General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Well, Hartcliffe Health Centre, Hareclive Road, Hartcliffe, BRISTOL, Avon, BS13 0JP

**Pharmacy reference:** 1084282

**Type of pharmacy:** Community

**Date of inspection:** 22/01/2020

## Pharmacy context

This is a busy community pharmacy interconnected with a health centre in the southern 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.

## 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 | 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 | 4.1 | Good practice | The pharmacy offers a good range of services to meet the needs of the local community. Everyone can access its services. |
| **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. It is appropriately insured to protect people if things go wrong. The pharmacy keeps the up-to-date records that it must by law. The pharmacy team members keep people's private information safe and they know how to protect vulnerable people. But, they could learn more from their mistakes to prevent them from happening again.

### Inspector's evidence

The pharmacy team identified and managed most risks. Any dispensing errors and incidents were recorded, reviewed and appropriately managed. There had been an error the week before the visit. A tablet was missing from a multi-compartment compliance aid. The patient had come in to collect the compliance aid, but the medicines were not ready. This had placed the dispensing staff under pressure. Because of the error, the pharmacy had reviewed their procedures for the ordering of prescriptions for compliance aids. They have asked the surgery if they can order these at least 10 days in advance. The pharmacy had also reviewed their procedures for patients who collect compliance aids to ensure that they are ready in time. Near misses were recorded electronically. Those seen included insufficient information to allow any useful analysis, such as a strength error with ramipril. It had not been documented what was on the prescription and what had been picked. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. The pharmacist seen, a regular locum, reported that the electronic recording of near misses was not conducive to all mistakes being recorded. She said that the pharmacy was busy and that the computers were constantly needed for dispensing purposes. When she was working at the branch, she used a paper near miss log and then uploaded these electronically when time allowed.

The dispensary was tidy and organised. There was a front walk-in area with labelling, assembly and checking benches. The back area of the dispensary was used for substance misuse patients, with a dedicated serving hatch and items that had to be added for the prescriptions that were sent off-site for dispensing. There was also a dedicated area for the assembly and checking of compliance aids. Coloured baskets were used and distinguished prescriptions for patients who were waiting, those sent to the off-site hub for dispensing, managed repeat prescriptions and prescriptions for deliveries. Approximately 40% of prescriptions were currently dispensed off-site. 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. All the prescriptions sent for off-site dispensing were clinically checked by the pharmacist prior to this and there was an audit trail demonstrating that this had been done.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were reviewed every two years, or sooner, if necessary, by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. A NVQ2 qualified dispenser said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. She was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as chloramphenicol eye drops and Ella One and referred requests for these to the pharmacist. All the staff were aware of the NFA-VPS (non-food animal – veterinarian, pharmacist, suitably qualified person) status of veterinary medicines. Another dispenser 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, 70% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback, 14%, about the time it took to be served. However, the manager reported that the pharmacy had lost 103 staff hours since November 2019 with a further 8 hours to be lost in the next four weeks (see further under principle 2). This meant that it was difficult to always allocate someone to the medicine counter.

Current public liability and indemnity insurance 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 in order.

An information governance procedure was in place and the staff had also completed training on the general data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had all read the company's procedures for the safeguarding of both children and vulnerable adults. The pharmacist 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 generally has enough staff to manage its workload safely. And, it is to their credit that the pharmacy is currently managing their work satisfactorily. But, there is uncertainty about future staffing levels and this is unsettling. The team members are encouraged to develop and keep their skills up to date but, they do this in their own time. Those team members who are in training are supported and the whole team are comfortable in providing feedback to their manager to improve services for patients.

### Inspector's evidence

The pharmacy was busy and it was interconnected with a health centre. They mainly dispensed NHS prescriptions with 40% of these, largely the non- 'walk-in' prescriptions, being dispensed off-site. Many domiciliary patients received their medicines in compliance aids and the pharmacy also had many supervised substance misuse patients.

The current staffing profile was one pharmacist, one full-time NVQ2 qualified dispenser (but she was also the manager), four part-time NVQ2 qualified dispensers (one an accuracy checker) and one full-time NVQ2 trainee dispenser. There was no dedicated medicine counter assistant. All the staff covered the medicine counter.

The part-time staff did their best to cover any unplanned absences but they had child-care and elderly-care commitments. Some help was available from relief dispensers in the area and the company was trying to recruit more of these. 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 and the manager did her best to ensure appropriate staffing levels with the desired skill mix. However, as mentioned under principle 1, the pharmacy had lost a total 103 staff hours since November 2019, with a consultation currently in place about losing a further 8 hours. This situation placed the team under pressure and also caused anxiety and uncertainty regarding the outcome. However, to the credit of the staff, they were not very far behind with their work schedule, just two days. Staff came in on their day's off to catch up. They were given this time back.

The staff clearly worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal with a six-monthly review where any learning needs could be identified. Review dates would be set to achieve this. But, the manager had asked about doing the NVQ3 technician's course in October 2019. She said that this had been denied and that she was not given any feedback as to the reason for the decision.

The staff were encouraged with learning and development and completed regular e-Learning but, in their own time. The NVQ2 trainee dispenser did have some allocated learning time, about 20 minutes each week. But the manager also provided training in her own time when the pharmacy was closed. The pharmacist reported that all learning was documented on her continuing professional development (CPD) record.

