General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Frome Valley Pharmacy, 2 Court Road, Frampton Cotterell, BRISTOL, Avon, BS36 2DE

Pharmacy reference: 1092987

Type of pharmacy: Community

Date of inspection: 14/10/2019

Pharmacy context

This is a community pharmacy in a doctors' surgery in the village of Frampton Cotterell. The village is situated to the north east of the city of Bristol. The population is increasing with several areas of new housing being developed. A wide variety of people use the pharmacy. The pharmacy dispenses NHS and private prescriptions and sells over-the counter 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	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. It keeps the up-to-date records that it must by law. The pharmacy is appropriately insured to protect people if things go wrong. The pharmacy team keeps people's private information safe and they know how to protect vulnerable people. But, they could learn more from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team identified and managed most risks. Dispensing errors and incidents were recorded, reviewed and appropriately managed. There had been a recent strength error with bisoprolol. It had been identified that the shelf where this was stored was untidy and the strengths had been mixed up. It was seen to be tidy on the day of the visit. However, there had been five errors in the last two months. The pharmacist said that he believed that a contributing factor for these was because of staffing. The pre-registration student had not been replaced and the pharmacy had a newly appointed trainee dispenser who was still in her probationary period.

Near misses were recorded. Learning points were identified but few actions to reduce the likelihood of similar recurrences were recorded. It had been documented that a recent picking error with fluoxetine and flucloxacillin was a 'look alike, sound alike' mistake, but, no actions had been put in place to prevent this error from happening again. General trends could be identified, but, whilst the log was signed as being reviewed, the details of the review were not documented.

The dispensary was limited in size but there were labelling, assembly, waiting to be checked and checking areas. The pharmacist was aware that the limited space posed a risk. So, he only placed one prescription at a time, in the checking area, to mitigate this. Coloured baskets were used and distinguished prescriptions for patients who were waiting, those calling back, those for delivery and those containing controlled drugs or items requiring refrigeration. 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.

Up-to-date, signed, but somewhat generic, standard operating procedures (SOPs) were in place and these were reviewed every two years by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. The questions to be asked of customers requesting to buy medicines were displayed on the till. The medicine counter assistant said that she would check the prescription medication record of anyone on prescribed medicines who asked to buy an over-the-counter medicine. If an interaction was flagged on the computer, or, if she was unsure of anything, she would refer the person to the pharmacist. She would also refer requests for young children and pregnant women to the pharmacist and requests for decongestant medicines.

The staff were clear about the complaints procedure and reported that feedback on concerns was encouraged. The pharmacy did an annual customer satisfaction survey. The staff were not aware of the results of the latest survey, 2019. This was accessed during the visit. Whilst the feedback was generally positive, the section for the areas for improvement within the control of the pharmacy, had not been completed. This meant that the staff were unable to address any negative feedback. However, the staff had a good relationship with the adjacent surgery and liaised with them over the recent shortages of

some hormone replacement therapy patches. Where necessary, the prescriptions were changed to products that were available.

Public liability and indemnity insurance provided by the National Pharmacy Association and valid until 30 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.

There was an information governance procedure and the staff had also recently completed training on the new 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 shredded. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had read the SOP on 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough staff to manage its workload safely. The pharmacy team are encouraged to keep their skills up to date and they are comfortable about providing feedback to their manager. But, the pharmacy could have better performance review procedures to identify any gaps in the skills and knowledge of the team. And, the company could provide more help when team members are on holiday or off sick so that they do not fall behind with their work.

Inspector's evidence

The pharmacy was in a doctors' surgery in the village of Frampton Cotterell. They dispensed approximately 8,500 NHS prescription items each month with the many of these being repeats. Due to the location, there were several acute 'walk-in' patients. Because of the limited size of the dispensary, the pharmacy did not assemble any multi-compartment compliance aids. Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, the manager, one full-time NVQ2 qualified dispenser, one full-time NVQ2 trainee dispenser, in her probationary period (not seen) and one full-time medicine counter assistant. This staffing profile allowed little flexibility to cover both unplanned absences and planned leave. The team said that they were given no help from their head office to accommodate these. On the Friday before the visit, the counter assistant was ill. The dispensary staff had to cover the medicine counter which put them behind with their own work. On the afternoon of the visit, the qualified dispenser had a booked half a day's holiday. No replacement was provided. In addition, as reported under principle 1, the pharmacy had also lost their pre-registration student. The staff believed these staffing levels had contributed to the increased errors in the last two months.

