General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Buzz Doctor Pharmacy, 229 Stratford Road, Shirley, SOLIHULL, West Midlands, B90 3AH

Pharmacy reference: 1038394

Type of pharmacy: Community

Date of inspection: 17/03/2022

Pharmacy context

This is a community pharmacy situated on a busy main road in Shirley town centre. It dispenses NHS and private prescriptions. And it sells a range of over-the-counter medicines. The pharmacy supplies medicines in multi-compartment compliance packs to some people who need assistance in managing their medicines at home. And it also offers a private prescribing service on-site for a range of conditions through a pharmacist independent prescriber (PIP). This was a targeted inspection undertaken during the Covid-19 pandemic following concerns raised which related to the pharmacy's prescribing services.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	There are some risks with the pharmacy's prescribing service that it does not always adequately identify and manage. For example, how people receiving medicines for long-term conditions are going to be appropriately monitored, and when people are prescribed medicines which can be misused or abused. The pharmacy also doesn't always have its written procedures available on the premises.
		1.2	Standard not met	The pharmacy doesn't adequately monitor the safety and quality of its prescribing services, for example by doing regular clinical audits.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The way the pharmacy advertises itself both from its premises and online has the potential to mislead people using the pharmacy that there is a medical doctor onsite. And its website does not contain all the required information.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy does not always provide its services safely, particularly its prescribing service. It does not routinely inform people's regular prescriber after they receive treatment for conditions which require ongoing monitoring, or for medicines which are liable to misuse or abuse. The pharmacy also assembles multi-compartment compliance packs before a prescription has been received, which increases the risk of mistakes happening.
		4.4	Standard not met	The pharmacy does not have a robust system to appropriately deal with safety alerts and recalls.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

There are risks with the pharmacy's prescribing service that it does not always adequately identify and manage. For example, how people receiving medicines for long-term conditions are going to be appropriately monitored, and when people are prescribed medicines which can be misused or abused. And its written procedures are not always available on the premises for staff to refer to. The pharmacy does not routinely monitor the safety and quality of its services, particularly its prescribing service. And it does not always record or review mistakes made during the dispensing process. This limits the pharmacy's ability to review incidents fully and opportunities to learn and improve processes may be missed. However, members of the pharmacy team keep people's private information securely and they have undertaken appropriate training to safeguard vulnerable people. The pharmacy generally keeps the records it needs to by law. But its records are not always easily accessible in the pharmacy.

Inspector's evidence

In addition to providing NHS dispensing services, the pharmacy offered a private walk-in consultation and prescribing services for a wide range of conditions. The prescribing services were provided by the superintendent pharmacist (SI) who was a pharmacist independent prescriber (PIP). The pharmacy started operating under the new ownership in March 2021.

The pharmacy had systems to report adverse events. But it was unable to produce records about dispensing and prescribing mistakes. The SI said that the team members were able to prioritise their workload adequately and did they did not have many dispensing mistakes to report. The volume of dispensing in the pharmacy was very low. And both she and the responsible pharmacist (RP) were able incorporate a mental break between labelling, dispensing, and checking prescriptions. A recent incident involving the incorrect hand-out of a medicine was discussed with the SI. The pharmacy's hand-out SOP had been updated as a result of the incident to ensure people's name and addresses were double checked. No records had been made of this incident, which may make it harder for the team to learn from it and make the pharmacy's services safer.

The pharmacy offered a prescribing service. But it did not undertake any audits in relation to its prescribing service. So, it could be harder for the pharmacy to show that the service is operating safely and effectively.

The pharmacy had indemnity insurance arrangements in place and the correct RP notice was displayed in the pharmacy. During the inspection, the pharmacy was not able to produce its RP records, standard operating procedures (SOPs) or risk assessments for its prescribing services. These were submitted after the inspection. The RP records were supplied in the form of a spreadsheet, which could make it harder to know if any changes had been made to it after the record has been made. And this could make it less easy for the pharmacy to rely on this document if there were any queries. The SOPs supplied following the inspection did not contain dates of when they were implemented, dates when they should be reviewed, or evidence that team members were familiar with them.

The pharmacy was unable to provide evidence during the inspection that it had completed a robust risk assessment to provide assurances that all the risks associated with the prescribing service had been identified and mitigated. The pharmacy's risk assessments did not take into consideration how long-

term conditions such as mental health, hypertension and diabetes would be monitored and reviewed. It did not consider the potential abuse of higher-risk medicines, including co-codamol 30/500 and zopiclone, antibiotic resistance and stewardship. Or prescribing audits to monitor and review the PIPs prescribing practice and routinely sharing prescribing information with a person's GP where consent has been given.

