General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cotham Pharmacy, 3-5 Cotham Hill, Clifton, BRISTOL, Avon, BS6 6LD

Pharmacy reference: 1028606

Type of pharmacy: Community

Date of inspection: 28/08/2019

Pharmacy context

This is a community pharmacy in a busy shopping area close to the centre of Bristol. A wide variety of people use the pharmacy. The pharmacy dispenses NHS and private prescription and sells over-the-counter medicines. It also supplies medicines in multi-compartment compliance aids to help people in their own homes to take their medicines and medicines to the residents of three local care homes.

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's working practices are generally safe and effective. But, they could learn more from mistakes to prevent them from happening again. The pharmacy is appropriately insured to protect people if things go wrong. It keeps the up-to-date records that it must do by law. The team keep people's private information safe and they know how to protect vulnerable people.

Inspector's evidence

The pharmacy team generally identified and managed risks. Dispensing errors and incidents were recorded and reviewed. There had been a labelling error in May 2019. It was documented that a contributing factor was that the pharmacy was busier than normal. However, no specific actions had been put in place the reduce the likelihood of a recurrence. Similarly, this was the case with near misses. In addition, near misses were recorded electronically which meant that any labelling task had to be interrupted in order to record the mistake. This did not encourage all near misses to be recorded. In addition, the log was not reviewed with the staff on a regular basis.

The dispensary was tidy and organised. There were two labelling areas, an assembly bench, a separate checking bench and a small care home assembly area. There was a lot of underutilised space downstairs in the pharmacy. Baskets were used but colours only distinguished prescriptions for those patients who were waiting. This meant that it may be difficult to prioritise the workload. There was a clear audit trail of the dispensing process and all the 'dispensed by and checked by' boxes on the labels examined had been initialled.

Up-to-date, signed and relevant Standard Operating Procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were reviewed every two years, or sooner, if necessary, by the Superintendent Pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. There was no displayed sales protocol but the medicine counter assistant was experienced and said that she would refer all requests for children, potential eye infections and patients also taking prescribed medicine to the pharmacist. The staff would also refer multiple sales requests for codeine-containing products to the pharmacist. They were all aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as, fluconazole capsules.

The staff were clear about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. In the 2018 survey, 90% of customers who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback about the seating for patients who were waiting. Because of this, the chairs had been replaced.

Public liability and indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 31 August 2020 was in place. The Responsible Pharmacist log, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were in order. Some out-of-date controlled drug items, such as diamorphine 10mg, had been removed from the register. The pharmacist seen sent the inspector an email on the evening of the visit, confirming that he had returned all of the out-of-date CD items, that had been removed from the registers, back to the appropriate register, so that they were now included in the running balance.

The dispenser seen was not sure if there was a formal information governance procedure but she was aware of confidentiality issues and completed the NPA training on the new data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was shredded. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had read the SOP on the safeguarding of both children and vulnerable adults. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers to escalate any concerns relating to both children and adults would be obtained electronically. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. The team members who are undertaking training are well supported by the manager. And, all the staff feel able to raise issues with him.

Inspector's evidence

The pharmacy was in a busy shopping street close to the centre of Bristol. They dispensed approximately 5,000 NHS prescription items each month with many of these being repeats. Due to the location, there were several ‘walk-in’ patients. 80 domiciliary patients and 60 care home patients (nursing and residential) received their medicines in compliance aids. Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, one full-time NVQ2 trainee dispenser, two part-time medicine counter assistants and one part-time driver. A new full-time dispenser was due to start work the week following the visit. Since the employed, and shortly to be employed dispensers, were both working full-time, there was little flexibility to cover any unplanned absences in the dispensary. The part-time counter assistants were flexible and covered unplanned absences and holidays on the counter. Planned leave was booked well in advance.

Staff performance was monitored, reviewed and discussed informally throughout the year. There were frequent one-to-one meetings but no formal appraisals. The trainee dispenser said that she was well supported with her course by the regular pharmacist who sometimes helped her after work. She was ambitious and eventually wanted to be an accuracy checking technician. This had been agreed in practice and she would be enrolled on the technician training course in 2020. The pharmacist seen reported that all learning was documented on his continuing professional development (CPD) record.

