General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bridgewater Pharmacy, Bridgewater House, 5 Printers Avenue, WATFORD, Hertfordshire, WD18 7QR

Pharmacy reference: 1091113

Type of pharmacy: Community

Date of inspection: 24/07/2019

Pharmacy context

The pharmacy is located in the same premises as a health centre with a connecting corridor for patient access. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance packs (blister packs) for people who have difficulty managing their medicines. Services include prescription collection and delivery, stop smoking, supply of anti-malaria medicines and seasonal flu vaccination.

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	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. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy manages risk and keeps people's information safe. The pharmacy has written procedures which tell staff how to complete tasks effectively. The pharmacy generally keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team members understand their role in protecting vulnerable people.

Inspector's evidence

Near misses were recorded and reviewed but records of actions taken to prevent a repeat near miss for each incident could have included more detail. Staff said near misses tended to be discussed as they arose. 'Lookalike, soundalike' (LASA) medicines had been separated on the dispensary shelves to reduce picking errors. Incident reports were completed and filed for dispensing incidents.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. Labels were generated and medicines were picked from reading the prescription. There were separate dispensing and checking areas. The pharmacist performed the final check of prescriptions apart from those checked by the accuracy checking technician. The dispensing audit trail was sometimes part completed identifying who had checked the medicines but not who had dispensed. Interactions were printed and shown to the pharmacist. There was a procedure for dealing with outstanding medication. The original prescription was retained, and an owing slip was issued to the patient. For "manufacturer cannot supply" items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance packs (blister packs) were prepared at a separate bench for a number of patients according to a matrix. The pharmacy managed prescription re-ordering on behalf of patients. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a blister pack. Patient information including discharge summaries was filed and notes were recorded on the patient medication record (PMR). Labelling included a description to identify individual medicines and the pharmacist gave an assurance that moving forward patient information leaflets would be supplied with each set of blister packs.

High-risk medicines such as sodium valproate and alendronate were supplied separately from the blister pack. The dates of controlled drug (CD) prescriptions were managed to ensure supply within 28-day validity of the prescription. Where possible, levothyroxine and lansoprazole were supplied in compartments positioned to ensure it was taken before other medication or food.

The practice leaflet was on display and included details of how to comment or complain. The annual patient questionnaire had been conducted and had resulted in positive feedback from people who used the pharmacy. The standard operating procedures (SOPs) were reviewed in July 2018 and staff training records were available. Procedures included responsible pharmacist (RP), complaints and business continuity. The medicines counter assistant (MCA) said she would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. Hydrocortisone cream would not be sold for use on the face.

To protect patients receiving services, there was professional indemnity insurance in place provided by NPA expiring 31 March 2020. The RP notice was on display and the RP log was completed although the RP did not always sign out at the end of the session. Records for private prescriptions and special supplies were generally complete. Patient group directions (PGDs) for anti-malaria medicines were seen to be valid.

The CD registers were electronic, and the balance of CDs was audited regularly although not always weekly in line with the SOP. A random check of actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. Full supplier details were recorded for receipt of CDs. Each pharmacist had their own password which resulted in an audit trail of who accessed CD registers. Patient returned CDs were recorded in the destruction register for patient returned CDs.

Staff had signed confidentiality agreements and were aware of procedures regarding General Data Protection Regulation (GDPR). There was a privacy notice displayed. Confidential waste paper was collected for shredding and a cordless phone enabled a private conversation. Staff generally used their own NHS cards. Staff had undertaken safeguarding and dementia friends training and the pharmacists were accredited at level 2 in safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together to manage the workload within the pharmacy. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time and one part-time pharmacist, one part-time accuracy checking technician (ACT), two full-time dispensers (also accredited as MCAs), one newly appointed part-time dispenser, one part-time dispenser who covered Saturdays, four part-time MCAs and one part-time delivery person. There was a part-time dispenser vacancy. The pharmacists' work pattern overlapped.

Newly recruited staff completed induction training. Staff were allocated protected learning time where possible. There were planned appraisals to monitor staff performance and set objectives. Staff felt able to provide feedback and had suggested updating the audit trail for 'as and when' medication supplied to the care home but not in a blister pack. To deal with future queries, the prescriptions were photocopied and annotated to show supply date. Targets and incentives were set but staff did not believe patient safety and wellbeing was adversely affected.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, secure and suitable for the provision of its services.