Following the inspection, the pharmacy provided a comprehensive set of policies and procedures in relation to their prescribing services. But the documents did not address aspects such as routinely sharing prescribing information with the person's GP, accessing people's summary care records (SCRs), or ensuring on-going monitoring of people supplied with medication for long-term conditions such as inhalers and anti-hypertensives. And they did not address identifying people at risk of medication abuse or misuse from opioid-based painkillers, 'Z drugs' and anti-depressants. Or de-prescribing and use of lifestyle interventions for people taking long-term opioids.

Records about controlled drugs (CDs) and private prescriptions were kept in line with requirements. Running balances of CDs were kept and audited at regular intervals. A random check of several CDs showed that the quantities of stock held in the cabinet matched the recorded balance in the register.

Confidential information was stored securely and prescriptions awaiting collected were stored appropriately. People's personal details were not visible to the public. Confidential waste was shredded on-site. The pharmacy's complaints procedure was provided after the inspection and members of the public could complain or provide feedback about the quality of services provided by the pharmacy by contacting the SI. The pharmacy's website did include the pharmacy's contact details, but it did not explain how people could make a complaint. The SI said that they had received many positive testimonials on the website about the pharmacy’s prescribing services. And further commented that there hadn’t been a single complaint received from people using the pharmacy’s services.

Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. And they had completed appropriate safeguarding training relevant to their roles and responsibilities. The SI had completed Level 3 safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to adequately manage its workload. Members of the pharmacy team have the appropriate skills and qualifications for their roles and responsibilities. And they undertake on-going training to help keep their skills and knowledge up to date.

Inspector's evidence

At the time of the visit, the SI, and the RP were on duty. No other staff members had been employed by the pharmacy. The team members were managing their workload adequately and worked well together. The SI was a PIP and she said that she had completed a PhD in cardiology and mental health. The SI provided a comprehensive professional development portfolio for training she had undertaken as a PIP. The portfolio did not always include the dates the training was completed, which could make it harder to provide assurances of how recently it had been completed. There were no targets or incentives set for the pharmacy services.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy advertises itself as a 'Doctor + Pharmacy All-in1', 'on-line doctor' and on its website as a 'private medical clinic'. Taken together, these have the potential to mislead people using the pharmacy or accessing its website into thinking that a medical doctor is available onsite. The pharmacy does not offer any supply of medicines or prescribing services online. So, the phrase 'on-line doctor' also has the potential to mislead people who use the pharmacy. The pharmacy's website does not display the name of the superintendent pharmacist, the registration number of the pharmacy, or how people can check these details. Or, how people using the pharmacy can give feedback or raise any concerns. Otherwise however, the premises are clean and suitably maintained for the provision of healthcare. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was in an adequate state of repair. It was clean and tidy. There was appropriate lighting throughout the premises and the room temperature was suitable for storing medicines. The dispensary was of an adequate size for the volume of dispensing undertaken. The sink for preparing liquid medicines was clean and there was a supply of hot and cold running water. The pharmacy stocked a range of healthcare products and pharmacy-only medicines couldn't be self-selected.

The signage in the pharmacy's window and the pharmacy's practice leaflet advertised 'Doctor + 'Pharmacy All-in1' and 'on-line doctor'. And the pharmacy's website detailed a 'private medical clinic'. Taken together, these could potentially mislead members of the public into thinking a medical doctor was available on-site and potentially on-line. The pharmacy's prescribing services were solely managed by a PIP without any medical doctor's involvement. And the SI confirmed that the pharmacy did not supply medicines or offer any prescribing services on-line and all consultations were done face to face. Prior to the inspection, the GPhC had received several concerns from people who felt that the way the pharmacy advertised itself was misleading and could lead people to believe that a medical doctor was onsite. The pharmacy's website did not display the name of the superintendent or their registration number, which could make it harder for people to know these details.

The pharmacy’s consultation room was fitted to a very good standard. It was signposted and private. The room was clean, well-equipped and tidy. The pharmacy premises were secured against unauthorised access.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy does not always provide its services safely, particularly its prescribing service. It does not ensure that people who are prescribed a treatment for conditions which require ongoing monitoring are receiving the appropriate monitoring. And it does not routinely contact people's regular prescriber about treatment the pharmacy has provided. It supplies some medicines which are liable to abuse or misuse on a long-term basis, and it does not proactively contact those people's regular prescriber such as their GP. Taken together this means that people's medical condition might not be properly monitored, or that their use of medication may not be appropriately controlled. The pharmacy assembles multi-compartment compliance packs in advance of a prescription, which increases the risk of a dispensing mistake happening. The pharmacy does not have a robust system for dealing with drug alerts or recalls. So, there is a risk that people get medicines or medical devices that not safe to use. However, the pharmacy otherwise gets its medicines from licensed wholesalers and it generally stores them safely.

