General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Broadway Pharmacy, 1 The Broadway, Bedford, Bedfordshire, MK40 2TJ

Pharmacy reference: 1028792

Type of pharmacy: Community

Date of inspection: 22/03/2024

Pharmacy context

This pharmacy is located on a busy main road in Bedford town centre. It dispenses both NHS and private prescriptions and supplies some people with medicines in multi-compartment compliance packs. The pharmacy provides some NHS services such as the Pharmacy First service and the New Medicine service. It also offers a service where people are supervised taking their medicines when needed. A COVID-19 vaccination service is also available.

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

Members of the pharmacy team follow written instructions to help them work safely and effectively. They make a record of their mistakes and discuss them so that they can learn from them. The pharmacy largely keeps the records that are needed by law. And its team members take appropriate action to safeguard people that are vulnerable.

Inspector's evidence

The pharmacy had a full set of electronic standard operating procedures (SOPs) to underpin its services. The SOPs were reviewed in January 2024 by the superintendent pharmacist (SI). Members of the team accessed the SOPs electronically and a record was kept showing that they had read and understood them. The roles and responsibilities were stated in each individual SOP and team members explained what their role was for the day. A trainee dispenser was able to correctly explain the tasks that could and could not be carried out if the responsible pharmacist (RP) took a short leave of absence from the pharmacy. A correct RP notice was on display in the retail area. The pharmacy had professional indemnity insurance which covered the services that it provided.

A complaints procedure was in place but was not advertised so people may not know how to raise a concern, complaint or provide feedback. The pharmacy had a process to support its team members with learning from mistakes that were identified during the final check by the accuracy checker, also known as near misses. The pharmacist completing the accuracy check asked the team member involved in the dispensing process to identify the mistake and correct it. A record of the error was made in a near miss log which meant team members could identify common mistakes and take action to try and reduce similar mistakes happening again. Shelf edge labels were used to prompt team members to check medicine stock as they were assembling prescriptions. An example of this was to highlight the different formulations of metformin tablets to prevent the modified-release version being mixed up with the normal release one. As there were only two members of the team, all near misses were discussed at the time they occurred but a formal review was not completed to identify any common trends. Any mistakes identified after medicines had been handed out, also known as dispensing errors, were recorded, and investigated by the SI. Dispensing errors were discussed with the team members to help reduce the risk of similar mistakes happening again.

The pharmacy largely kept the records it needed to by law. The RP record was kept electronically but there were some gaps where the pharmacist hadn’t signed out of the record which meant that it may make it harder to identify when their responsibility had ended. The SI, who was also the regular RP, provided an assurance that this would be recorded accurately going forwards. The pharmacy supplied some medicines in accordance with a private prescription. The records of these were made electronically and contained all the information required. Controlled drugs (CDs) records were in paper format and complied with the requirements. The SI explained that they checked the stock when dispensing CDs against a prescription. The physical stock of two CDs were checked against the recorded running balance and were found to be correct. CDs returned to the pharmacy were recorded in a book and signed when destroyed. The pharmacy had supplied some people with unlicensed medicines and a record of this was maintained.

There was a process to appropriately dispose of confidential information. Team members separated

confidential waste into a basket and would shred it on site. However, there was a backlog of shredding as the team was waiting for a new shredder to arrive. When questioned, members of the team described other ways in which they protected people's private information. For example, they knew not to have private conversations in the retail area or to share people's information. Safeguarding procedures were in place and team members knew what to do if they had any concerns about wellbeing of anyone vulnerable. The SI had completed level three safeguarding training and the trainee dispensing assistant had completing some learning with a previous employer. Details of the local safeguarding contacts were not on display, but the team knew how to access them.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to safely provide its services. And it provides support to members of the team who are on training courses. Members of the team feel comfortable to raise concerns and provide feedback.

Inspector's evidence

The pharmacy team consisted of one regular pharmacist, who was also the SI, one trainee dispensing assistant and one delivery driver. The SI explained that they were looking to recruit another dispensing assistant as the pharmacy had considerably grown the number of prescriptions it dispensed over the past 12 months. A locum dispenser was used to cover any absences to help make sure a consistent service level was achieved. The pharmacy team members were seen working well together and they supported each other to manage the workload safely.

The trainee dispensing assistant felt well supported with their learning and development and they were provided with adequate learning time to complete their training. Team members explained the questions they would ask when selling pharmacy medicines. And they identified medicines that are liable to misuse. In such cases, they would refer to the pharmacist if they felt the sale was inappropriate or if repeated requests were made.

The pharmacy completed annual appraisals with its team members to discuss how they had performed and to help identify any future training needs. Members of the team also felt comfortable raising concerns or providing feedback to the SI. As the pharmacy team was small, meetings took place daily to discuss workload, dispensing mistakes, and changes to processes.

