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: 23/01/2023

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).

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

Overall, the pharmacy has safe and effective working practices. It has written procedures and appropriate risk assessments to help deliver its dispensing and prescribing services safely. And it keeps the records it needs to, to show that medicines are supplied safely and legally to people. Members of the pharmacy team record and review their mistakes so that they can learn and improve from these events. The pharmacy keeps people's private information securely and its team members know how to protect vulnerable people.

Inspector's evidence

The pharmacy had made significant progress since the last inspection. The pharmacy had a comprehensive range of in-date standard operating procedures, and these had been read and signed by team members.

In addition to providing NHS dispensing services, the pharmacy offered a private walk-in consultation and prescribing service for a wide range of conditions including ear microsuction, steroid joint injections, supply of inhalers for asthma and chronic pulmonary obstructive disease (COPD) flare ups, infections such as urinary tract infections, chest, ear and throat infections and skin conditions such as eczema. The pharmacy also provided a very small number of private prescriptions for weight loss, hay fever, erectile dysfunction, anti-virals and migraine. The prescribing service was provided by the superintendent pharmacist (SI) who was a pharmacist independent prescriber (PIP).

The risk assessments for the prescribing service seen were adequate and took into consideration a description of the activity, and controls and safeguards in place. There were also inclusion and exclusion criteria, stop gap limits and clear actions to take when possible complications arose. Risk assessments had taken into consideration the need for people to provide consent for the pharmacy to contact their regular prescribers. If consent to contact a person's regular prescriber was not provided, the PIP would refuse to carry out an assessment of the person. A number of records were viewed during the inspection, and these showed that comprehensive consultations were being done and that discussions with patients were well documented. Furthermore, evidence was seen that the pharmacy was sharing relevant information with the person's regular prescriber.

The risk assessment covered prescribing for long term conditions and higher-risk medicines such as 'z drugs'. The pharmacy had clear criteria that the PIP would not prescribe treatments where blood monitoring was needed. Furthermore, for additional safeguards, the risk assessments had stop gaps. This was to ensure that people were not over-ordering medicines and inappropriate quantities were not being supplied to people. The pharmacy had reduced the number of medicines they would supply over a defined period through the private prescribing service. For example, the supply of Ventolin was limited to four inhalers a year. The responsible pharmacist (RP) involved in dispensing prescriptions generated from the prescribing service would intervene if they noticed issues and would flag these to the PIP to prevent an inappropriate supply.

Prescribing was done in line with national guidelines and evidence-based prescribing. The PIP mainly followed Birmingham and Solihull's local formulary for antibiotic prescribing. The PIP undertook a chest examination and used validated tools to check if a person's asthma was controlled, such as an 'asthma

control test'. This was to check if it was appropriate to supply the treatment.

The PIP's specialist area was in mental health. Before prescribing 'z-drugs' the PIP completed a thorough mental health assessment first. In practice, 'z-drugs' were prescribed very infrequently. A sample record viewed showed that the patient assessment was comprehensive. And the consultation notes took into consideration the risk associated with these medicines before a prescribing decision was made.

The pharmacy conducted six-monthly prescribing audits to check if the pharmacy's prescribing service was safe, effective, and justified. The audits were reviewed by a medical doctor, who was also the PIP's mentor. A sample of the consultations was also checked by the RP. In the most recent audit, the mentor and the RP had no issues to report about the PIP's prescribing.

The pharmacy had a system to report dispensing mistakes. Mistakes which were identified before the medicine was handed out to a person (near misses) were routinely recorded and reviewed. A report about near misses was generated and discussed with the SI to share any learnings. Dispensing mistakes that had reached people (dispensing errors) were recorded and reviewed by the SI. The RP said that the dispensing workload in the pharmacy was very manageable, and the pharmacist was able to incorporate a mental break between labelling, dispensing and checking prescriptions. They further commented that there hadn't been any dispensing mistakes to report since the last inspection.

The pharmacy had current indemnity insurance which covered the prescribing service. Records about the RP, controlled drugs (CDs), unlicensed medicines, consultations, treatment plans and private prescriptions were kept in line with requirements. A random balance check of a CD was correct. Running balances of CDs were kept and audited at regular intervals. A separate register was used to record patient-returned CDs. The correct RP notice was on display.

