General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bretts Pharmacy, 11-12 Millbrook Square, Grove, WANTAGE, Oxfordshire, OX12 7JZ

Pharmacy reference: 1035999

Type of pharmacy: Community

Date of inspection: 11/12/2019

Pharmacy context

The pharmacy is located on a busy shopping precinct in a village. 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, substance misuse and seasonal flu vaccination.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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 the risks associated with providing its services.
		1.2	Good practice	The pharmacy reviews and monitors the safety and quality of its services.
2. Staff	Standards met	2.2	Good practice	Staff training and development is supported.
		2.5	Good practice	Staff are able to provide feedback to improve services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy manages and delivers 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, and it manages risk well. The pharmacy has written procedures which tell staff how to complete tasks effectively. It keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. They understand their role in protecting vulnerable people and keep people's information secure.

Inspector's evidence

Near misses were recorded manually and on Pharmapod along with dispensing incidents and controlled drugs (CD) discrepancies on the pharmacy computer. Near misses were reviewed and any trends which were identified were discussed with staff regularly.

'Lookalike, soundalike' (LASA) medicines were separated on the dispensary shelves to reduce picking errors during dispensing. Amitriptyline and amlodipine were separated by a divider between both medicines and azathioprine and azithromycin were separated. Shelf edge stickers highlighted LASA medicines such as amiodarone or amiloride. A patient safety review was compiled. Staff had undertaken a risk review involving patient returned medicines and bagged CD and fridge prescription medicines. The procedure for dealing with patient returned medicines was amended so these medicines were placed straight into pharmaceutical waste bins as soon as they were received from members of the public. CD and fridge prescription medicines were placed in clear plastic bags to allow a further check prior to transfer to the patient. The pharmacist explained that she preferred to avoid stacking baskets containing prescriptions and medicines awaiting final check so items did not fall into another basket.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. The pharmacist performed the clinical and final check of prescriptions and completed the dispensing label audit trail. A four-way stamp was initialled to identify staff involved in dispensing, checking and handing out of medication. Accuracy checking technicians (ACTs) final checked those prescriptions which had been clinically checked by the pharmacist and the four-way stamp was endorsed by the pharmacist. Interactions between medicines for the same patient were printed and shown to the pharmacist. There were designated dispensing and checking areas in the dispensary. 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 both domiciliary and in care or nursing homes on a rolling basis to manage workload. There was a spacious room behind the dispensary where compliance aids were prepared. The pharmacy managed prescription re-ordering on behalf of domiciliary patients and medication administration record (MAR) charts were supplied to patients who had a carer. New patients were risk assessed for suitability to have medicines supplied in a compliance aid. Factors assessed included sight, memory and dexterity. The pharmacy team liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance aid. Staff had completed a risk assessment and concluded that the

pharmacy had no capacity currently to take on new patients. Information regarding compliance aids was retained in a folder and each patient had their own polythene sleeve containing their discharge summaries and a sample backing sheet which was re-written each time there was a change in medication.

Labelling included a description to identify individual medicines and patient information leaflets (PILs) were supplied with each set of compliance aids. High-risk medicines such as sodium valproate were supplied separately to the compliance aid. Alendronate was generally supplied separately except in a few cases where it could be contained in a separate compartment ensuring it was consumed by the patient. The dates of CD prescriptions were managed to ensure supply within the 28-day validity of the prescription. Levothyroxine and lansoprazole were sometimes supplied in compartments positioned to ensure being taken before other medication or food. Special instructions were highlighted on the backing sheet.

Medicines were supplied in compliance aids for nursing and care homes. Two homes completed a repeat prescription request which was sent to the pharmacy and on to the doctor's surgeries. The pharmacy checked the prescriptions against the prescription requests and chased any missing items. Compliance aids were supplied monthly with MAR charts and acute prescription items were supplied as needed. The dispenser liaised with the homes' staff to sort out ongoing issues and the pharmacist and dispenser visited the homes to monitor the service. An audit trail was maintained of delivery items.

The annual patient questionnaire was being undertaken at the time of the visit. The practice leaflet was being updated and a complaints procedure was displayed. Members of the pharmacy team were up to date with training in standard operating procedures (SOPs) at the time of the visit. SOPs were audited annually. The staff member serving at the medicines counter said she would not give out a prescription or sell a pharmacy only medicine if the pharmacist were not on the premises. She said she would not sell Nurofen Plus and Solpadeine Max to the same person because both medicines contained codeine.

To protect patients receiving services, there was valid professional indemnity insurance provided by NPA expiring 31 Mar 2020. The responsible pharmacist notice was on display and the responsible pharmacist log was completed. Records for private prescriptions, emergency and 'specials' supplies were generally complete although some prescriber details were missing. The NHS flu patient group direction (PGD) was signed and in date.

The CD and methadone registers were mostly complete, and the balance of CDs and methadone were audited weekly in line with the SOP. A random check of the actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. Footnotes correcting entries were not always signed and dated. Invoice number and name but not always address of the supplier were recorded for receipt of CDs. Patient returned CDs were recorded in the destruction register for patient returned CDs. FP10MDA prescriptions were endorsed at the time of supply.

Staff had signed the confidentiality procedure and were aware of procedures regarding General Data Protection Regulation (GDPR). Confidential waste paper was shredded and there was a cordless phone to enable a private conversation. Staff used their own NHS cards. A mini poster 'Your data matters to the NHS' was displayed. The pharmacy computer was password protected and backed up regularly. Staff had undertaken safeguarding and dementia friends training. The pharmacists had undertaken level 2 safeguarding via Centre for Pharmacy Postgraduate Education (CPPE).