Inspector's evidence

On the day of the visit, staff had nearly finished clearing up after a flood the previous day. The premises were generally clean and tidy. Damaged stock had been quarantined. Lavatory facilities were clean and handwashing equipment was available.

There was a seating area where health related information and the privacy notice was displayed. The consultation room was located to one side of the medicines counter and there were blinds to protect patient privacy. There were lockable cabinets to secure equipment and documentation. Health related leaflets were displayed. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective, and it gets its medicines from reputable sources. The pharmacy team takes the right action if any medicines or devices need to be returned to the suppliers. The pharmacy's team members are helpful and give advice to people about where they can get other support. They also make sure that people have all the information they need so that they can use their medicines safely. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe and effective.

Inspector's evidence

There was wheelchair access to the pharmacy and large font labels could be printed to assist visually impaired patients. Staff could converse in Gujarati to assist patients whose first language was not English. Patients were signposted to other local services including the doctor, NHS 111 and mental health support services. The pharmacy did not have healthy living status but there were health campaigns to raise public awareness including sepsis and dealing with heat wave. Audits were conducted including for referral for prescription of a proton pump inhibitor for gastric protection while taking a non-steroidal anti-inflammatory drug (NSAID) and both phases of the sodium valproate audit.

The pharmacists were aware of the procedure for supply of sodium valproate to people in the at-risk group and information on the pregnancy prevention programme (PPP) would be explained. The pharmacists explained the procedure for supply of isotretinoin to people in the at-risk group. The prescriber would be contacted regarding prescriptions for more than 30 days' supply of CD. Interventions were not always recorded on the patient medication record (PMR) of checks that medicines were safe for people to take and showing appropriate counselling was provided to protect patient safety.

Prescriptions were highlighted to indicate that the pharmacist would provide counselling on high risk medicines. For schedule 4 CDs the date was highlighted so the CD was supplied within the 28-day validity of the prescription. When supplying warfarin people were asked about blood test dates and for their record of INR. The timing of their dose of the warfarin and how to deal with a missed of warfarin was explained. Advice was given about side effects of bruising and bleeding. Advice was given about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. Patients taking lithium were asked about blood test dates and advised to take the same brand of lithium each time. Side effects such as stomach ache and metallic taste in the mouth were explained.

The pharmacy premises had been flooded the day before the visit. Staff had informed the local clinical commissioning group and made alternative arrangements for members of the public to obtain their medication. If necessary, paper FP10 prescriptions were issued by the doctors in place of electronic prescriptions so people could visit other local pharmacies.

Medicines and medical devices were delivered outside the pharmacy by a delivery person. The SOP referred to a delivery record book and patient signatures being recorded for a successful delivery. A delivery drop sheet was compiled and patient signatures were not always recorded but the delivery person ticked the sheet to indicate the delivery was complete. The pharmacist said the delivery procedure would be reviewed to include a delivery record book.

Medicines and medical devices were obtained from Alliance, AAH, Phoenix, Colorama, Sigma and IPS specials. Floor areas were clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and recorded. Stickers were attached to highlight short-dated stock. No date-expired medicines were found in a random check. Liquid medicines were marked with the date of opening. Medicines were generally stored in original manufacturer's packaging. Cold chain items were stored in the medical fridge. Uncollected prescriptions were removed from retrieval after two months. CD prescriptions were returned to the doctor. Waste medicines were stored separate from other stock. Falsified medicines directive (FMD) hardware and software were not operational at the time of the visit. Drug alerts were actioned on receipt, annotated and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

Current reference sources included BNF and Drug Tariff. There were British standard glass measures to measure liquids. Minimum and maximum fridge temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinets were fixed with bolts. Stop smoking equipment was supplied and maintained by Hertfordshire County Council. The blood pressure monitor was due for re-calibration. The sharps bin was due to be uplifted and the adrenaline injection devices for use in anaphylaxis were in date. The consultation rom protected patient privacy. Confidential waste paper was collected for shredding and a cordless phone enabled a private conversation. Staff generally used their own NHS cards.

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.