General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Air Balloon Pharmacy, Air Balloon Surgery, Kenn Road, St George, BRISTOL, Avon, BS5 7PD

Pharmacy reference: 1028674

Type of pharmacy: Community

Date of inspection: 27/08/2020

Pharmacy context

This is a community pharmacy in the eastern suburbs of the city of Bristol. It is interconnected with a surgery. A wide variety of people visit the pharmacy. The pharmacy team members dispense prescriptions, sell over-the-counter medicines and give advice. They also supply some medicines in multi-compartment compliance packs to help vulnerable people in their own homes to take their medicines. The pharmacy offers Medicines Use Reviews (MURs), the New Medicine Service (NMS) and the Community Pharmacy Consultation Service (CPCS). This inspection was carried out during the COVID-19 pandemic.

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. It has made some changes to reduce the risk of transmission of coronavirus. The pharmacy is appropriately insured to protect people if things go wrong. It mainly keeps the required records. The pharmacy team members keep people's private information safe and they know how to protect vulnerable people. But, they could learn more from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team members identified and managed most of the risks associated with providing its services. They had put some changes in place, as a result of the COVID-19 pandemic, to reduce the risk of transmission of coronavirus. But the pharmacy had not updated its standard operating procedures (SOPs) with changes relating to the pandemic. It had updated its business continuity plan to accommodate any potential issues relating to the current NHS 'test and trace' scheme. The team members would liaise with the other branches in the group to ensure that there was no disruption in the supply of medicines to their patients if the pharmacy had to close. The manager had conducted risk assessments of the premises and occupational risk assessments of all the staff. The team members were asked about any potentially vulnerable people in their households and also about their mental health. The manager reviewed the risk assessments each month. The pharmacy team members were aware that they needed to report any COVID-19 positive test results.

The pharmacy team members recorded near miss mistakes, that is, mistakes that were detected before they had left the premises. They did not document learning points and actions to prevent future recurrences. And so, only general trends could be identified. The dispensary team reviewed and discussed the near miss log each month. In July 2020 they had identified that formulation errors were the most common mistake. As a result of this, the pharmacist had provided training on the different forms of common medicines. The pharmacy had had an error in July 2020 where the incorrect medicine had left the pharmacy. This error had been identified as a look alike, sound alike (LASA) mistake. Brinzolamide/timolol eye drops had been given instead of bimatoprost/timolol eye drops. But, the team had not put any specific actions in place to prevent a similar mistake in the future.

The dispensary was generally tidy and organised. There were dedicated working areas, including a marked checking area. The dispensary team placed the prescriptions and their accompanying medicines into baskets and this reduced the risk of errors.

All the staff were clear about their roles and responsibilities. A medicine counter assistant (MCA) knew that codeine-containing medicines should not be sold to people for more than three days use. The team referred sales of pseudoephedrine-containing medicines to the pharmacist and knew that people on anti-hypertensive medicines should not take this.

The pharmacy team members were largely newly appointed. They had not all read the pharmacy's complaints policy. There was no displayed leaflet for customers. The place where this was kept was empty. The pharmacist said that she would re-fill this space and ensure that the staff read the complaints policy. The pharmacy had not received any recent complaints and most people had been

complimentary about the service they had received since the beginning of the pandemic.

The pharmacy had current public liability and indemnity insurance. It kept most of the required up-to-date records: the responsible pharmacist (RP) log, controlled drug (CD) records, emergency supply records and specials records. The pharmacy kept its private prescription records electronically. Several of these did not include the details of the prescriber. It had fridge temperature records, date checking records, patient-returned CD records and cleaning rotas.

All the staff understood the importance of keeping people's private information safe. They stored all confidential information securely. The computers, which were not visible to the customers, were password protected. The correct NHS smartcards were seen in the appropriate computers. The pharmacy team members shredded all confidential wastepaper. The pharmacy offered face-to-face services. These were done in the consultation room. People could not be overheard or seen in the consultation room.

The pharmacy team understood safeguarding issues. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. The team members would access the local telephone numbers to escalate any concerns relating to both children and adults electronically. The pharmacist was aware of the national 'safe space' initiative for victims of domestic violence but she had not registered the pharmacy as participating in the scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage their workload safely. The team members are flexible and generally cover holidays and sickness. The pharmacy team are comfortable about providing feedback to their manager. They are given updates about COVID-19 but are doing little other ongoing learning. So, their knowledge and skills may not be up to date.

Inspector's evidence

The pharmacy's current staffing profile was: one pharmacist, one full-time NVQ2 qualified dispenser (the manager), one part-time NVQ2 qualified dispenser, one part-time NVQ2 trainee dispenser, one part-time medicine counter assistant (MCA), one part-time MCA trainee and two part-time delivery drivers. The part-time staff were flexible and generally covered any unplanned absences. Planned leave was booked well in advance and only one member of staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

Many of the team, including the pharmacist and manager were newly appointed. The manager monitored the performance of the team members but he had yet to do any formal appraisals. The staff felt able to raise any issues or concerns with him. They had recently raised an issue about uniforms. As a result of this, uniforms had been ordered.

The staff were encouraged with learning and development. But, since the outbreak of the pandemic, most of their learning was related to updates regarding coronavirus. The staff newly enrolled on accredited training courses will be allocated dedicated learning time. The other team members were doing little non-COVID learning. The dispensary staff reported that they were supported to learn from errors. The pharmacist documented all learning on her continuing professional development (CPD) record.

