General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Shaunak's Pharmacy, 7 Flaxpitts Lane, Winterbourne, BRISTOL, Avon, BS36 1JY

Pharmacy reference: 1028745

Type of pharmacy: Community

Date of inspection: 21/09/2020

Pharmacy context

This is a community pharmacy in a shopping area in the village of Winterbourne to the north of the city of Bristol. Most people who use the pharmacy are elderly. The pharmacy team members dispense prescriptions, sell over-the-counter medicines and give advice. They also supply several medicines in multi-compartment compliance packs to help vulnerable people in their own homes to take their medicines. The pharmacy offers the New Medicine Service (NMS), the Community Pharmacy Consultation Service (CPCS) and seasonal flu vaccinations. The inspection was carried out during the COVID-19 pandemic.

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

The pharmacy's working practices are safe and effective. It has made some changes to its written procedures as a result of COVID-19. And, physical measures are in place to reduce the risk of transmission of coronavirus. The pharmacy team members learn from mistakes to prevent them from happening again. The pharmacy is appropriately insured to protect people if things go wrong. It keeps the required records. The pharmacy team members keep people's private information safe and they know how to protect vulnerable people.

Inspector's evidence

The pharmacy team members identified and managed the risks associated with providing its services. They had put some physical changes in place, as a result of the COVID-19 pandemic, to reduce the risk of transmission of coronavirus (see under principle 5). The pharmacist, the manager, had herself updated some of the pharmacy's standard operating procedures (SOPs) with changes relating to the pandemic. But the company as a whole had not updated its business continuity plan to accommodate any potential issues relating to the current NHS 'test and trace' scheme. The superintendent gave assurances that this would be done as a matter of urgency. He will put procedures in place to ensure that there was no disruption in the supply of medicines to people if any pharmacy in the group had to close as a result of the 'test and trace' scheme. The manager had conducted risk assessments of the premises and occupational risk assessments of all the staff. The team members were asked about any potentially vulnerable people in their households. The pharmacy team members were aware that they needed to report any COVID-19 positive test results.

The pharmacy team members recorded near miss mistakes, that is, mistakes that were detected before they had left the premises. They documented learning points to prevent future recurrences. The pharmacist had made information posters, such as one showing all the different calcium products. These were displayed in the dispensary. The dispensary team reviewed and discussed the near miss log each month. As a result of the review in August 2020, where most mistakes were the wrong drug, all the dispensary shelves had been tidied and different strengths of the same medicine had been clearly separated.

The dispensary was tidy and organised. There were dedicated working areas, including a taped-off checking area. The dispensary team members placed the prescriptions and their accompanying medicines into baskets to reduce the risk of mistakes. The pharmacist only had one basket at a time in the checking area and this too reduced the risk of mistakes. The team used different coloured baskets for different types of prescriptions and this allowed the pharmacist to prioritise her workload.

All the staff were clear about their roles and responsibilities. A medicine counter assistant said that she would refer any person who was on prescribed medicines but, requested a cough medicine, to the pharmacist. The pre-registration student knew that codeine-containing medicines should only be sold to people for three days use.

The pharmacy team were clear about their complaints procedure. The company's policy was displayed. And there was a dedicated 'posting box' where people could 'post' their feedback comments. The

pharmacy had received many ‘thank you’ cards praising its dedication and hard work since the outbreak of the COVID-19 pandemic.

The pharmacy had current public liability and indemnity insurance provided by the National Pharmacy Association (NPA). It kept the required up-to-date records: the responsible pharmacist (RP) log, controlled drug (CD) records, private prescription records, emergency supply records and specials records. The pharmacy did many emergency supplies. The pharmacist said that this was because people could not get through to the local surgery on the phone. Or, if they went to the surgery because they were going to run out of their medicines, the surgery staff told them to go to the pharmacy. The pharmacy also had fridge temperature records, date checking records, patient-returned CD records and cleaning rotas.

All the staff understood the importance of keeping people’s private information safe. They stored all confidential information securely. The computers, which were not visible to the customers, were password protected. The correct NHS smartcards were seen in the appropriate computers. The pharmacy team members shredded all confidential wastepaper. The pharmacy was not using its consultation room. The room used prior to the pandemic was also the staff kitchen. It was located behind the dispensary. The pharmacist was concerned about people walking through the dispensary in the current situation.

