General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Vantage Pharmacy, Hanham Surgery, Whittucks Road, Hanham, BRISTOL, Avon, BS15 3HY

Pharmacy reference: 1074456

Type of pharmacy: Community

Date of inspection: 04/03/2020

Pharmacy context

This is a busy community pharmacy inter-connected with a doctors' surgery in the south-eastern suburbs of the city of Bristol. A wide variety of people use the pharmacy. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy also supplies several medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines. And it supplies some medicines to the residents of local care homes.

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	1.1	Good practice	The team members learn and act on mistakes to prevent them from happening again.
2. Staff	Standards met	2.2	Good practice	The team members are encouraged to develop and keep their skills up to date and they are given time to do this. Those team members who are in training are well supported by the pharmacists.
		2.5	Good practice	The pharmacy team members are actively encouraged to provide feedback to improve services which is acted on.
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 generally safe and effective. The team members learn and act on mistakes to prevent them from happening again. The pharmacy asks people for their feedback and it uses this to improve services. It is appropriately insured to protect people if things go wrong. The team members keep the up-to-date records that they must by law and they know how to protect vulnerable people. But, some of the pharmacy's written procedures are not up to date. So, the team members may not be working according to current good practice guidelines.

Inspector's evidence

The pharmacy team identified and managed most risks. All dispensing errors and incidents were recorded, reviewed and appropriately managed. There had been a recent error involving eplereone 25mg and exemestane 25mg. A prominent alert had been placed on the patient's electronic prescription medication record about the error. The two medicines has also been clearly separated and alert labels had been placed on the shelf edges where they were stored. In addition, the staff had all discussed this potentially serious 'look alike, sound alike' (LASA) error. Near misses were recorded. Learning points were documented and actions were taken to reduce the likelihood of similar recurrences, such as putting amiodarone on the top shelf in the dispensary. Sildenafil had been placed in a clearly labelled separate basket to reduce picking errors with this. The near miss log was reviewed and discussed each month. Agreed actions were recorded and all the staff signed these. In January 2020, the staff had discussed potential patient safety issues if wrong strengths were given, such as with digoxin, which has a low therapeutic index.

The dispensary was organised with labelling, assembly, waiting to be checked and checking areas. Baskets were used but different colours were not used to distinguish different types of prescriptions. This meant that the pharmacist could not easily prioritise the workload. There was a clear audit trail of the dispensing process and all the 'dispensed by' and 'checked by' boxes on the labels examined had been initialled.

The pharmacy had signed standard operating procedures (SOPs), but they were generic in nature and several were overdue a review. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. The company's sales protocol was displayed and included questions to be asked of customers requesting to buy medicines and when customers should be referred to the pharmacist, such as specific patient groups and those requesting multiple sales. This was signed and dated and included local additions such as Daktarin Oral Gel. A NVQ2 trained dispenser said that she would refer medicine sale requests for children under two, customers who were pregnant or those who were also taking prescribed medicines, to the pharmacist. She knew that fluconazole capsules should not be sold to women over the age of 60 for the treatment of vaginal thrush.

The staff were clear about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. In the 2019 survey, over 96% of people who completed the questionnaire were satisfied with the service at the pharmacy. There had been some feedback about having medicines in stock. The pharmacist said that this was due to ongoing manufacturer supply issues. The pharmacy had a good relationship with the adjacent surgery. They liaised with surgery to get prescriptions altered to appropriate medicines that were available.

Public liability and professional indemnity insurance provided by the National Pharmacy Association and valid until 20 April 2020, was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order.

An information governance procedure was in place and the staff had also completed training on the general data protection regulations. The pharmacy computers, which were not visible to the customers, were password protected. At the time of the visit, not all confidential information was stored securely. The room had Digi-pad access but this was not working. The door was seen to be left open. The Digi-pad was repaired during the visit. The pharmacist gave assurance that all the confidential information would be moved from the consultation room to an adjacent area that had a lockable door. Confidential waste paper information was shredded. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues. The pharmacists had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available to escalate any concerns relating to both children and adults. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. And, the team members are able to cover anyone who is sick or on holiday. The team members are encouraged to develop and keep their skills up to date and they are given time to do this. Those team members who are in training are well supported by the pharmacists. The team members are actively encouraged to provide feedback to their managers to improve services which is acted on.

