General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bhogal Dispensing Chemist, 79-81 St. Marks Road, Easton, BRISTOL, Avon, BS5 6HX

Pharmacy reference: 1028686

Type of pharmacy: Community

Date of inspection: 03/02/2020

Pharmacy context

This is a community pharmacy in a shopping street in the vibrant inner, eastern area of the city of Bristol. A wide variety of people use the pharmacy. It pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy also supplies several medicines in multi-compartment compliance aids to help vulnerable people in their own homes to 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	4.1	Good practice	The pharmacy offers a good range of services for the benefit of the local population. And, everyone can access the services it offers.
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 is appropriately insured to protect people if things go wrong. The pharmacy mainly keeps the up-to-date records that it must by law. The team members keep people's private information safe and they know how to protect vulnerable people. But, they could be better at learning from 'near miss' mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team identified and managed most risks. Any dispensing error or incidents would be recorded, reviewed and appropriately managed. However, the staff reported that there had not been an error for several years. Near misses were recorded but insufficient information was documented to allow any useful analysis, such as a picking error involving saxagliptin 5mg. No other information was documented. The log had no learning points or actions taken to reduce the likelihood of similar recurrences. General trends could however be identified.

The dispensary was spacious and organised. There was a 'walk-in' and electronically transferred prescription area, with labelling and assembly space. A separate area was used for checking. This also had a Methameasure machine for the assembly of methadone prescriptions for substance misuse patients. A separate organised room was used for the multi-compartment compliance aids. 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.

Signed standard operating procedures (SOPs) were in place but these were generic and included no local additions specific to the business. The superintendent was in the process of reviewing the SOPs and gave assurance that he would add specific local changes. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. A medicine counter assistant (MCA) said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. She was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as chloramphenicol eye drops and Ella One and referred requests for these to the pharmacist. All the staff knew that fluconazole capsules should not be sold to women over the age of 60 for the treatment of vaginal thrush and that aspirin should not be sold for the use of anyone under 16.

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 2019 survey, 93% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback about the seating area for patients who were waiting. The staff said that a re-fit of the pharmacy was planned in the next few months and that they would be looking at the layout of the premises.

Public liability and indemnity insurance provided by Numark and valid until 31 July 2020, was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, emergency supply records, specials records, fridge temperature records and date checking records were in order. Private prescriptions were kept electronically and a few did not include the address of the prescriber.

An information governance procedure was in place and the staff had also completed training on the general data protection regulations. The pharmacy computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was shredded daily. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available on-line to escalate any concerns relating to both children and adults.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. And, additional support is available when team members are on holiday of off sick. The team members are encouraged to keep their skills up to date and they are given time to do this at work. But, they do not have any formal appraisals and so any gaps in their knowledge and skills may not be identified. The team members are comfortable in providing feedback to their managers to improve services and this is acted on.

Inspector's evidence

The pharmacy was in the vibrant inner, eastern area of the city of Bristol. They mainly dispensed NHS prescriptions with the majority of these being repeats. Several domiciliary patients received their medicines in multi-compartment compliance aids. And, several substance misuse patients had their medicines supervised.

The current staffing profile was one pharmacist, two full-time NVQ2 trained dispensers, one full-time medicine counter assistant (MCA), the manager and one part-time delivery driver. The owner and superintendent pharmacist would help in the event of unplanned or planned absences. He would also engage locum dispensers or pharmacists, if necessary. A staffing rota was used to ensure appropriate staffing levels.

The staff worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year but there was no formal performance appraisals. And so, any gaps in their skills and knowledge may not be identified. The staff were encouraged with learning and development and completed regular e-Learning, such as recently on sepsis. They said that they spent about 30 minutes each month of protected time learning. The dispensary staff reported that they were supported to learn from errors. The pharmacist said that all learning was documented on his continuing professional development (CPD) records.