The staff knew how to raise a concern and reported that this was encouraged by their manager. They had raised concerns about the previous off-site dispensing model, CAPA. This had been replaced with a new system, Analyst, which they all said was much more efficient. The staff said that the area manager

was supportive over the current consultation on staffing. The manager said that it was difficult to organise formal staff meetings because she was the main and only full-time dispenser. They did have daily staff huddles. The pharmacist reported that she was set overall targets, such as for Medicine Use Reviews (MURs). She said that she only did clinically appropriate reviews and did not feel unduly pressured by the targets.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy generally looks professional and is suitable for the services it provides. The work areas are tidy and organised. The pharmacy signposts its consultation room so it is clear to people that there is somewhere private for them to talk.

### Inspector's evidence

The pharmacy was well laid out and generally presented a professional image. The dispensing areas were organised and the benches were uncluttered. The floors were clear. The premises were clean and well maintained.

The consultation room was relatively spacious and well signposted. It contained a computer, two chairs but no sink. Some items, such as a vacuum cleaner, boxes of paper and cardboard were stored in here. This did not present a professional image. The manager said that storage was an issue at the pharmacy and that they were in discussion with the surgery about having some additional storage. Conversations in the consultation room could not be overheard. 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 centigrade. There was good lighting throughout. Most items for sale were healthcare related.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy offers a good range of services to meet the needs of the local community. And everyone can access its services. The pharmacy generally manages its services effectively to make sure that they are delivered safely. The team members usually make sure that people have the information that they need to take their medicines properly. The pharmacy gets its medicines from appropriate sources. And, it stores and disposes of them safely. The team members make sure that people only get medicines or devices that are safe.

### Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room via an automatic opening front door to the surgery. The staff could access an electronic translation application for non-English speakers. The pharmacy printed large labels for a couple of sight-impaired patients.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), supervised consumption of methadone and buprenorphine, emergency hormonal contraception (EHC) (regular pharmacist and some locums), chlamydia screening, Community Pharmacy Consultation Service (CPCS), the local urgent repeat medicine service and seasonal flu vaccinations. The latter was also provided under a private scheme. The services were well displayed and the staff were aware of the services offered.

The pharmacist had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. She had also completed suitable training for the provision of the free NHS EHC service.

Many substance misuse patients had their medicines supervised and a few patients took their medicines home. There was a dedicated box for the prescriptions for these patients. A diary was used to record any concerns and some were also recorded on the patient's electronic prescription medication record. A member of staff from the service provider, The Bristol Drugs Project worked at the adjacent surgery every Wednesday. Methadone was assembled when the patients presented using a Methameasure machine. Not all patients had their photographs uploaded. So, the full functionality of the machine to ensure supply to the correct patient, was not made. There was a dedicated hatch for the substance misuse patients. Supervised patients were offered water or engaged in conversation to reduce the likelihood of diversion.

Many domiciliary patients received their medicines in compliance aids. There was a clear weekly dispensing cycle. The compliance aids were assembled in an organised separate area on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There were dedicated folders for these patients where information such as hospital discharge sheets and changes in dose were kept. But there was no concise audit trail of past changes for easy reference by the checking pharmacist. The assembled compliance aids were stored tidily in dedicated boxes. Any containing CDs were marked with a sticker to remind staff they were in the cabinet. Those for collection were separated from those for delivery. The pharmacy staff made sure that any of these patients, who were also prescribed high-risk drugs, were having the required blood tests.

Most non- ‘walk-in’ prescriptions were sent off-site for assembly. These were all clinically checked by the pharmacist prior to this and so they were aware of changes, interactions or other issues. There was said to be a three-day turnaround time for these. Several items had to be dispensed locally and the staff said that at the time of the visit, they were about two days behind with these (see under principle 2). They said that they should be able to catch up on Saturday when it was quiet.

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 pharmacist seen routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. International normalised ratios (INR) were asked about. The pharmacist also counselled patients prescribed amongst others, antibiotics and oral steroids. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. All the staff were aware of the sodium valproate guidance relating to the pregnancy protection programme. They had identified two ‘at risk’ patients but there were no guidance leaflets available. Not all prescriptions, entirely dispensed at the pharmacy, mainly ‘walk-ins’, containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. This meant that some people may not be getting the appropriate counselling. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Suitable patients were encouraged to use the company’s managed repeat prescription service to reduce wastage, to optimise the use of medicines and to identify any non-adherence concerns. The pharmacist said that the patients using the pharmacy were generally well informed. She said that she gave diabetic patients advice about a healthy lifestyle during MURs and advised all smokers on nicotine replacement therapies.

Medicines and medical devices were obtained from AAH and Alliance Healthcare. Specials were obtained from IPS Specials. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations but one assembled prescription for Concerta XL 36mg, dated 17 December 2019 was seen in the cabinet. There had been no contact, either with the prescriber or with the patient about this prior to the expiry of the prescription. There were several patient-returned CDs and 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. Date checking procedures were in place but these were behind schedule. 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. Any required actions were recorded electronically. The pharmacy had received an alert on 29 November 2019 about paracetamol tablets 500mg. The pharmacy had none of the affected batches in stock and this was recorded.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the appropriate equipment and facilities for the services its 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 (5 - 500ml). There was a tablet-counting triangle and an automatic counter. 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.

The fridges were in good working order and maximum and minimum temperatures were recorded daily. The Methameasure machine was cleaned and calibrated daily. 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 collected for appropriate disposal. 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. |