The staff knew how to raise a concern and reported that this was encouraged and acted on by their manager. They had recently raised an issue about the rubbish not being taken out. Because of this, a rota had been set up. There were monthly staff meetings where the team members could raise any issues. No targets or incentives were set.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional. The work areas are small for the quantity of compliance aid services done, but they are tidy and organised. The consultation room is well fitted and it is signposted on the door. But, this is not easily visible, and so, some people may not know that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was well laid out and presented a professional image. The dispensing areas were small for the quantity of compliance aid services done, but tidy and organised. There was a lot of underutilised space downstairs. The premises were clean and well maintained. But, the downstairs area smelt damp.

The consultation room was spacious but could be better signposted. It was tucked away behind a pillar and not easily seen. The room, which had Digi-pad access, was spacious and well fitted. There were three chairs, but one was fabric-covered, a sink, a fridge and a laptop computer. Conversations in the consultation room could not be overheard. The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

There was air conditioning in the dispensary and the temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a good range of services which people can access. The services are effectively managed to make sure that they are provided safely. The team make sure that people have the information that they need to use their medicines safely and effectively. They intervene if they are worried. The pharmacy obtains its medicines from appropriate sources. The medicines are stored and disposed of safely. The pharmacy team make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room. There was no bell on the door for their use, but the staff said that the door was always open. Part of the premises was a post office. There was access to Google translate on the pharmacy computers and this had been used for Chinese-speaking students. The pharmacy printed large labels for sight-impaired patients.

Advanced and enhanced NHS services offered by the pharmacy were Medicine Use Reviews (MURs), New Medicine Service (NMS), emergency hormonal contraception (EHC) (regular pharmacist – not seen), urgent repeat medicines (recorded on PharmOutcomes), supervised consumption of methadone and buprenorphine (currently just one client) and seasonal flu vaccinations. The latter was also provided under a private agreement as were travel vaccines, malaria prophylaxis and child vaccines. The services were well displayed and the staff were aware of the services offered.

The regular pharmacist (not seen) had completed suitable training for the provision of seasonal flu vaccinations and other vaccinations, including face to face training on injection technique, needle stick injuries and anaphylaxis. He had also completed suitable training for the provision of the free NHS EHC service.

80 domiciliary patients and 60 care home patients (nursing and residential) received their medicines in compliance aids. The domiciliary dosettes were assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. They were assembled in quiet periods. Any changes or other issues were recorded on the patient's electronic prescription medication record (PMR) and also in dedicated folders. These were referred to at the checking stage and so the pharmacist had a clear clinical picture of the patient. The trays were delivered on Thursdays. The pharmacy prepared the trays at least a week in advance.

The pharmacy also provided services to three care homes (nursing and residential). The homes filled in the repeat requests for their patients. The pharmacy kept a copy of these and checked the prescriptions against the copy. Copies of the prescriptions were not sent to the homes for checking. Any changes were recorded on the patient's PMR. The assembly of the medicines took place on a small bench in the main dispensary despite there being a large amount of underutilised space downstairs at the pharmacy.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. Interventions were seen to be recorded on the patient's PMR. Green 'see the pharmacist' stickers were used. The pharmacist seen routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. He asked bout INR levels. He also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. All the staff were aware of the new

sodium valproate guidance.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Potential non-adherence or other issues were identified at labelling and ordering. Any patients giving rise to concerns were targeted for counselling.

Medicines and medical devices were obtained from AAH, Alliance Healthcare, Colorama and OTC. Specials were obtained from Thame Laboratories. Invoices for all these suppliers were available. Unlicenced thiamine was seen on the shelves. CDs were stored tidily in accordance with the regulations and access to the cabinets was appropriate. There were no patient-returned CD but several out-of-date CDs. These were clearly labelled and separated form usable stock. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with electronic records. Date checking procedures were in place with signatures recording who had undertaken the task. Waste bins were available for waste and used.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically and the stock checked. They were not routinely printed off and any appropriate alerts were not routinely kept. The staff said that they would do this in future. They were aware of a recent alert about Emerade pens. The pharmacy had several of the effected batches. The dispenser printed of the alert and annotated it appropriately. The effected stock had been quarantined.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment for the services it provides.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures but had no small measure, for less than 10ml, at the time of the visit. This was ordered during the visit. There were three tablet-counting triangles, one of which was kept specifically for cytotoxic substances and one capsule counter. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2018/2019 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum/minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential was information was shredded. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.