The pharmacy team understood safeguarding issues. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. The pharmacy had local telephone numbers to escalate any concerns relating to both children and adults. The pharmacist was aware of the national ‘safe space’ initiative for victims of domestic abuse. She had not signed the pharmacy up to provide this service because her consultation area was not suitable. The pharmacist would however support anyone, as best as she could, given the constraints of the premises.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage their workload safely. And the company provides some additional help when people are sick or on holiday. The pharmacy team members are encouraged to keep their skills and knowledge up to date. They work well together and are comfortable about providing feedback to their manager to improve their services and this is acted on.

Inspector's evidence

The pharmacy's current staffing profile was: one pharmacist, one pre-registration student, one full-time NVQ2 qualified dispenser (not seen – on holiday), two part-time medicine counter assistants (MCAs) and one full-time delivery driver. A relief dispenser was covering some of the hours of the full-time dispenser who was on holiday. She had family commitments and so could not cover all the hours. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time. The company had some provision to cover any unplanned absences. The manager had a staffing rota to ensure appropriate staffing levels.

The staff worked well together as a team. The manager monitored the performance of the team members. They had an annual appraisal where any learning needs could be identified. Review dates would be set to achieve this. The team members had monthly staff meetings and written notes were taken. All the staff felt able to raise any issues or concerns with their manager and that these would be acted on. At the beginning of the pandemic, the team members were concerned about people in the pharmacy who were stopping to browse. Because of this, they had re-located the stock from one gondola and introduced a clear one-way flow of people. This meant that people were able to remain two metres from each other and hence reduced the risk of transmission of coronavirus.

The staff were encouraged with learning and development. They did regular e-learning such as recently on flu. Most of this learning was done in work time. The team members were also told about any updates regarding COVID-19. All the dispensary staff reported that they were supported to learn from errors. The pre-registration student was newly appointed. He had attended a 'zoom' meeting with other students employed by the company. The manager had yet to formally set out his allocated learning time but she planned to do this soon. The pharmacist documented all her learning on her continuing professional development (CPD) records.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional and is suitable for the services it offers. It is clean, tidy and organised. The premises are thoroughly cleaned to reduce the likelihood of transmission of coronavirus. And the pharmacy team members use alcohol gel after each interaction with people. This also reduces the risk of transmission of the disease.

Inspector's evidence

The premises presented a professional image. The retail area of the pharmacy was spacious and well organised. The dispensary was also spacious. It was tidy and organised. The dispensing benches were uncluttered and the floors were clear. The premises was clean. As a result of COVID-19, the premises was cleaned twice a day. The manager had updated the pharmacy's cleaning rota to accommodate this. The team members used alcohol gel after each interaction with people.

The consultation room doubled as the staff kitchen. As mentioned in principle 1, the manager had decided that it was not appropriate to use this area for consultations at present. She had created a 'screened-off' area for flu vaccinations as permitted under this year's flu service specification. The telephone was cordless and the staff took all sensitive calls out of earshot. The temperature in the pharmacy was below 25 degrees Celsius and it was well lit.

Principle 4 - Services ✔ Standards met

Summary findings

People can access the services the pharmacy offers. It manages its services effectively to make sure that they are delivered safely. The pharmacy has adapted its premises so it can safely deliver the 2020 flu vaccine during the COVID-19 pandemic. The pharmacy team members make sure that people have the information they need to use their medicines properly. The pharmacy gets its medicines from appropriate sources and stores them safely. The pharmacy makes sure that people only get medicines or devices that are safe.

Inspector's evidence

People could access the pharmacy. The consultation room was not currently being used. The pharmacy team members could access an electronic translation application for any non-English speakers. The team members could print large labels for sight-impaired people.

The pharmacy was located in the village of Winterbourne to the north of the city of Bristol. Most of its prescriptions were electronically transferred from the local surgery and most were for local residents. The pharmacy had experienced some difficulties with the surgery. The manager had tried to resolve these issues and had set up a meeting in July 2020 to discuss the problems. The pharmacy still experienced some delays with notifications of medicine changes, particularly for people who had their medicines in multi-compartment compliance packs. The inspector suggested to the manager that she enlist the help of someone from Avon Local Pharmaceutical Committee to resolve the outstanding problems.