The staff seen worked well together as a team. Staff performance was monitored informally throughout the year. But, the counter assistant, who had been appointed for one and a half years had had only one formal appraisal in that time. The pharmacist, in post for ten months, had had no appraisal. The staff said that there was no formal induction with a review at the end of the probationary period. The dispensary staff had not completed an accredited medicine counter assistant course.

The staff were encouraged with learning and development and completed Virtual Outcomes e-Learning. But, they were usually unable to complete this in work time because of lack of time. The trained dispenser had recently completed her course. She said that she did most of this study at home. The dispensary staff reported that they were supported to learn from errors. The pharmacist said that all learning was documented on his continuing professional development (CPD) record.

The staff said that they felt able to raise any issues with their manager but there were no formal staff meetings. There were however, daily informal 'huddles'. The pharmacist reported that he was set overall targets, such as 400 annual Medicines Use Reviews (MURs). He said that he only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional. It signposts the consultation room well so that it is clear to people that there is somewhere private for them to talk. But, the room is small and it is difficult for people to sit face-to-face. This may hinder some conversations.

Inspector's evidence

The pharmacy presented a professional image. The dispensing space was limited but the staff did their best to manage this. The premises were clean and well maintained.

The consultation room was well signposted but the room was small. However, the door opened outwards which meant that access by the emergency services should not be hampered if a person had to be placed in the recovery position on the floor. The pharmacy offered a flu vaccination service. The design of the room made it difficult for people to sit face-to-face. In addition, there was no sink for use during flu vaccinations or a computer for use during Medicines Use Reviews. Conversations in the consultation room could not be overheard. The 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

People can access the services the pharmacy offers. The services are generally effectively managed to make sure that they are provided safely. The pharmacy team makes sure that people have the information that they need to use their medicines safely and effectively. They intervene if anyone is suffering from side effects. The pharmacy generally gets its medicines from appropriate sources. The medicines are stored and disposed of safely.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with an automatic opening front door to the surgery. There was access to Google translate on the pharmacy computers for use by non-English speakers. The pharmacy could print large labels for 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 (but currently no clients), emergency hormonal contraception (EHC) and seasonal flu vaccinations. 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. He had also completed suitable training for the provision of the free NHS EHC service.

Because of the limited dispensary size, no patients received their medicines in compliance aids. These were all done in a nearby branch. There was a good audit trail for all items dispensed by the pharmacy. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were asked about. He also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs were checked with the patient on hand-out, but not insulin. One of the pharmacy's recent errors involved insulin. All the staff were aware of the new sodium valproate guidance.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were only routinely obtained indicating the safe delivery of CDs. The pharmacist reported that he checked the inhaler technique of asthma patients and that he gave them advice on the new types of inhalers. He identified, during MURs, that some patients prescribed simvastatin suffered with muscle ache. These people were referred to the surgery where the simvastatin was usually changed to atorvastatin.

Medicines and medical devices were obtained from AAH, Lexon, Phoenix, Alliance Healthcare and Shaunaks Head Office. Some medicines obtained from the latter were unlicenced, such as thiamine 100mg and cholecalciferol 800iu. Specials were obtained from Lexon Specials. Invoices for all these suppliers were available. There was no scanner to check for falsified medicines as required by the Falsified Medicines Directive (FMD) but the staff had received training on FMD. CDs were stored tidily and access to the cabinet was appropriate. There were no patient-returned CDs but a few out-of-dates. 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 a recent alert about aripiprazole 1mg/ml liquid. One patient had been supplied with an affected batch. This was returned to the pharmacy and destroyed.

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.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 250ml). 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) 76 and the 2018/2019 Children's BNF. There was access to the internet.

The fridges were in good working order and maximum/minimum temperatures were recorded 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 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.