The pharmacy had a complaints procedure and the RP said that there had been some very positive testimonials about the pharmacy's prescribing service on the website. And they hadn't received a single complaint about the service offered by the pharmacy. The website included the pharmacy's contact details and explained how people could make a complaint.

Access to patient medication records (PMR) was password protected and confidential waste was managed appropriately. People's private information was stored securely and prescriptions awaiting collection were stored appropriately. No person-identifiable information was visible to members of the public. The pharmacists used their own NHS smartcards to access electronic prescriptions.

The pharmacists knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. The RP had completed level 2 safeguarding training and the SI had completed level 3 safeguarding training. The PIP did not prescribe weight-loss medicines or z-drugs for anyone under the age of 18; this was also clearly set out in the individual risk assessments. The Summary Care Record (SCR) was checked routinely to make sure a person was not receiving treatment for mental health conditions, to safeguard more vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. The pharmacists work well together, and are supportive of each other. They have the right skills and qualifications to deliver the services they offer effectively. And they have access to training resources and peer support 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 two pharmacists were managing their workload comfortably and they worked well together.

The SI provided a comprehensive professional development portfolio for training she had undertaken as a PIP. She had a competency framework which she regularly updated and she completed continuous professional development (CPD).

The PIP demonstrated years of experience of working in general practice, urgent care, and hospital with the appropriate training to back it up. She had completed training in minor illness, administering joint injections and microsuction procedures. In addition to that, the PIP had completed a PhD in cardiology and mental health. The PIP had access to various clinicians for advice and had a medical doctor mentor who regularly reviewed her prescribing patterns. A testimonial from the mentor to verify the PIP's competencies was seen. This covered the various services offered by the PIP and the mentor raised no concerns about these in the feedback given. The PIP had training in basic life support in the event of complications resulting from higher-risk procedures such as joint injections.

The RP completed annual mandatory CPD to remain on the register and had completed various training courses including weight management, urinary tract infections, chest examination and ear infections. There were no targets or incentives set for the pharmacy's services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are secure, clean, and tidy. And they are professional in appearance and suitable for the provision of healthcare services.

Inspector's evidence

The pharmacy was in an adequate state of repair. It was clean and tidy. There was suitable lighting throughout the premises and the room temperatures were 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's website was currently under maintenance and it was not accessible. However, the pharmacy did not supply medicines or offer any prescribing services on-line. And all consultations were done face to face.

The pharmacy’s private consultation room was signposted and fitted to a very good standard. The room was clean, well-equipped, and tidy. There were suitable infection control arrangements and the equipment was cleaned by the PIP between each patient. The premises were secured against unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its prescribing service and other pharmacy services well to ensure people get appropriate care and support to manage their medicines safely. People with different needs can access the pharmacy's services. The pharmacy gets its medicines from licensed wholesalers and stores them correctly. And members of the pharmacy team take the right action in response to safety alerts and recalls so that people get medicines and medical devices that are safe to use. Advertising information about the prescribing service could be clearer so that people understand that the service is provided by a non-medical prescriber.

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 healthcare providers where appropriate.

The pharmacy offered a medicine delivery service mainly to housebound and vulnerable people. The deliveries were mainly undertaken by the RP or PIP outside of pharmacy opening hours. And records for all deliveries were kept in the pharmacy to provide an audit trail.

The pharmacy's opening hours and the services it offered were advertised in-store. The pharmacy's prescribing service was advertised to people via posters and on social media. The information presented could have been clearer about who was prescribing medicines or this service. i.e., that it was a non-medical prescriber so as not to cause confusion for people using this service.

People accessed the pharmacy's private consultation and prescribing service by walking into the pharmacy or by booking an appointment with the PIP. Most appointments were made via a telephone call to the pharmacy and these were managed by the RP. The pharmacy did not have any formal contingency plans for the prescribing service, in the event of the PIP's unplanned absence. The RP said that people would either be signposted to their own GP or the appointment would be re-scheduled.