In addition to the essential NHS services, the pharmacy offered some additional services, the New Medicine Service (NMS), the Community Pharmacy Consultation Service (CPCS) and the flu vaccination service (NHS and private). As mentioned previously, the consultation room was unsuitable to be used, in the current climate, for vaccinations. The manager had created a clearly screened off area at the front of the premises where she administered the vaccine. The people receiving the vaccination filled in the assessment form at the time of the vaccination. The inspector told the pharmacist about 'PreConsult' and the use of a QR code (a two-dimensional version of a barcode made up of black and white pixel patterns) to pre-populate the form. PreConsult had been funded by the NHS in the south-west. Everyone who received the vaccine wore a face covering and the pharmacist wore a type 2R fluid resistant mask and gloves. Her eyes were protected by glasses. She used alcohol gel or washed her hands before and after the vaccination.

The pharmacy had no substance misuse clients who usually had their medicines supervised. It did have several domiciliary people who had their medicines in compliance packs. The staff kept dedicated folders for these people where they recorded any changes in dose or other issues. The pharmacist referred to these when doing the final accuracy check. The dispensary team assembled the compliance packs on a separate dedicated bench. The assembled packs were stored tidily. The pharmacist said that most of the people who had their medicines in compliance packs were vulnerable and would not cope with their medicines in original packs. She had however identified a few suitable people who now received their medicines this way.

The dispensary team members initialled the ‘dispensed by’ and ‘checked by’ boxes on the labels, so providing a clear audit trail of the dispensing process. They also highlighted any prescriptions containing potential drug interactions, changes in dose or new drugs to the pharmacist. The pharmacist routinely counselled people prescribed high-risk drugs such as warfarin and lithium and also those prescribed antibiotics, new medicines and complex doses. All pharmacy team members were aware of the pregnancy protection programme regarding sodium valproate. The pharmacy currently had no ‘at risk’ patients who were prescribed sodium valproate.

The pharmacy delivered medicines to many people. The number of deliveries had increased at the beginning of the pandemic and still remained high. Because of the pandemic, the delivery driver did not currently ask people to sign for their medicines to indicate that they had received them safely. He knocked or rang the doorbell and left the medicines on the doorstep. The driver retreated and waited until the medicines had been taken safely inside. The driver annotated the delivery sheets accordingly.

The pharmacy got its medicines from Alliance Healthcare, AAH, Phoenix, Lexon and Shaunaks head Office. The pharmacy had a scanner to check for falsified medicines as required by the Falsified Medicines Directive (FMD) but this was not being used. It stored its CDs tidily in accordance with the regulations and access to the cabinet was appropriate. The pharmacy had no out-of-date or patient-returned CDs. Appropriate CD destruction kits were on the premises. The pharmacy stored its fridge lines correctly and it had date checking procedures. The pharmacy team members were accepting patient-returned medicines. The pharmacist had updated the pharmacy’s written procedures for accepting patient-returned medicines during the pandemic. Patient-returned medicines were now double bagged. The staff member who accepted the returned medicines wore gloves and washed their hands after disposing of the medicines into a dedicated waste bag. The team members placed any medicines, considered hazardous for waste purposes, into a separate dedicated waste bin.

The pharmacy had procedures for dealing with concerns about medicines and medical devices. The pharmacy received drug alerts electronically. They were printed off and the stock was checked. The pharmacy had received a recent alert regarding some zopiclone 3.75 mg tablets having the incorrect patient information leaflets. The pharmacy had four packets of the affected tablets in stock. The staff printed off the correct leaflets and replaced the incorrect ones.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides. And, the team members make sure that they are clean and fit-for-purpose. The pharmacy has taken action to reduce the spread of coronavirus with changes to its flow of customers and the use of protective screens and equipment. But the protective screens could be longer to provide better protection both to the people visiting the pharmacy and to the pharmacy team members.

Inspector's evidence

As a result of the COVID-19 pandemic, the manager had done a risk assessment of the premises. Because of this, the pharmacy had created a clear one-way flow of people. The pharmacy had clear arrows, indicating the flow of people and foot marks, indicating where people should stand. Perspex screens had been erected across some of the medicine counter. There was however a large gap in the middle. Most people visiting the pharmacy were seen to be standing at this gap. This gap may increase the risk of transmission of the disease. The medicine counter staff wore face shields. The dispensary staff wore Type 2R fluid resistant face masks.

The pharmacy used British Standard crown-stamped conical and ISO marked straight measures. There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. The pharmacy had up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children’s BNF. The staff could access to the internet.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and the staff took any sensitive calls out of earshot. The pharmacy team members shredded all confidential waste information.

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.