No targets or incentives were set.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally looks professional and is suitable for the services it offers. The premises are thoroughly cleaned to reduce the likelihood of transmission of coronavirus. The pharmacy signposts its consultation room so it is clear to people that there is somewhere private to talk.

Inspector's evidence

The pharmacy generally presented a professional image. The dispensary was relatively small and could have been tidier. Some baskets were stored on top of one another on the dispensary benches. This could increase the risk of errors. One basket at a time was placed in the checking area which mitigated this risk. The floors were clear. The premises were clean. As a result of COVID, the premises was thoroughly cleaned each day. The hard surfaces were wiped over more frequently than this. The staff used alcohol gel after each interaction with people.

The consultation room was signposted. It had three chairs, a computer and a small sink. People could not be seen or overheard in the consultation room. The pharmacy's computer screens were not visible to customers. The telephone was cordless and the staff took all sensitive calls out of earshot.

The temperature in the pharmacy was below 25 degrees Celsius and it was well lit.

Principle 4 - Services ✔ Standards met

Summary findings

Everyone can access the services the pharmacy offers. It manages its services effectively to make sure that they are delivered safely. The team members make sure that people have the information they need to use their medicines properly. They intervene if they are worried about anyone. The pharmacy gets its medicines from appropriate sources and stores them safely. The pharmacy makes sure that people only get medicines or devices that are safe.

Inspector's evidence

Everyone could access the pharmacy and the consultation room. There was an automatic opening front door. The pharmacy team members could access an electronic translation application for any non-English speakers. The team members could print large labels for sight-impaired people.

The pharmacy was located in the eastern suburbs of the city of Bristol. Most of its prescriptions were electronically transferred from the interconnected surgery and for local residents. Due to the location, the pharmacy did receive some acute green FP10 prescriptions. The dispensary staff initialled the 'dispensed by' and 'checked by' boxes on the labels, so providing a clear audit trail of the dispensing process.

In addition to the essential NHS services, the pharmacy offered several additional services: Medicines Use Reviews (MURs), New Medicine Service (NMS), Community Pharmacy Consultation Service (CPCS), treatment of impetigo, use of hydrocortisone on the face and chloramphenicol for the treatment of bacterial conjunctivitis in children under two. The pharmacist had attended a recent Local Pharmaceutical Committee (LPC) zoom meeting about the safe provision of the 2020 flu vaccination service. But she had not yet ordered any stock for this.

The pharmacy had several substance misuse clients who usually had their medicines supervised. Due to COVID-19, most of these clients now collected their medicines. A couple were still supervised. This took place in the consultation room. The supervising pharmacist washed their hands after the supervision.

The pharmacy had a few domiciliary people who had their medicines in compliance packs. The staff kept dedicated folders for these people where they recorded any changes in dose or other issues. The pharmacist referred to these when doing the final accuracy check. The dispensary team assembled the compliance packs when it was quiet on a small, separate dedicated bench. The assembled packs were stored tidily. The pharmacist had done risk assessments of the people who had their medicines in compliance packs. All the people were vulnerable and would not cope with their medicines in original packs.

The dispensary team highlighted any prescriptions containing potential drug interactions, changes in dose or new drugs to the pharmacist. She targeted anyone she was concerned about for counselling. The pharmacist routinely counselled people prescribed high-risk drugs such as warfarin and lithium and also those prescribed antibiotics, complex doses and oral steroids. All pharmacy team members were aware of the pregnancy protection programme regarding sodium valproate.

The pharmacy delivered several medicines to people. Because of the pandemic, the delivery drivers did not currently ask people to sign for their medicines to indicate that they had received them safely. They knocked or rang the doorbell and left the medicines on the doorstep. The drivers retreated and waited until the medicines had been taken safely inside. They annotated the delivery sheets accordingly.

The pharmacy got its medicines from Alliance Healthcare, AAH, Phoenix and Sigma. Invoices for all these suppliers were available. The pharmacy had no operational scanner to check for falsified medicines as required by the Falsified Medicines Directive (FMD). It stored its CDs tidily in accordance with the regulations and access to the cabinet was appropriate. The pharmacy had no patient-returned CDs. Appropriate CD destruction kits were on the premises. The pharmacy stored its fridge lines correctly and it had date checking procedures. The pharmacy team members were accepting patient-returned medicines. These were double bagged. The staff member who accepted the returned medicines wore gloves and washed their hands after disposing of the medicines into a dedicated waste bag. The team members placed any medicines, considered hazardous for waste purposes, into a separate dedicated waste bin.

The pharmacy had procedures for dealing with concerns about medicines and medical devices. It received drug alerts electronically. They were printed off and the stock was checked. The pharmacy had received an alert on 3 August 2020 about digoxin 250mcg. It had none of the affected batches in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the appropriate equipment and facilities for the services it provides. And, the team members make sure that it is clean and fit-for-purpose. The pharmacy has taken some action to reduce the spread of coronavirus but these measures could be more robust.

Inspector's evidence

As a result of the pandemic, the pharmacy only allowed two people in at a time. But they had not erected a Perspex or other protective screen. And, there were no marks on the floor indicating where people should stand. The area manager gave assurances that this would be addressed so that there was appropriate protection both for the staff members and for the people visiting the pharmacy. The staff were wearing Type 2R fluid resistant face masks or face shields.

The pharmacy used ISO marked measures. But it had no small measure. A 10ml measure was ordered during the visit. There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. The pharmacy had up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. The staff could access to the internet.

The fridge was in good working order and maximum and minimum temperatures were recorded daily.

The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and the staff took any sensitive calls out of earshot. The pharmacy team members shredded all confidential waste 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.