Once registered, a check was made to confirm the identity of the person accessing the prescribing service. The pharmacy would check a physical copy of the passport or driving license. If the person's identity could not be confirmed, the PIP would not undertake the consultation and the person was signposted to their regular prescriber. People also had to consent for information about the consultation to be shared with their GP and for their SCR to be accessed. If people did not consent to these steps, the PIP would not undertake the consultation.

All consultations for the prescribing service were undertaken physically at the pharmacy. The PIP had a generic template for recording consultations. This included documenting a person's past medical history, social history, and any medicines they were taking. The PIP would, as part of the consultation process, check the person's SCR to make sure it was safe and appropriate to prescribe any medicines. The PIP also documented any findings from physical examinations and observations such as blood pressure. They documented any red flags ruled out and safety-netting advice given. The PIP documented what they prescribed and sent details about the medicines prescribed and indications for

the treatment to the person's regular prescriber.

When records were checked during the inspection, there was a clear audit trail for who wrote the prescriptions. And the consultation records checked showed that the PIP had conducted appropriate assessments, and had ruled out any red flags. Safety-netting and counselling advice were also clearly documented.

The PIP prescribed and the pharmacy supplied a range of prescription-only medicines (POMS), including for conditions such as chest infections, asthma and chronic obstructive pulmonary disease flare ups, tonsillitis, ear infection, urine infection, gastric problems, sleeping problems, arthritis and joint pain. The most prescribed medicines were antibiotics. The SI said that she followed Birmingham and Solihull Area Prescribing Committee formulary (APC) S Birmingham CCG antibiotics guidelines. The PIP had completed training in antimicrobial stewardship. And she was able to provide evidence where antibiotics were not prescribed as they were deemed inappropriate.

Where the PIP undertook procedures such as joint injections or microsuction, the pharmacy had emergency equipment including a defibrillator to deal with any potential complications. The person's weight was checked and an in-depth counselling was provided when weight loss medication was issued. Medicines that were liable to misuse were flagged to the person's GP to make them aware.

The RP could access the consultation notes if he had any queries when dispensing prescriptions generated from the prescribing service. Furthermore, the RP could check if the person had regular supplies of medicines and would flag up to the PIP if he had any concerns about this.

Multi-compartment compliance packs seen during the inspection were labelled with a description inside to help people or their carers identify individual medicines correctly. The RP said that patient information leaflets (PILS) were routinely supplied.

The pharmacists were aware of the risks involved in supplying valproate-containing medicines to people in the at-risk group. The pharmacy's stock packs seen on the shelves had warning cards and alert stickers attached. The pharmacy had additional information leaflets and patient cards available to supply to people when dispensing smaller quantities.

The pharmacy ordered its stock medicines from licensed wholesalers, and these were stored tidily on the shelves. No extemporaneous dispensing was carried out. The pharmacy stocked a range of healthcare products and pharmacy-only medicines were restricted from self-selection. Stock medicines were dated checked and short-dated medicines were marked for removal at an appropriate time. Medicines were randomly checked during the inspection and no date-expired medicines were found amongst the in-date stock.

Temperature-sensitive medicines were stored appropriately, and the maximum and minimum temperatures of the fridges were recorded daily. The records showed that the temperatures had been maintained within the required range of 2 and 8 degrees Celsius.

All CDs were stored appropriately in the CD cabinet. Access to the CD keys was managed appropriately. The pharmacy had denaturing kits to dispose of waste CDs safely. The pharmacists knew that prescriptions for CDs not requiring secure storage such as tramadol, had a 28-day validity period.

The pharmacy had a process to deal with safety alerts and medicines recalls making sure the medicines it supplied to people were fit for purpose. Records about these and the action taken by the pharmacists were kept, providing an audit trail.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And its team members use the equipment in a way that protects people's privacy and dignity.

Inspector's evidence

Members of the pharmacy team had access to up-to-date reference sources. The PIP had access to various clinical resources and clinicians to help with prescribing decisions. There was a range of clean crown-stamped measures and equipment for counting loose tablets and capsules was clean. And a separate triangle was used for cytotoxic medicines. Medicine containers were capped to prevent cross-contamination. The pharmacy's computers were password protected and computer terminals were not visible to people visiting the pharmacy. Hand-sanitising gels were available at the medicines counter and in the dispensary. All electrical equipment appeared to be in good working order.

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.