrees Celsius. The SI said that they would ensure that they recorded an explanation and did further monitoring if this happened again.

The pharmacy received drug alerts and recalls via email from the NHS and the MHRA. Team members had recently actioned a recall for prednisolone, and this had been recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for its services.

Inspector's evidence

Calibrated glass measures were available, and a separate one was used for liquid methadone to help avoid cross-contamination. Tablet counting triangles were clean, with one marked for use with cytotoxic medicines.

The blood pressure meter had been replaced in 2018 and this had been recorded. Current reference sources were available online. The fax machine was away from the shop area, and the phone could be moved somewhere more private 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.