General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bishopscote Chemist, 54 Bishopscote Road, LUTON, Bedfordshire, LU3 1PB

Pharmacy reference: 1028846

Type of pharmacy: Community

Date of inspection: 20/11/2019

Pharmacy context

The pharmacy is located in a parade of businesses in a residential area of Luton. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include prescription collection and delivery, stop smoking, emergency hormonal contraception, meningitis ACWY and seasonal flu vaccinations. The pharmacy has healthy living status.

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	1.1	Good practice	The pharmacy identifies and manages risks associated with providing its services.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members have the appropriate training to deliver services safely.
		2.5	Good practice	The pharmacy team members make suggestions to improve safety and workflow in the dispensary.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy provides its services safely and effectively.
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 safe and effective. It manages risk well and it has written procedures which tell staff how to provide services safely. The pharmacy team makes sure that people have the information they need so that they can use their medicines in the right way. They keep the records they need to so that medicines are supplied safely and legally. The team members understand their role in protecting vulnerable people and make sure confidential information is secure.

Inspector's evidence

Near misses were recorded, reviewed and learnings were shared with the team. Fast moving medicines had been located in one section of the dispensary thus separating some 'Lookalike, soundalike' (LASA) medicines such as atenolol and allopurinol and amitriptyline and amlodipine and reducing picking errors. Carbimazole and carbamazepine and prednisolone and propranolol had been separated. LASA stickers on the dispensary shelved alerted staff when picking medicines. Insulins with similar names had been separated in the medical fridge. A key learning point in the patient safety review was to highlight the middle name on labels for patients with similar names to minimise the risk of mixing up prescriptions and medicines for those patients.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. Labels were generated and medicines were picked from reading the prescription. Interactions between medicines for the same patient were shown to the pharmacist. There were separate dispensing and checking areas. The pharmacist performed the final check of all prescriptions prior to completing the dispensing audit trail to identify who dispensed and checked medicines. There was a procedure for dealing with outstanding medication. The original prescription was retained, and an owing slip was issued to the patient. For 'manufacturer cannot supply' items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance aids were prepared for a number of patients in a separate area. The pharmacy managed prescription re-ordering on behalf of some patients. There was a folder containing discharge summaries and notes for compliance aid patients. Labelling included a description to identify individual medicines and patient information leaflets were supplied with each set of compliance aids. High-risk medicines such as alendronate, sodium valproate and controlled drugs (CDs) were supplied separately from the compliance aids. Lansoprazole was supplied in compartments positioned to ensure it was taken before other medication or food. Special instructions were highlighted on the backing sheet.

The practice leaflet was on display and included details of how to comment or complain. The annual patient questionnaire had been conducted and the questionnaires had been submitted for analysis. The standard operating procedures (SOPs) had a review date of June 2019. The procedures included dealing with complaints, CD management, delivery, safeguarding and responsible pharmacist (RP). Staff training in SOPs was up to date. The staff member who served at the medicines counter said she would not give out a prescription or sell a P medicine if the pharmacist were not on the premises.

To protect patients receiving services, there was professional indemnity insurance in place provided by NPA expiring 31 Dec 2019. The responsible pharmacist notice was on display and the responsible

pharmacist log was completed. Records for private prescriptions and 'specials' (unlicensed medicines) supplies were complete. Patient group directions (PGDs) to administer flu and ACWY vaccinations, erectile dysfunction medicines and emergency hormonal contraception (EHC) with chlamydia screening and treatment were in date.

The CD and methadone registers were complete, and the balance of CDs was audited weekly. A random check of the actual stock of MST 10mg reconciled with the recorded balance in the CD register. Invoice number, supplier name and address were recorded for receipt of CDs. Patient returned CDs and destruction were recorded in the private prescription register.

Staff had signed confidentiality agreements and were aware of procedures regarding General Data Protection Regulation (GDPR). A privacy notice was displayed. There was a video camera alert on display. The Data Security and Protection toolkit had been completed. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly. Staff had undertaken safeguarding and dementia friends training and the pharmacist was accredited at level 2 in safeguarding training. The pharmacist had attended a Centre for Pharmacy Postgraduate Education (CPPE) safeguarding event in connection with supplying EHC. Safeguarding contact details to report concerns were displayed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to deliver its services safely. The team members work well together and manage the workload within the pharmacy. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: one regular full-time pharmacist, one full-time and one part-time dispenser also accredited as medicines counter assistants.

Staff were provided with ongoing training including Careway modules on topics such as flu and hay fever. In line with the Pharmacy Quality Scheme (PQS) training had been completed in sepsis, LASA errors, risk management and safeguarding. Training had also been undertaken in the Community Pharmacist Consultation Service (CPCS). The pharmacist had printed off the sepsis symptoms and trained staff. Staff progress in achieving objectives was discussed on an ongoing basis and there was an annual documented appraisal. Staff felt able to provide feedback and had suggested arranging dispensary stock into fast moving medicine lines and the dispenser should check the dose of medication prescribed in the BNF during the dispensing process. The pharmacist said targets and incentives were set to promote flu vaccination and to complete audits.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean and suitable for the provision of its services. The pharmacy prevents people accessing the premises when it is closed to keep medicines and information safe.