Principle 3 - Premises ✔ Standards met

Summary findings

The environment is suitable for the provision of pharmacy services. The pharmacy premises are clean and large enough to manage the workload safely. A consultation room is available for people to have a private conversation with a member of the team.

Inspector's evidence

The pharmacy was large, clean, and well-lit which made it suitable to supply medicines in an effective manner. There was enough clear workspace for its team members to assemble medicines safely. However, some areas within the pharmacy were untidy following a refit of pharmacy but this did not pose a hazard. A clean sink was available and suitable for preparing medicines that required mixing before being supplied to people.

A clean and tidy consultation was available and suitable for people to have a private conversation if needed. The pharmacy had climate control available to help maintain a comfortable working temperature. The pharmacy was secured when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides the services it offers in a safe manner. The pharmacy gets its medicines and devices from appropriate sources. Its team members carry out sufficient checks to make sure they are safe to supply to people, but a record is not always made which means some medicine stock may be overlooked. Members of the team give advice to people when supplying higher-risk medicines to help make sure they are appropriate for people to use.

Inspector's evidence

There was level access to the pharmacy which made it easier for people with mobility issues to enter. Team members were seen assisting people with opening the door when necessary. The entrance led into the retail area of the pharmacy which had some seating for people to wait to receive a service. The opening hours of the pharmacy were displayed on the entrance door. A range of health information leaflets were situated in the retail area for people to access if they wished.

The pharmacy provided some NHS services including the New Medicine Service and the Pharmacy First Service. The SI had read and signed the patient group directions (PGDs) which covered the Pharmacy First service and explained that they had offered around 10 consultations in the previous month. The initial feedback from people was positive as it was easily accessible. A COVID-19 vaccination service had been provided but had stopped until spring. Supervised consumption of specified higher-risk medicines was in operation and people were accompanied to the consultation room for privacy when using the service.

NHS prescriptions were received electronically, and dispensing baskets were used to keep individual prescriptions separate to avoid medicines being mixed up during the dispensing process. Dispensed medicines awaiting collection were bagged and stored securely away from unauthorised access. The pharmacist attached stickers to the bags to highlight when controlled drugs or fridge lines needed to be added. This also acted as a prompt for team members to check the validity of CD prescriptions before being supplied to people. A note was made on the top of a prescription to highlight when counselling was needed. The dispenser explained how they always asked people to confirm their names and addresses before medicines were handed out, to make sure they were correctly identified. Some people had their medicines delivered to their homes and team members had a diary so that they could schedule the deliveries. But a record of the successful deliveries was not maintained which was not in line with the SOPs. This meant that the pharmacy may not be able to appropriately respond to a query following a delivery. The risk of this was discussed with the SI and they provided an assurance that a record will be kept.

The pharmacist was aware of the risks associated with the use of valproate during pregnancy and an audit of patients taking valproate had been carried out. The pharmacy did not currently have any patients who met the risk criteria, but the pharmacist knew that such patients should be counselled. The pharmacy team knew that valproate should always be supplied in original packs and knew how to attach dispensing labels to avoid covering important information.

The pharmacy supplied medicines in multi-compartment compliance packs for about 11 patients. Record sheets were kept for all the patients, showing their current medication and dosage times. This

information was checked against repeat prescriptions and any discrepancies would be checked with the surgery. The compliance packs were not labelled with descriptions, so people may not be able to identify the individual medicines. But patient information leaflets were routinely supplied.

The pharmacy obtained its medicines from licensed wholesalers and unlicensed specials were ordered from a specials manufacturer. Stock medicines were stored tidily but a few medicines were found stored outside of the original pack and without some of the key identifiable information such as the strength, expiry date, brand or batch number. The SI removed these from the shelf for disposal as soon as it was highlighted to them. The expiry dates of medicine stock were checked every three months, but a record of the checks was not kept. This meant that some stock may be overlooked. CDs were appropriately stored in a locked cabinet. There was a medicines fridge in the dispensary. It was clean and tidy and equipped with a thermometer. The maximum and minimum temperatures were recorded daily and had remained within the required range. Waste medicines were disposed of in dedicated bins that were collected periodically by a specialist waste contractor. Drug alerts and recalls were received electronically, and records were kept showing what action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains the equipment appropriately and keeps it securely.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting triangles. There was a suitable medicine fridge with a thermometer. Members of the team had access to electronic resources such as the British National Formulary (BNF) and the electronic medicines compendium. This meant the pharmacy team could refer to the most recent information on medicines.

Electrical equipment looked to be in good working order. Two computer terminals were available for team members to use, and the screens were positioned in a way so that any confidential information could not be seen by people waiting in the pharmacy. Access to people's electronic data on the pharmacy's computers was password protected. A tympanic ear thermometer, an otoscope and a blood pressure meter were available for the services provided. Calibration information was known by the SI.

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.