Inspector's evidence

The pharmacy was inter-connected with a doctors' surgery. It was busy and they mainly dispensed NHS prescriptions. Several domiciliary patients received their medicines in multi-compartment compliance aids but plans were in place to reduce these. The pharmacy also supplied medicines to the residents of a couple of local care homes.

The current staffing profile was: two part-time pharmacists (job-share managers), one pre-registration student (not seen), two full-time NVQ2 qualified dispensers (one of whom was a NVQ3 trainee technician and the other, an accuracy checking dispenser), one full-time NVQ2 trainee dispenser (recently employed), three part-time NVQ2 qualified dispensers and one part-time medicine counter assistant. Two pharmacists worked one day each week. This had been reduced from two pharmacists on two days each week, about four weeks ago. This was said to be a trial and the staff said that they were not behind with their workload as a result of the change.

The part-time staff were flexible and generally covered any unplanned absences. One part-time staff member mainly worked on the medicine counter but she was a qualified dispenser. On the day of the visit, one dispenser had called in sick and the pre-registration student was on a study day. Because of this, the second part-time pharmacist came in to ensure that the pharmacy had enough staff. Planned leave was booked well in advance and only one member of the staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The staff worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal where any learning needs could be identified. Review dates would be set to achieve this. A qualified dispenser had recently raised that she would like to do the technician training. Because of this, she had been enrolled on the course.

The staff were encouraged with learning and development and completed regular e-Learning such as recently on respiratory problems. They said that they spent about 30 minutes each month of protected time learning. Generally, the staff did this learning at home but they left work early in order to do this. Staff enrolled on accredited courses, such as the NVQ3 technician's course, were allocated further time for learning. All the dispensary staff reported that they were supported to learn from errors. The pharmacists reported that all learning was documented on their continuing professional development (CPD) records.

The staff knew how to raise a concern and said that this was actively encouraged and acted on. The pharmacy had a dedicated book where the staff could write any suggestions. These were then discussed at the monthly meetings. A qualified dispenser had recently raised issues with the 'end tabs' of split boxes of medicines not being left out. This was the pharmacy's policy to alert everyone that the

box was not full and so reduce the risk of quantity errors. All the staff were aware of the company's whistle-blowing policy. The pharmacists said that they were not pressured to undertake additional services, such as the New Medicine Service (NMS) reviews.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally looks professional and is suitable for the services it provides. The pharmacy signposts its consultation room so it is clear to people that there is somewhere private for them to talk. But, the design of the room may hamper conversations. And, it would benefit from updating.

Inspector's evidence

The pharmacy generally presented a professional image. The dispensary was tidy and organised. The dispensing benches were uncluttered and the floors were clear. But, at the time of the visit, the Digi-pad lock to the consultation room was not working and the door was open. Confidential information and medicines were being stored in here. In addition, the two CD cabinets were located in this room. The lock to the door was repaired during the visit. Later that day, the superintendent sent an email stating that the CD cabinets and the medicines would be re-located to the dispensary. On 9 March 2020, the staff reported that all the medicines and confidential information had been moved. Some ceiling tiles in the consultation room were damaged and this did not present a professional image.

The consultation room was small and the design meant that people had to sit side-by-side. This may hamper discussions. There were two chairs but no sink. A lockable room off the consultation room was used for the storage of assembled compliance aids. There was a large hole in the back wall. This was a joint wall with the dispensary. Conversations in the consultation room could not be overheard when the door was closed. But, the door contained clear glass. An attempt to obscure this had been made, but people could still be easily seen. The pharmacist said that he would address this issue.

