General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Easton Pharmacy, 116 Stapleton Road, Easton, BRISTOL, Avon, BS5 0PS

Pharmacy reference: 1094061

Type of pharmacy: Community

Date of inspection: 07/05/2019

Pharmacy context

This is a community pharmacy on a busy road of shops in the north-eastern suburbs of the of the city of Bristol. There is an eclectic mix of both people and houses. It dispenses NHS prescriptions and sells over-the-counter medicines. They supply medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The standard operating procedures are overdue a review and are not being followed. No incident report or learning has been documented following a recent error which is a risk to people's safety. And, the work areas are untidy and disorganised which poses a further risk.
		1.2	Standard not met	The pharmacy team does not routinely assess the safety and quality of the services provided.
		1.3	Standard not met	Some team members do not understand their roles and responsibilities.
		1.6	Standard not met	The pharmacy does not keep all the up-to-date records that they are required to do so by law.
		1.7	Standard not met	Not all people’s private information is stored safely.
2. Staff	Standards not all met	2.1	Standard not met	Some team members are doing tasks that they are not qualified to do. This poses a risk to people’s safety and is against the minimum training requirements of the GPhC.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy does not present a professional pharmacy image.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	There is evidence that some of the pharmacy services are not managed safely and effectively.
		4.3	Standard not met	Not all medicines are stored and disposed of safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy team members do not identify and manage risks. And, this poses a risk to people's safety. They do not record or learn from mistakes to prevent them from happening again. The work areas are untidy and disorganised and this increases the risk of mistakes. The pharmacy's written procedures are out of date and they are not being followed. And, they have not all been signed to show that the team has read and understood them. Some team members are doing tasks that they are not qualified to do. The team ask their customers for feedback but do not use this this to improve their services. The pharmacy does not keep all the up-to-date records that they are required to do so by law. Not all people's private information is stored safely.

Inspector's evidence

The pharmacy staff did not identify and manage risks well. The pharmacist said that the last error at the pharmacy was in February 2019. He could not remember any details and no incident report had been completed. The standard operating procedures (SOPs), which were highly generic and should have been reviewed in October 2016, stated that a full incident report should be completed following any dispensing error. In addition, not all the staff had signed the SOPs to demonstrate that they had read them.

There were no near miss records. The labels of mistakes were said to be kept, but those seen had insufficient information to allow any useful analysis. Such as, an error where citalopram 10mg had been labelled for a person's husband. No other information was recorded.

A staff member was seen to be bagging up medicines in the dispensary when the inspector arrived. This person was the delivery driver. She had been working at the pharmacy for two years but was not enrolled on a dispensing assistant course.

The dispensary was small, cluttered and untidy. Assembled medicines were stored on the floor. There was no clear assembly and checking area. There was no audit trail of the dispensing process on the labels for some medicines and patient information leaflets were not being routinely supplied. (see further under principle 4).

There was no displayed sales protocol but the NVQ2 trainee dispenser was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches such as Viagra Connect and would refer all requests for these to the pharmacist. She would also refer medicines for pregnant women, children under two any anything that she was uncertain of.

The pharmacy did an annual customer satisfaction survey. In the 2018 survey, the customers who completed the questionnaire were happy with the service from the pharmacy. But, there had been some feedback about the provision of advice on exercise and the pharmacist said that he had not done anything specific to address this.

Public liability and indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 13 August 2019 was in place. The responsible pharmacist log and fridge temperature records were in order. Several pages in the controlled drug (CD) records had not been correctly headed. There was a

large quantity of patient-returned CDs that were not entered in the records. Private prescriptions were recorded electronically. Several of these had no prescriber details. There were no formal date-checking records and no records of medicines that were delivered to patients. The responsible pharmacist notice was not displayed when the inspector arrived at the premises.

The staff were aware of information governance issues and the new data protection regulations. But, the consultation room was being used for the storage of assembled medicines, with the prescriptions, containing confidential information, attached. The room was not locked and there was a large hole in the door, which appeared as it there should be a pane of glass installed in here. The pharmacy computer, which was not visible to the customers, was password protected. Confidential waste paper information was shredded.

The staff understood safeguarding issues. The pharmacist said that he completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding but that this was some time ago. Local telephone numbers were available to escalate any concerns relating to both children and adults but the sheet containing this information was dated 2015.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough staff to manage its workload safely. But, some team members are doing tasks that they are not qualified to do. This poses a risk to people's safety and is against the minimum training requirements of the GPhC. Most of the staff are in training and they are supported by the pharmacist with this. But, the team members do not have regular performance reviews. So, any gaps in their skills and knowledge are not identified and supported. The pharmacy team members are comfortable about providing feedback to their manager and this is acted on.

Inspector's evidence

The pharmacy was in a busy shopping area in the north-eastern suburbs of Bristol city. They dispensed approximately 3,500 NHS prescription items each month with the majority of these being repeats. 15 to 20 patients receiving care at home received their medicines in multi-compartment compliance aids. Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, the owner, one full-time NVQ2 trainee dispenser, one part-time NVQ2 trainee dispenser (not seen) and one part-time qualified medicine counter assistant (MCA) who was the delivery driver. But, the MCA, who had been employed for two years, was seen to be bagging up a prescription for delivery. The pharmacist said that he would enrol her on the dispensing assistant course.

The part-time dispenser was flexible and was said to generally cover any unplanned absences of the full-time dispenser. Planned leave was booked well in advance and only one member of staff could be off at one time.

