General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Burwash Pharmacy, 9 Burwash Road, HOVE, East Sussex, BN3 8GP

Pharmacy reference: 1107887

Type of pharmacy: Community

Date of inspection: 10/06/2024

Pharmacy context

This is a community pharmacy in a residential area of Hove. It offers NHS services such as dispensing, the New Medicine Service, and the Pharmacy First service. It supplies medicines in multi-compartment compliance packs to some people who need this additional support. It provides a blood collection service, where blood samples are sent away to an external lab for testing who then notifies people of the results. And it offers a travel vaccination service using patient group directions (PGDs). The pharmacy previously offered a prescribing service, but this stopped after the last inspection. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

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 adequately identifies and manages the risks associated with its services. Team members know how to protect the welfare of vulnerable people. The pharmacy largely keeps the records it needs to by law, to show that its medicines are supplied safely and legally. It protects people's personal information. Team members generally respond appropriately when a dispensing mistake happens. But they do not always record them, which could mean that they are missing out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

The pharmacy had not met several standards on its previous inspection. These standards related to the pharmacy's prescribing service, which it had since stopped. The pharmacy had in-date standard operating procedures (SOPs) available, and team members had read and signed the ones relevant to their roles. The SOPs included ones about the responsible pharmacist (RP), dealing with complaints, and safeguarding.

The pharmacy had installed new patient medication record software since the last inspection. The superintendent pharmacist (SI) said that the number of dispensing mistakes had decreased significantly since the change, as the system now asked team members to scan packs when dispensing. If there was a dispensing mistake that was identified before the medicine had been handed to a person (known as a near miss), then there was a QR code for staff to scan. This would prompt them to enter details about the near miss, although the SI was not aware of any near misses that had occurred recently. Records about near misses could be accessed using the dispensary computer, and there were no recent ones recorded. The SI described how she would record a dispensing error, where a mistake happened and the wrong medicine was handed to a person. She described an error that occurred the previous year, but a record had not been made about it as the SI said the person had not highlighted it with the pharmacy directly. However, she could describe the actions that had been taken to prevent a recurrence and gave assurances that records would be made in the future. The computer system also helped provide an audit trail of when medicines were dispensed and handed out, as it required team members to scan a code.

A dispenser was able to explain what they could and could not do if a pharmacist had not turned up in the morning. Team members were observed referring queries to the SI as appropriate.

People could provide feedback or raise concerns via various ways, including in person, by phone, or on the pharmacy's website. There was a complaints SOP for staff to follow if needed, and a sign in the retail area which explained to people how they could make a complaint or provide feedback.

The pharmacy had current indemnity insurance. The right RP notice was displayed, and in the records seen, the required information had been entered. Records about private prescriptions dispensed were largely complete, but some were missing the prescriber's details. The SI thought that they had been emergency supplies, but entered in error as private prescriptions when the team was getting used to the new software. Team members said that they did enter in the required details for emergency supplies but were unable to retrieve a list of them during the inspection. They raised this with the software provider. Controlled drug (CD) registers seen complied with requirements, and the running

balances were checked regularly. A discrepancy was found for one CD between the recorded balance and the physical stock present, but this was found to be due to a recent missed entry and resolved during the inspection. Records about unlicensed medicines supplied mostly complied with requirements.

No confidential information was visible from the retail area, and confidential waste was shredded. Team members had individual smartcards to access the NHS electronic systems. The SI explained that the phone calls to people for the New Medicine Service were done by a separate organisation. She was initially unsure how people's consent for this service was obtained, but checked with the separate organisation who confirmed that people were asked for consent when they were contacted. Team members explained that the computer system printed out a form for people to sign when they were identified as being eligible for the New Medicine Service. And this including asking people for their consent for the external organisation to undertake the check. There were no examples of these printouts available to see during the inspection.

The SI confirmed she had undertaken level 3 safeguarding training, and most other staff had completed level 2. She was able to describe what she would do if she had a concern about a vulnerable person. There was a safeguarding SOP for staff to refer to. The delivery driver had not undertaken any safeguarding training, but soon after the inspection the SI sent evidence that the driver had been registered for and completed the training.

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 do ongoing training to help keep their knowledge and skills up to date. And they feel comfortable about raising any concerns.

