General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bridge Road Pharmacy, 6 Bridge Road, Cove, FARNBOROUGH, Hampshire, GU14 0HS

Pharmacy reference: 1031718

Type of pharmacy: Community

Date of inspection: 28/11/2019

Pharmacy context

A small independently owned community pharmacy. It is on a parade of shops in Cove, on the outskirts of Farnborough. As well as NHS Essential Services, the pharmacy provides Medicines Use Reviews (MURs), New Medicines Service (NMS) and multi-compartment compliance aids for people living in the local community. The pharmacy also has a delivery service. It provides seasonal flu vaccinations and a travel vaccination and malaria prophylaxis service. It provides substance misuse services including supervised consumption of methadone.

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	2.5	Good practice	Team members were observed to work well together. They assisted each other when required and discussed matters openly
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 safe and effective. Its team members understand their roles and responsibilities. They listen to people's concerns and keep people's information safe. Team members discuss any mistakes they make, and they share information on what could go wrong to help reduce the chance of making mistakes in future.

Inspector's evidence

Staff worked under the supervision of the responsible pharmacist (RP) whose sign was displayed for the public to see. They worked in accordance with a set of standard operating procedures (SOPs). Staff had read the SOPs relevant to their roles. The pharmacy had a procedure for managing risks in the dispensing process. All incidents, including near misses were recorded and discussed at the time. This was a small, close-knit team and staff had regular discussions as part of the day to day running of the pharmacy. The pharmacist said that every so often they held team meetings to review and discuss any mistakes and ways of preventing a reoccurrence. But while mistakes were discussed in detail, so that staff could learn from them, near miss records did not provide details of what had led to the mistake and what would be done differently in future. Accurate records of what had gone wrong would help staff to conduct a more thorough review of their mistakes so that they could continue to learn from them. This could be particularly relevant for dispensing staff in training.

It was clear that the team discussed any incidents and were aware of the risk of error. Staff were required to take extra care when selecting 'look alike sound alike' drugs (LASAs). The RP had discussed LASAs with them to help reduce the chance of selecting the wrong one. LASA's discussed included gabapentin and pregabalin and fluoxetine and furosemide. The team said that when dispensing a prescription for LASAs they would break down the drug names in the following way; ga-ba-pen-tin and pre-ga-ba-lin to help ensure that the correct one was dispensed. Staff had also placed stickers on shelf edges, in front of pregabalin products, which said 'check drug'. The RP described how he had also reorganised all the dispensary stock to make products easier to find and improve workflow.

Since taking over the business, the pharmacist had employed an apprentice dispenser and registered an MCA on a dispensing training course. He did this to ensure that more than one trained member of staff was involved in the dispensing and checking process.

The pharmacy team had a positive approach to customer feedback. The results of a recent survey had prompted staff to discuss smoking cessation, diet and exercise when appropriate with customers. The medicines counter assistant (MCA) described how the team ordered the same brands of medicines for certain people to help them to take their medicines properly. Customer preferences included the Metabet brand of metformin MR 500mg and Dr Reddy's omeprazole 20mg. Notes about individual brand preferences were put on patients' medication records and on labels to ensure that these specific brands were dispensed for those who needed them. The team said that they had received many positive comments from customers and local surgery staff since the new RP had taken over the business. The pharmacy had also won an LPC award for expanding its range of services.

The pharmacy had a documented complaints procedure. And had a notice on the wall explaining the procedure to its customers. Customer concerns were generally dealt with at the time by the RP (superintendent). Staff said that complaints were rare but if they were to get a formal complaint it

would be recorded. Details of the local NHS complaints advocacy and PALs would be provided on request. The pharmacy had professional indemnity and public liability arrangements so, they could provide insurance protection for staff and customers. Insurance arrangements were in place until 30 November 2019. And, the pharmacy had renewed its insurance arrangements for the following year.

All the necessary records were kept and were generally in order including records for private prescriptions, emergency supplies and the responsible pharmacist record. Records for unlicensed 'Specials' were generally in order although some were missing labelling and prescriber details. Controlled drug (CD) registers were also generally in order although some older registers included different strengths and brands of drugs. The pharmacy had a system for recording the receipt and destruction of patient returned CDs. These records are necessary as they provide an audit trail and give an account of all the non-stock CDs which pharmacists have under their control. But there were several CD items returned by patients, including Oxynorm 5mg/5ml liquid, which had not been recorded.