The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot. There was air conditioning and the temperature in the pharmacy was below 25 degrees Celsius. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

Everyone can access the services the pharmacy offers. It generally manages its services effectively to make sure that they are delivered safely. The team members make sure that people have the information that they need to take their medicines properly. They intervene if they are worried or think that people may be suffering from side effects. The pharmacy mainly gets its medicines from appropriate sources. But, some medicines are not subject to recognised standards. This means that people may not be getting medicines of a desired quality.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room via a push-button opening front door to the surgery. The staff could access an electronic translation application for use by non-English speakers. The pharmacy printed large labels for one sight-impaired patient.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), the Community Pharmacy Consultation Service (CPCS), the South Gloucestershire urgent repeat medicine service and seasonal flu vaccinations. No private services were offered.

The pharmacists had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. The pharmacy had no supervised substance misuse patients.

A large number of domiciliary patients and a few care home patients received their medicines in compliance aids. The pharmacy was currently doing Disability Discrimination Act (DDA) assessments on their domiciliary patients. It was thought that there would be a reduction in the number of patients receiving this service. Plans were also in place to move those compliance aids that were delivered to another store. The compliance aids were mainly assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There were dedicated folders for these patients where relevant information such as hospital discharge sheets and changes in dose were kept. But, there was no concise, chronological audit trail of changes for easy reference at the checking stage. Most of the compliance aids were checked by the accuracy checking dispenser (ACD). The prescriptions were all clinically checked by the pharmacist prior to this and there was an audit trail demonstrating this to be the case. The assembled compliance aids were stored tidily in the small room located off the consultation room.

The pharmacy also provided services to a couple of local homes. The medicines were assembled into compliance aids. The pharmacy ordered the prescriptions from medication administration record (MAR) charts that the homes completed. The pharmacy did not send the prescriptions to the homes for checking so any changes in the interim period may go undetected. The staff at the pharmacy were not sure if anyone visited the homes to look at their medicines management procedures. The pharmacy staff also did not know if the care home staff were provided with any training.

There were no procedures in place to ensure that all patients who had their medicines in compliance aids and were prescribed high-risk drugs, were having the required blood tests. The pharmacist said that he would discuss this with the practice pharmacist at the surgery. There was a good audit trail for

all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. The pharmacists routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. International normalised ratios were asked about. They also counselled patients with learning difficulties and those prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were checked with the patient on hand-out. All the staff were aware of the sodium valproate guidance relating to the pregnancy protection programme. Two 'at risk' patients had been identified. They had been counselled and guidance cards were included with each prescription for them.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were only obtained indicating the safe delivery of CDs. The staff said that medicines were not posted through letterboxes of left in 'safe places'. Owing slips were used for any items owed to patients. Potential non-adherence or other issues were identified at labelling, ordering and hand-out. Any patients giving rise to concerns were targeted for counselling. Patients were thoroughly counselled during the NMS sign-up process. The pharmacists explained potential side effects such a dry cough with ramipril and swollen ankles with amlodipine. If anyone experienced any side effects, they were referred to the surgery. Alternative medicines were sometimes prescribed.

Medicines and medical devices were obtained from AAH, Alliance Healthcare, Phoenix, Lexon and Shaunaks Head Office. The latter sent unlicenced medicines such as thiamine and vitamin B compound strong. Specials were obtained from Lexon Specials. Invoices for all these suppliers were available. A scanner was not used to check for falsified medicines as required by the Falsified Medicines Directive (FMD). CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were no patient-returned but some out-of-date CDs. These were clearly labelled and separated from usable stock. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 3 March 2020 about tetrabenazine 25mg. The pharmacy had none in stock and this was recorded. A separate audit log was also completed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally 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.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 100ml). There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was access to the internet.

There were two fridges, both quite old. Some high maximum temperatures were recorded, 8 degrees Celsius, but these were still just within the required range. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was shredded. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.