The staff had no formal performance appraisals. Both dispensary staff employed were in training. The member of staff seen did report that she was supported by the pharmacist with her course but did not receive dedicated learning time towards this. But, she did say that she did do learning in work time, mainly on Saturdays. The pharmacist said that he had not signed his staff up to any regular ongoing learning because he wanted them to finish their courses first. He said that he would investigate the provision of this, such as Virtual Outcomes. The pharmacist said that he recorded all learning on his continuing professional development (CPD) record.

The staff knew how to raise concerns and said that this was encouraged and acted on. The full-time trainee dispenser had recently suggested that it would be good if the pharmacy offered a wider range of vitamins and other health supplements. The owner had agreed and this had been implemented. There were 'ad hoc' staff meetings.

The pharmacist seen was the owner and he said that no formal targets or incentives were set.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy does not present a professional pharmacy image. It is untidy and cluttered and best use of the space is not made. People cannot use the consultation room because it is full of medicines. And, this room is not signposted and so people are not aware that, if it was clear, there would be somewhere for them to talk privately.

Inspector's evidence

The pharmacy was cluttered and untidy. There was a hole in the door that was supposed to be the consultation room. It appeared that this should have been filled with a glass panel. This did not present a professional pharmacy image. In addition, the room could not be used for any consultations because of the volume of assembled medicines, with the prescriptions attached, being stored in here. These were being stored on the floor. There was a large office area, largely unused. The pharmacist said that this used to be used for wholesale activities. Piles of papers were on the floor in this room and a couple of unused wooden pallets. The premises were clean.

The pharmacy computer screen was not visible to customers. The telephone was cordless and all sensitive calls were said to be taken out of earshot.

There was good lighting throughout. The temperature in the pharmacy was below 25 degrees Celsius. Most items for sale were healthcare related.

Principle 4 - Services **Standards not all met**

Summary findings

Most people can access the services the pharmacy offers. But, some people with specific mobility needs may have difficulty entering the pharmacy. And, the pharmacy is currently doing few extra services. The room used for private conversations is not being used. So, people are denied the opportunity to speak to the pharmacist in confidence. The pharmacy team do not always make sure that people have the information that they need to use their medicines safely and effectively. And, that they do not make sure that all people who are taking high-risk medicines are getting the blood tests that they need. The team do not help vulnerable people having their medicines in multi-compartment compliance aids by giving them descriptions of the medicines in the box. This information would also be useful for any doctor attending to the person. The pharmacy has no delivery records and so cannot show that medicines have been delivered safely if something goes wrong. The pharmacy gets its medicines from appropriate resources. But, some are not stored and or disposed of safely.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room but there was no bell on the door to alert the staff to anyone who may need assistance. In addition, the consultation could not be used as such at the time of the inspection because it was full of assembled prescriptions. There was access to Google translate on the pharmacy computer 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) and supervised substance misuse services. But, the pharmacist said that he had done MUR and NMS reviews recently.

Substance misuse patients had their medicines supervised. There was no dedicated folder for these patients to keep any relevant information or concerns. The prescriptions were kept in a separate basket. The telephone numbers of key workers were not available. The clients were not offered water or engaged in conversation to reduce the likelihood of diversion. The pharmacist was not aware of the local shared care guidelines, The Recovery Orientated Alcohol and Drugs Services (ROADS) guidance. The inspector sent these.

15 to 20 patients receiving care at home received their medicines in multi-compartment compliance aids. The compliance aids were assembled on a four week rolling basis and evenly distributed throughout the week to manage the workload. The patients had individual wallets. Some changes of dose were recorded but most did not have a clear concise, chronological audit trail of changes or issues. One month’s compliance aids were seen to have no tablet descriptions and no patient information leaflets were provided. The pharmacy had no procedures to ensure that any compliance aid patients receiving high-risk drugs were having the required blood tests.

There was not always a good audit trail for all items dispensed by the pharmacy. An assembled prescription for pyridostigmine bromide 60 mg was seen. There were no initials in either the ‘dispensed by’ or the ‘checked by’ box on the label. The original container was not with the assembled medicines for checking. CDs and insulin were not checked with the patient on hand-out. Not all the staff were aware of the new sodium valproate guidance.

The pharmacy had no delivery records and so could not demonstrate that medicines had been delivered safely.

Medicines and medical devices were obtained from AAH and Alliance Healthcare. There were a very large number of patient-returned and out-of-date CDs. The patient-returned CDs had not been entered in the records. These were clearly separated from usable stock but were occupying more than one whole cabinet. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with electronic records. There were no formal date checking records. Designated bins for storing waste medicines were available for waste and used and there was no cytotoxic bin or list of substances that should be treated as hazardous for waste purposes. Stock was not stored tidily on the dispensary shelves and there were loose blisters of tablets and capsules, such as, levothyroxine and loperamide. The pharmacist was aware of the Falsified Medicines Directive. He had a scanner to check for any falsified medicines but needed to get the accompanying tablet from Lexon.

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 9 April 2019 about chloramphenicol eye drops. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the appropriate equipment and facilities for the services it provides.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 to 100ml). There were tablet-counting triangles which were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2018/2018 Children's BNF. There was access to the internet.

The pharmacy and dispensary were generally safeguarded from unauthorised access. The fridge was in good working order and maximum and minimum temperatures were recorded daily. Designated bins for storing waste medicines were available and used. There was limited space for the storage of assembled medicines.

The pharmacy computer was password protected and not visible to the public. There was a cordless telephone and any sensitive calls were said to be taken out of earshot. Confidential waste information was shredded. The consultation room was not being used at the time of the visit.

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.