Staff had received confidentiality training and signed a confidentiality agreement. Completed prescriptions were stored in the dispensary in a way that patient details couldn't be viewed from customer areas. And discarded patient labels and prescription tokens were shredded on a regular basis. The pharmacy's delivery records had one patient's details per page, so their details couldn't be viewed by anyone else receiving a delivery. The pharmacist had completed level 2 CPPE training for safeguarding children and vulnerable adults. Support staff, including the delivery driver had completed dementia friends training. Staff knew to raise concerns with pharmacists and knew where to find details of the local safeguarding authorities. The pharmacy team had not had any specific safeguarding concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload safely and effectively and team members work well together. They are comfortable about providing feedback to one another which helps the pharmacy to improve the quality of its services.

Inspector's evidence

The pharmacy had a regular responsible pharmacist (RP) who managed services Monday to Saturday. The RP was also the superintendent and one of two company directors. The rest of the team included a full-time apprentice dispenser and two part- time MCAs, one of which had begun a dispensing assistant's course. On the day of the inspection the RP was supported by an MCA and the apprentice dispenser. Team members were observed to work well together. They assisted each other when required and discussed matters openly. The daily workload of prescriptions was in hand and customers were attended to promptly. There was a changeover of MCAs during the inspection. The MCAs were observed having an informal handover meeting where the assistant taking over was updated on the business of the day. Staff kept their knowledge up to date through the training provider 'virtual outcomes'. Recent training topics included diabetes awareness and dealing with difficult discussions. Staff said the next training topic was on sepsis.

The dispensing assistant MCA described being able to raise concerns. She said she had regular informal discussions with the owner. Staff would have informal discussions during which they could make suggestions and raise concerns. She described how she had suggested reorganising the repeat prescription ordering system, by using less paper and more electronic communication with surgery. Staff agreed that the new system was quicker, and easier to audit and track. The pharmacist felt able to make his own professional decisions in the interest of patients. He would offer an MUR or NMS when he felt it beneficial for someone. He was generally able to provide services in with his daily workload, but occasionally he invited people to come back on quieter days such as Thursdays or Saturdays. His current priorities were to build the business and provide people with the services they needed. He had noticed a good uptake of the travel vaccination service and the private flu service. He said he worked with the surgery by referring patients eligible for the NHS service to the surgery and in turn, the surgery referred patients eligible for the private service to the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a safe, secure environment for people to receive healthcare services. But the pharmacy's storage arrangements meant that it did not look as tidy and organised as it could. And its décor did not look fresh.

Inspector's evidence

The pharmacy's premises had a traditional appearance. It had a large window and a glass door, both providing natural light. The pharmacy entrance had a step up from outside. The pharmacy had been partially upgraded since being taken into new ownership less than one year ago. It had new flooring, new ceiling and lighting, and a consultation room had been installed. And plans were in place for further refurbishments. The premises were generally clean. The shop floor area was clear of obstructions. There was a small seating area for waiting customers. Items stocked included a range of baby care, healthcare, beauty and personal care items.

The pharmacist used the new consultation room for private conversations and services such as MURs. The door to the room was on the shop floor. The pharmacy had a small medicines counter to the side of the dispensary. The dispensary was also small. The pharmacy had staff facilities and a reinforced door to the rear. Floors, walls and ceilings in the back-shop areas were marked and worn and in need of an upgrade. The dispensary had a three to four metre, L- shaped, run of bench space and open shelves and drawers for storing medicines. It had an additional one to two metre run of bench space with a sink. The dispensary was small but well organised.

The dispensary was generally clean, tidy and organised but there was a lack of storage space, which meant that some bulky items had to be stored on the floor. Staff cleared benches as they worked to keep work surfaces tidy. But there was not much free space with two computers and dispensing baskets occupying much of the available surface. In general, the pharmacy was tidy and organised and had a professional appearance. Shelves, worksurfaces, floors and sinks were generally clean.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively and tries to make them available to everyone. In general, the pharmacy manages its medicines safely and effectively. It checks stocks of medicines regularly to make sure they are in date and fit for purpose. They store medicines appropriately and dispose of waste medicines safely. But the pharmacy's team members are not thorough enough in ensuring that they give everyone the advice and support they need to help them use their medicines safely and properly.

Inspector's evidence

A selection of the pharmacy's services was advertised at the front window although the list needed updating. And there was a small range of information leaflets for customer selection. The step up at the pharmacy entrance meant that wheelchair users would not be able to gain access without assistance. Services were provided in accordance with an up-to-date set of SOPs. And in general, staff appeared to be following the SOPs. CD stock was audited regularly as per the CD SOP. And the quantity of stock checked (Oxycontin 30mg) matched the running balance total in the CD register.