Inspector's evidence

The premises were clean and tidy. Stock was neatly arranged in the retail area and the dispensary was slightly elevated allowing the pharmacist to see what was happening at the medicines counter. The consultation room was located to one side of the medicines counter at the rear of the pharmacy. It was locked when not in use and the door was labelled. There were lockable cabinets to secure documents and equipment. Patient privacy was protected. Lavatory facilities were clean and handwashing equipment was provided. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

People with different needs can access the pharmacy's services. The pharmacy provides its services safely and effectively and it gets its medicines from reputable sources to protect people from harm. The pharmacy team knows what to do if any medicines or devices need to be returned to the suppliers. The pharmacy makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe to use. The pharmacy's team members are helpful and give advice to people about where they can get other support. They also make sure that people have all the information they need so that they can use their medicines safely.

Inspector's evidence

There was wide, level access at the entrance and wide aisles to assist people with mobility issues. Large font labels could be printed to assist visually impaired people. Staff could converse in Gujarati and Hindi to assist patients whose first language was not English. Patients were signposted to other local services including walk-in centres in the town centre and local hospital, NHS 111, physiotherapy and osteopathy clinics and a private doctor. Signposting events were recorded on the patient medication record (PMR) if possible. Nicotine replacement therapy was provided via vouchers for members of the public accessing stop smoking service. There were health related leaflets for members of the public.

The pharmacist explained the procedure for supply of sodium valproate to people in the at-risk group. There was information on the pregnancy prevention programme (PPP) which was explained to at-risk people. An alert regarding sodium valproate and PPP was printed on the prescription. There was a poster displayed regarding supply of isotretinoin. The pharmacist explained the procedure for supply of isotretinoin to people in the at-risk group. Isotretinoin should be prescribed by a specialist and supplied within seven days following a negative pregnancy test. The prescriber would be contacted regarding prescriptions for more than 30 days' supply of a CD. CD prescriptions were highlighted, and the date checked to ensure supply within the 28-day validity period. Interventions were recorded on the PMR.

Prescriptions for high-risk medicines such as CDs and fridge items were highlighted by marking the bag label. The pharmacist said when supplying warfarin, people were asked for their record of INR along with blood test due dates. The surgery was contacted if necessary regarding INR. The INR was recorded on the PMR. Side effects of bruising and bleeding were explained. Advice was given about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. If asked for Daktarin oral gel, staff referred to the pharmacist because of the interaction with warfarin. People taking methotrexate were reminded to have regular blood tests and about the weekly dose, when to take folic acid. People were advised to seek medical advice if they developed an unexplained fever. Information sources such as steroid warning cards and methotrexate purple books were available to give to patients.

Audits had been conducted to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking a non-steroidal anti-inflammatory drug (NSAID). The audits regarding prescription of salbutamol with no steroid inhaler for six months and acute kidney injury had been conducted. At the time of the visit there were planned audits of dates of last foot checks and retinopathy screening for diabetic people and sodium valproate identifying people in the at-risk group.

Medicines and medical devices were delivered outside the pharmacy by a member of staff. There was a delivery record book for the patient to sign. A copy of the delivery record was given to the patient. The pharmacist delivered or called if counselling was required.

Medicines and medical devices were obtained from Alliance, AAH, Phoenix, Sigma, IPS and DE South. Floor areas were clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and recorded. Short-dated items were marked. No date-expired medicines were found in a random check. Liquid medicines were marked with the date of opening and medicines were stored in original manufacturer's packaging. Cold chain items were stored in the medical fridge. Uncollected prescriptions were cleared from retrieval regularly and patients were contacted depending on the type of medication. Waste medicines were stored separately from other stock. Falsified medicines directive (FMD) hardware and software was operational at the time of the visit. Drug alerts were received, actioned and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment and facilities appropriately to keep people's private information safe.

Inspector's evidence

Current reference sources included BNF, NHS Choices and Counter Intelligence. The dispensary sink was clean and there were clean standard glass measures. The medical fridge was in good working order with a sticker on the outside to remind staff to ensure the readings were within range. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius.

The CD cabinet was fixed with bolts. The stop smoking service carbon monoxide meter was supplied and maintained by Turning Point. The blood pressure monitor was not due for recalibration. A health check machine in the public area measured height, weight, blood pressure, pulse and body mass index and was maintained by the company who supplied it.

The sharps bin for vaccination sharps disposal was in the consultation room. Due to availability issues regarding adrenaline injection devices the pharmacist planned to stock adrenaline vials and syringes instead in case of anaphylaxis during vaccination. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly.

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.