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together and manage the workload within the pharmacy. They are actively encouraged to complete ongoing training. Pharmacy staff are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: two part-time regular pharmacists, two full-time ACTs, four full-time and two part-time dispensers, six part-time medicines counter assistants (MCAs) and three part-time delivery persons.

Staff were provided with set-aside training time and each had their own Numark training profile to access regular training. The pharmacy team were in the process of completing healthy living pharmacy training and had undertaken 'Help yourself' training. To meet Pharmacy Quality Scheme (PQS), training had been undertaken in sepsis, reducing LASA errors, safeguarding and Community Pharmacist Consultation Service (CPCS). For risk management, stock control had been risk assessed. There were annual appraisals to monitor performance at work. Staff felt able to provide feedback to the pharmacists and had suggested: storing delivery items in a specific basket to reduce repeat trips to a residential home, owing or outstanding medicines to be stored in a separate shelf in retrieval and checking the order before transmitting to manage stock control. The pharmacist said targets and incentives were not set.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure 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 pharmacy was a large double unit with the medicines counter and dispensary positioned on one side. The dispensary was at the same level as the public retail area. There was a 'Queue this way' notice which directed members of the public waiting at the medicines counter. The pharmacy was clean and tidy and presented a professional image. The dispensary had bench space extending around two walls and a central double-sided island bench. The pharmacist checking area was on one side of the island bench. There was a large consultation room which was locked on the retail side when not in use but could be accessed by staff from the dispensary. Although the consultation room was a bit cluttered it protected patient privacy. Lavatory facilities were hygienic and handwashing equipment was provided. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable sources to protect people from harm. It knows what to do if any medicines or devices need to be returned to the suppliers. The pharmacy team members make sure that medicines are securely stored and at the correct temperature so that medicines are safe to use. They make sure that people have all the information they need so that they can use their medicines in the right way. The pharmacy team give advice to people about where they can get other support.

Inspector's evidence

There was wheelchair access via a wide power assisted door and large font labels could be printed to assist visually impaired people. Staff could converse in Arabic to assist people whose first language was not English. Patients were signposted to other local services including treatment for minor illnesses. Interventions were recorded in an intervention log or on the patient medication record (PMR). Emergency hormonal contraception (EHC) PGD was due to be updated so the service would become available.

The pharmacist described the procedure for supply of sodium valproate to people in the at-risk group and information on the pregnancy prevention programme (PPP) to be explained. An information card was always given to the patient. The intervention was recorded on the PMR. The pharmacist was aware of the procedure to supply isotretinoin to people in the at-risk group. The treatment had to be initiated by a consultant and would be supplied following a negative pregnancy test result. The patient would be counselled on PPP and the intervention recorded on the PMR. The prescriber was contacted regarding prescriptions for more than 30 days' supply of a CD as good practice. Interventions were recorded on the PMR showing checks that medicines were safe for people to take and appropriate counselling was provided to protect patient safety. When contacted about covert administration of medication, the pharmacist checked the doctor and family were aware. Checks were made with the National Pharmacy Association (NPA) on the suitability of medicines for covert administration or if an alternative was available.

The pharmacist said that when supplying warfarin people were asked for their record of INR along with blood test due dates. INR was recorded on the PMR. Advice was given about side effects of bruising and bleeding including internal bleeding. Advice was given about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were reminded about the weekly dose and when to take folic acid. Counselling was given on handling the tablets and people were advised to seek medical advice if they developed an unexplained fever. All CD prescriptions were highlighted, and CD warning stickers were used to alert staff when giving out prescriptions.

Audits had been conducted to identify people for referral for prescription of proton pump inhibitor for gastric protection during the non-steroidal anti-inflammatory drug (NSAID) audit. The audits regarding use of inhalers to treat asthma in children and adults had been conducted and both phases of the sodium valproate audit. Audits were planned for lithium, sodium valproate and monitoring diabetic patients regarding foot checks and retinopathy screening. Health promotions to increase public awareness in reducing taking antibiotics unnecessarily, winter health and Stoptober. To meet quality

payments criteria, staff had previously completed children's oral health and risk management training.

Medicines and medical devices were delivered outside the pharmacy. Prescriptions suitable for delivery were placed in a pink basket to be dispensed and the bag label was endorsed 'Delivery'. Patient signature and time of delivery was recorded, and a spare bag label was attached to the delivery record sheet indicating effective delivery. There were separate CD delivery sheets for CD deliveries.

Medicines and medical devices were obtained from Alliance, AAH, Phoenix and Day Lewis. Floor areas were mostly clear, and stock was neatly stored. Stock was date checked and recorded. 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 two medical fridges. Uncollected prescriptions were cleared from retrieval every four to six weeks after the patient had been contacted. CD prescriptions were highlighted with stickers to ensure they were not given out after the 28-day validity period. Waste medicines were stored separate from other stock. Falsified medicines directive (FMD) hardware and software was operational at the time of the visit but there was only one scanner. Drug alerts and recalls were actioned and annotated. There was quarantined stock of Emerade devices, paracetamol and ranitidine syrup in response to alerts.

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 appropriately to keep people's private information secure.

Inspector's evidence

Current reference sources included BNF, NPA and EMC to locate and print PILs. The dispensary sink was clean and there was a range of stamped glass measures to measure liquids including a separate marked measure for methadone. Minimum and maximum fridge temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinets were fixed with bolts. Three sharps bins for vaccination sharps disposal were positioned safely in the locked consultation room. There were in-date adrenaline ampoules, syringes and needles for use in the event of anaphylaxis. A blood pressure monitor was available to measure blood pressure. Confidential waste paper was shredded and there was a cordless phone to enable a private conversation. Staff used their own NHS cards. A mini poster 'Your data matters to the NHS' was displayed. 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.