Inspector's evidence

The pharmacy's services were accessible to a range of people, including people with mobility difficulties and wheelchair users. Members of the pharmacy team used their local knowledge to signpost people to other providers if a service required was not offered at the pharmacy. The pharmacy's private and NHS services were advertised throughout the premises and stated in the pharmacy's practice leaflet.

People accessed the pharmacy's private consultation and prescribing services by walking into the pharmacy or by booking an appointment with the PIP (who was also the SI). The majority of appointments were made via a telephone call to the pharmacy and these were managed by the RP. The PIP prescribed, and the pharmacy supplied a wide range of prescription-only medicines (POMs), including for conditions such as chest infections, asthma and chronic obstructive pulmonary disease, tonsillitis, ear infection, urine infection, sleeping problems anxiety and depression, gastric problems pain, arthritis, and joint symptoms. The most commonly prescribed medicines were anti-bacterials. The SI said that she followed Birmingham and Solihull Area Prescribing Committee formulary (APC) and Birmingham CCG antibiotics guidelines. The clinical advisor signposted the PIP to a recent article in Regulate about antimicrobial stewardship. The SI has subsequently provided a certificate pledging to be an antibiotic guardian.

The pharmacy did not routinely contact people's regular prescribers, such as their GPs, when prescribing medicines for long-term conditions or conditions which required on-going monitoring. And the pharmacy did not routinely access people's previous prescribing history from other prescribers, such as their Summary Care Records (SCRs). Taken together, these made it harder for the pharmacy to know if medicines were always being prescribed appropriately or if the person was receiving the appropriate on-going monitoring.

From the prescribing records seen, a few people were prescribed opioid-based painkillers. It was noted that several patients had received regular supplies of co-codamol 30/500. A person had received a supply of 50 co-codamol 30/500 at least 10 times. And another person who had reported suffering previously with opioid dependence many years ago had been supplied with 50 co-codamol 30/500 at least nine times. The consultation notes for the above patients were sent after the inspection. And

their GPs had not been informed of the supplies.

Records of any regular audits including records of decisions to make or refuse a sale or supply of a medicine subject to abuse or misuse could not be produced. The SI was signposted to GPhC guidance about monitoring the sale and supply of medicines subject to abuse or misuse. The SI confirmed that she had changed her consultation form to ensure that consent is obtained to access people's SCRs and inform the person's GP about the supply of medicines.

The SI said the people accessing treatments for mental health such as anti-depressants were supported by her prescribing on-going treatments. And the Birmingham APC and Mental Health Assessments were used to assess people. The SI said that she did not instigate any new mental health treatments but supported the person with continued treatment. But there was no evidence to show that the person's SCR had been accessed or their GP had been contacted to inform them of the supplies. People with long-term conditions were not referred for annual reviews. The onus was left on the person to inform their GP.

The pharmacy delivered some medicines dispensed against NHS prescriptions to people in their own homes. The deliveries were undertaken by the RP and the SI and due to the pandemic, signatures were not obtained from recipients to help reduce the spread of infection. A record of all deliveries was kept in the pharmacy to provide an audit trail.

Multi-compartment compliance packs seen were not labelled with a description inside, which would have helped people and their carers identify the medication. And they had been assembled before the prescriptions had been received by the pharmacy. This could increase the chances of mistakes happening. The RP said that the packs were routinely checked against the prescriptions for any anomalies or changes in the medication before a supply was made. Patient information leaflets were not always supplied, and the RP said that this would be done in the future.

Members of the pharmacy team were aware of the valproate Pregnancy Prevention Programme and additional counselling to be given to people in the at-risk group. The valproate information leaflets, and patient cards were available to ensure any new at-risk people prescribed valproate were given the appropriate information.

The pharmacy ordered its stock medicines from licensed wholesalers. Stock medicines were date checked at regular intervals and short-dated medicines were marked for removal at an appropriate time. Stock medicines were randomly checked during the inspection and no date-expired medicines were found in amongst the stock.

Medicines requiring cold storage were kept in a refrigerator and these were stored between 2 and 8 degrees Celsius. The maximum and minimum temperatures were recorded daily, and records showed that the temperatures had been maintained within the required range. All CDs were stored in line with requirements.

The pharmacy had not actioned any safety alerts or medicine recalls notices since it started operating under its new ownership in March 2021. The SI said that she had registered with the MHRA and NHS. But the pharmacy had not received any emails and consequently, no action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. And it maintains these appropriately.

Inspector's evidence

Members of the pharmacy team had access to reference sources including a British National Formulary and internet access. The pharmacy's diagnostic equipment such as stethoscope, thermometer, pulse oximeter, weighing scales and blood measure monitor were in good working order. The examination bed in the consultation room was clean. All other electrical equipment appeared to be in good working order. Computer systems were password protected and no confidential information was visible from the public area of the pharmacy.

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.