Inspector's evidence

During the inspection there was the SI, a pharmacy technician, and three trained dispensers. One of the dispensers had completed an accuracy checking course. All team members confirmed that they had completed the accredited training relevant to their roles. The team was up to date with its workload.

Team members felt comfortable about raising any concerns, and the SI often worked in the pharmacy and was easily contactable. Team members described the ongoing training they did, which included doing packages from eLearning for healthcare. They said that the pharmacy had training sessions at least monthly, and a recent one had included information about head lice treatments. A dispenser said that she had recently completed a course about antimicrobials, and used the information to update the rest of the team. There were certificates to show that the SI and a dispenser had undertaken training about the phlebotomy service. Team members were not set any numerical targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean and tidy, and secure from unauthorised access when closed. People can have a conversation with a team member in a private area.

Inspector's evidence

The premises were clean and tidy, with adequate space for safe dispensing. Shelves which held medicines were organised to minimise the risk of mistakes. There was a consultation room in the pharmacy which provided an adequate level of privacy if someone wanted to talk with a team member in private. The premises were secure from unauthorised access when closed. The pharmacy had clear plastic screens protecting the counter, to help control the spread of infection. There was a sink in the dispensary area with both hot and cold-water supplies. This was suitable for preparing liquid medicines if needed. The premises maintained a suitable temperature with air conditioning and had adequate lighting to allow safe working. The pharmacy’s websites were no longer used for the supply of medicines online.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services in a safe and effective way. People with a range of needs can access its services. The pharmacy gets its medicines from reputable sources and stores them appropriately. The team takes the right action in response to safety alerts and recalls so that people get medicines and medical devices that are safe to use.

Inspector's evidence

There was step-free access from the street through a manual door. There was enough space in the retail area for people with wheelchairs or pushchairs to manoeuvre. There were two seats for people who wanted to wait for their prescriptions to be dispensed. The pharmacy's computer could generate large-print labels if required.

Baskets were used during the dispensing process to keep different people's medicines separate, and there was one area of the pharmacy which was used for checking dispensed items.

Dispensed multi-compartment compliance packs were labelled with a description of the medicines inside and the required warnings. Patient information leaflets were routinely supplied with the packs, to help ensure people had up to date information about their medicines. A sheet was filled in for the packs to show who had dispensed and clinically checked each one. The pharmacy delivered medicines to some people in their own homes, and kept an audit trail of when a delivery had been made.

Team members were aware of the update guidance about valproate-containing medicines, including the need to supply them in their original pack. They were not aware of any people using the pharmacy who were currently in the at-risk group. The pharmacy computer highlighted any dispensed prescriptions for higher-risk medicines on the bag label. And it also highlighted dispensed prescriptions for CDs on the bag label. Team members were seen referring to the SI when people came to collect CDs which these labels.

A selection of PGDs for the travel vaccination service were examined, and they were in date. The pharmacy had printouts of the pathways and inclusion and exclusion criteria for the Pharmacy First service, and electronic versions were available online. The SI had signed the master authorisation form for the Pharmacy First service, and another pharmacist had signed to say that they would be providing the service. The SI had not signed to say that she would be providing the service and said that she would check with the NHS whether she needed to do this.

The pharmacy obtained its medicines from licensed wholesale dealers and specials suppliers, and generally stored them tidily. There were three fridges, and the temperatures were checked and recorded daily. Records seen were within the required range of 2 to 8 degrees Celsius. Date-checking of stock was done regularly, and this activity was recorded. No date-expired medicines were found when a random selection of stock was checked. Bulk liquids were marked with the date of opening, and CDs were stored securely. Medicines for destruction were appropriately separated from current stock.

Drug alerts and recalls were received electronically. The pharmacy technician explained the action the pharmacy took in response, and sometimes use a software application to record when the action had

been taken. She said that in the future she would use the application so that a record was maintained of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had clean glass measures, with one marked for use with only certain liquids. The SI was unsure how old the blood pressure meter was and said she would find out and replace it if needed. Following the inspection, she sent evidence that a new meter had been ordered. There was an otoscope for use with the Pharmacy First service. Computers screens were turned away from people using the pharmacy. And the phone was cordless, so could be taken to a quieter part of the pharmacy to help protect people's personal information. The anaphylaxis kit in the consultation room was out of date, but in-date injections were available in the adjacent dispensary and the kit was were immediately replaced.

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.