General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Saturn Pharmacy, 75 Mitcham Lane, LONDON, SW16 6LY

Pharmacy reference: 1041179

Type of pharmacy: Community

Date of inspection: 03/11/2023

Pharmacy context

This NHS community pharmacy is located on a main road in Streatham. The pharmacy opens six days a week. It sells medicines over the counter. It dispenses people's prescriptions. And it delivers medicines to a few people who have difficulty in leaving their homes. The pharmacy supplies multi-compartment compliance packs (compliance packs) to 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 pharmacist can check a person's blood pressure. And people can get their flu jabs from 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	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 manages its risks appropriately. It has written instructions to help its team members work safely. It keeps the records it needs to by law. It has the insurance it needs 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 write down and review the mistakes they make to try to 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 usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had some plastic screens on its counter to help reduce the spread of airborne infections such as coronavirus. And hand sanitising gel was also available for people to use. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed recently. Members of the pharmacy team were required to read and follow the SOPs relevant to their roles. They knew what they could and couldn't do, what they were responsible for and when they might seek help. Their responsibilities were also described within the SOPs. And a notice in the pharmacy told people who the responsible pharmacist (RP) was at that time. 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 the pharmacist. The pharmacy team kept the dispensing workstation tidy. The RP was responsible for the dispensing service throughout the inspection. And baskets were used to keep each person's prescription separate from other people's prescriptions. The RP referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. They took a break after assembling each prescription. And they checked what they had assembled was right before initialling the label again and handing out the prescription. 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). The pharmacy team discussed, reviewed and recorded the mistakes it made to learn from them, and help stop the same sort of things happening again. And, for example, it highlighted the locations of some look-alike and sound-alike drugs on the shelves to help reduce the risks of the wrong product being picked.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. And its practice leaflet told people how they could provide feedback about the pharmacy or its team. People could share their views and make suggestions to the pharmacy team about how the pharmacy could do things better. And, for example, the pharmacy team tried to order a person's preferred make of a prescription medicine 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 an appropriately maintained controlled drug (CD) register. But the stock levels recorded in this register weren't checked as often as the SOPs required them to be. The pharmacy kept adequate records for the supplies of the unlicensed medicinal products it made. And it had appropriate records to show which pharmacist was the RP and when. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied. And a

sample of these were looked at during the inspection and were found to be in order.

The pharmacy was registered with the Information Commissioner's Office. And people using the pharmacy couldn't see other people's personal information. The pharmacy team completed a self-assessment each year and made a declaration to the NHS that it was practising good data security and it was handling personal information correctly. The pharmacy had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always obliterated or removed from the unwanted medicines returned to it before being disposed of. The pharmacy had a safeguarding process. 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. And the pharmacy's consulting room could be used by someone if they felt they were in danger.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. Members of the pharmacy team work well together and use their judgement to make decisions about what is right for the people they care for. They know how to raise a concern if they have one. And they can give feedback to help the pharmacy do things better.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist, a part-time pharmacist, two part-time medicines counter assistants (MCAs) and a part-time assistant. The part-time assistant kept the pharmacy clean and helped with administrative tasks. And they didn't sell or dispense medicines. The pharmacy depended upon its team and locum pharmacists to cover absences. The people working at the pharmacy during the inspection included the owner (the RP) and a MCA. The pharmacy didn't set any targets or incentives for its team. It had seen an increase in its dispensing volume since its last inspection. But its team was up to date with the workload. Members of the pharmacy team helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they felt able to make decisions that kept people safe. The RP managed the pharmacy and its team. And they supervised and oversaw the supply of medicines and advice given by the team. The MCA 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 needed to complete accredited training relevant to their roles. And they could ask the pharmacists questions, discuss their development needs, read pharmacy-related literature and familiarise themselves with products when they had the time to do so. The pharmacy had a whistleblowing policy. Team members knew who they should raise a concern with if they had one. They were comfortable about making suggestions on how to improve the pharmacy and its services. And their feedback led to the pharmacists working alongside each other two days a week. This meant the pharmacy could provide a vaccination service more easily and one pharmacist could make sure people's compliance packs were assembled properly.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate environment to deliver it services from. And people can receive services in private when they need to. But the pharmacy team doesn’t always have the space it needs to work in when the pharmacy is busy.

Inspector's evidence

The pharmacy was air-conditioned, tidy and secure. And its public-facing area was adequately lit and presented. The pharmacy had a retail area, a counter, a dispensary, a consulting room, a stockroom and a toilet. Its flooring was worn in places. And some of its fixtures were dated too. The dispensary had limited workspace and storage available. And worksurfaces could become cluttered when the pharmacy was busy. The pharmacy had a consulting room for the services it offered that required one or if someone needed to speak to a team member in private. The consulting room was locked when it wasn’t being used. So, its contents were kept secure. People’s conversations in the consulting room couldn’t be overheard outside of it. The pharmacy had some sinks and a supply of hot and cold water. And its team was responsible for keeping its premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are safe and effective. Its team is friendly and helps people access the services they need. 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 them appropriately and securely. Members of the pharmacy team dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy didn't have step-free access. So, members of the pharmacy team remained alert to make sure they could help people use the pharmacy and access its services. The pharmacy had notices that told people when it was open and what services it offered. And it had a seating area for people to use if they wanted to wait. The pharmacy team asked people who were prescribed a new medicine if they wanted to speak to the pharmacist about it. The pharmacy dealt with CPCS referrals. People benefited from this service 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 a few people who couldn't attend its premises in person. It kept a log to show the right medicine had been delivered to the right person. The pharmacy offered a flu jab service when there were two pharmacists working together. It had the anaphylaxis resources it needed for its vaccination service. And the pharmacist providing the service was appropriately trained. 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 pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And the pharmacist assessed whether a person needed a compliance pack. The pharmacy provided people with patient information leaflets and a brief description of each medicine contained within a compliance pack. But it could do more to make sure an audit trail of the person who had assembled and checked each prescription was kept. The pharmacy marked 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. They were aware of the new rules on dispensing valproate-containing medicines in the manufacturer's original full pack. 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 its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team marked the containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. And they marked products which were soon to expire. These steps helped reduce the

chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. 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 the alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And the RP described the actions they took and demonstrated what records they made when the pharmacy received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is clean.

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 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 refrigerators to store pharmaceutical stock requiring refrigeration. And its team checked and recorded each refrigerator's maximum and minimum temperatures on the days the pharmacy was open. The pharmacists could check a person's blood pressure when asked. And the monitor they used for this service was new. 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 positioned 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.