The RP had increased the range of services available since taking the business over and was working towards gaining healthy living pharmacy (HLP) status. The RP was working with the local surgery to improve the quality of patient care. He attended regular clinical meetings and was working with them to support asthmatic patients who often did not turn up for their asthma reviews at the surgery. The RP described how he would conduct a MUR with asthma patients in which he would provide a COPD check, including inhaler technique, FEV1 measurement, lung volume, peak flow, and blood oxygen saturation levels. The results of these tests were fed back to the surgery, who were generally then able to pick up on patients who still required a review. They could also continue to prescribe for those who seemed to be managing their asthma reasonably well.

Multi-compartment compliance aids were provided for people who needed them. Patient information leaflets (PILs) were offered to patients with new medicines but were not provided regularly with repeat medicines. Medication in compliance aids wasn't given a description, including colour and shape, to help people to identify them. And, the labelling directions on compliance aids did not have the required BNF advisory information to help people take their medicines properly. But the pharmacist said he would always provide counselling to patients on new medicines to make sure they understood how to take them properly. He added that the local hospitals were good at sending out discharge notices. This meant that he was able to anticipate any prescription changes and amend compliance aids in a timely manner.

The pharmacy had procedures for targeting and counselling all female patients taking sodium valproate. The RP had access to warning cards, and the MHRA guidance sheet. He said he had checked the pharmacy's records and had provided counselling as appropriate. All packs of sodium valproate in stock bore the updated warning label, and the pharmacist had extra updated warning labels to apply to packs if needed. The pharmacist described how he worked with local surgeries and pharmacies to help ensure that medicines shortages did not impact their patients. He had noticed a steady increase in the number of patients choosing to have their prescriptions dispensed at the pharmacy. And, had increased the amount of healthy living advice offered. He described having regular discussions with patients about stopping smoking, diet, exercise and alcohol intake.

The pharmacy had up-to-date PGDs and service specifications for both the private and NHS flu vaccination services. People were briefed on what to expect when receiving a vaccination and asked to complete a consent form. Records were kept of the consultation for each vaccination, including details of the product administered. The pharmacy had procedures in place for managing an anaphylactic response to vaccinations.

Medicines and medical equipment were obtained from: AAH, Alliance Healthcare and Sigma. Unlicensed 'specials' were obtained from Avicenna. All suppliers held the appropriate licences and stock was generally stored in a tidy, organised fashion. A CD cabinet and fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read, recorded and monitored to ensure that the medication inside was kept within the correct temperature range. Stock was regularly date checked and records kept. And short-dated stock was highlighted. However, although stock had been expiry date checked recently, the last recorded date check was July, four months earlier. The CD cabinet contained a bottle of approximately 50ml of Oxynorm 5mg/5ml liquid, which had expired two months earlier and a bottle of non-sugar-free Methadone liquid 1mg/ml which had expired over two years ago. Neither of these expired products had been clearly marked to ensure that they were not dispensed in error.

The pharmacy team were not yet scanning products with a unique barcode, in accordance with the European Falsified Medicines Directive (FMD). The RP was aware of the requirement but was investigating the best system to use. Waste medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. Drug recalls and safety alerts were generally responded to and records were kept. No faulty stock had been identified in yesterday's recall for paracetamol products. But some stock of ranitidine 75mg tablets had been identified and returned following an earlier recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities for the services it provides. In general, it uses its facilities and equipment to keep people's information safe.

Inspector's evidence

The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures and tablet triangles were of the appropriate BS standard and clean, although measures were slightly lime-scaled. Precautions were taken to help prevent cross contamination by using a separate triangle for counting loose cytotoxic tablets. And amber dispensing bottles were stored with their caps on, to prevent contamination with dust and debris. CD denaturing kits were used for the safe disposal of CDs. There were up-to-date information sources available in the form of a BNF, a BNF for children, Stockley and the drug tariff. Pharmacists also used the NPA advice line service and had access to a range of reputable online information sources such as the NHS, NICE and EMC websites.

There were 2 computer terminals available for use. One in the dispensary and one in the consultation room. Both computers had a PMR facility, were password protected and were out of view of patients and the public. It was noted that the RP was using his own smart card when working on patient medication records. Staff used their own smart cards to maintain an accurate audit trail and to ensure that access to patient records was appropriate and secure. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was collected for safe disposal.

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.