The staff knew how to raise a concern and reported that this was encouraged and acted on. All the staff had recently raised concerns about the staffing levels. Because of this, the pharmacy was actively trying to recruit a part-time qualified dispenser. ‘Ad hoc’ staff meetings were held and the staff said that they felt able to raise any issues with the pharmacist, the manager and the superintendent. The pharmacist said that he was not set any targets or incentives. He did as many advanced and enhanced NHS services, as well as some private services, that he could and in the interest of the local community.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks generally professional and is suitable for the services it provides. The work areas are clean, tidy and organised. The pharmacy signposts its consultation room so it is clear to people 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 benches were organised and uncluttered. The floors were clear. The premises were clean and well generally maintained. A few ceiling tiles showed the remnants of previous water damage.

The consultation room was small and the door opened inwards which further impacted on the available space. The manager said that he would get the door re-hung. He also said that the pharmacy was going to have a re-fit in the next few months and that he would ensure that sufficient space was allocated to the consultation room. The pharmacy did offer vaccination services and so being able to lay a patient in the recovery position may be necessary. The room was well signposted and had Digi-lock entry. 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 and the temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a good range of services for the benefit of the local population. And, everyone can access the services it offers. The pharmacy manages its services effectively to make sure that they are delivered safely. The team members make sure that people have the information that they need to use their medicines properly. And, they intervene if they are worried about anyone. The pharmacy gets its medicines from appropriate sources. And, it stores and disposes of them safely. The team members make sure that people only get medicines and devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room and a bell on the door for anyone who may need assistance entering the pharmacy. The staff could access an electronic application for use by non-English speakers and they also spoke the common Asian languages. The pharmacy could print large labels for sight-impaired patients.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), sexual health services including emergency hormonal contraception (EHC), Community Pharmacy Consultation Service, supervised consumption of methadone and buprenorphine and seasonal flu vaccinations. The latter was also provided under a private scheme as was the meningitis A, C and W135 and Y vaccine and prophylaxis of malaria. The meningitis vaccine was mainly offered to customers travelling to Mecca for the hajj. The services were well displayed and the staff were aware of the services offered.

The pharmacist had completed suitable training for the provision of seasonal flu 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 sexual health services.

Several substance misuse patients had their medicines supervised. There was a dedicated folder for these patients where any relevant information was kept. Any concerns about these patients were recorded on their prescription medication record. The telephone numbers of key workers were not available. The pharmacist said that he would try to get these because the pharmacy was open for longer hours than the service provider. A Methameasure machine was used for methadone. Photographs for all the patients were attached. The pharmacist was aware of the local shared care guidance, The Recovery Orientated Alcohol and Drugs Service (ROADS) guidance and the supervised patients were offered water or engaged in conversation to reduce the likelihood of diversion.

A number of domiciliary patients received their medicines in compliance aids. These were assembled in a separate, organised room on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There were dedicated folders for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. The changes were recorded in concise chronological order for easy reference by the pharmacist at the checking stage. Procedures were in place to ensure that all patients who had their medicines in compliance aids and were prescribed high-risk drugs, were having the required blood tests.

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 prescription medication record. Green 'see the pharmacist' stickers were used. The staff at the pharmacy clearly knew all their patients well. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. International normalised ratios (INR) were asked about. The pharmacist also counselled patients prescribed amongst others, antibiotics, unusual doses, oral steroids, new drugs and any changes. CDs and insulin were checked with the patient on hand-out. All the staff were aware of the sodium valproate guidance relating to the pregnancy protection programme. Three 'at risk' patients had been identified. They had been suitably counselled and guidance cards were included with all prescriptions for them.

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. The pharmacist reported that the patients visiting the pharmacy were generally well informed about their medicines. He gave advice on inhaler technique and asked patients prescribed pain killers, if they bought over-the-counter pain relief medicines, during MURs.

Medicines and medical devices were obtained from AAH and Alliance Healthcare. Specials were obtained from Thame Laboratory. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There was one patient-returned CD but no out-of-date CDs. This was clearly labelled and separated from 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. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 19 November 2019 about ranitidine oral solution. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides. And, the team members make sure that they are clean and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 100ml). There were three tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was 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 any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was collected for appropriate disposal. 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.