General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Alveston Pharmacy, 2 Greenhill Parade, Alveston, BRISTOL, Avon, BS35 3LU

Pharmacy reference: 1094101

Type of pharmacy: Community

Date of inspection: 24/02/2020

Pharmacy context

This is a community pharmacy in a shopping area in the village of Alveston, close to the town of Thornbury. Most people who use the pharmacy are elderly. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It also supplies several medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines. The pharmacy offered a range of other services.

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	N/A	N/A	N/A
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 at work. Those team members who are in training are supported with their courses.
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 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 keep people's private information safe and they know how to protect vulnerable people. But, they could be better at recording and learning from 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 electronically. An incident report was completed. Near misses were also recorded electronically. But, only two mistakes had been documented for January 2020 and these included insufficient information to allow any useful analysis. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. However, the staff did proactively identify possible issues, such as bendroflumethiazide 5mg, tamsulosin tablets and loperamide tablets. These were highlighted on the prescription to reduce the risk of picking errors with these.

The main dispensary was limited in size but the staff did their best to manage the space. Several baskets waiting to be checked were stored in top of one another which increased the risk of errors. The pharmacist was aware of this and only took one basket at a time into the checking area at a time to mitigate this risk. A small separate area at the back of the main dispensary was used for the assembly of the monthly multi-compartment compliance aids. At the time of the visit, there was no clear assembly and checking areas for the compliance aids. The pharmacist said that he would re-arrange this area to include dedicated areas for this. Weekly compliance aids were assembled and checked on a back bench in the main dispensary.

Coloured baskets were used and distinguished prescriptions for patients who were waiting, those for delivery and those for collection. 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 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. The questions to be asked of customers requesting to buy medicines were displayed. A NVQ2 trained 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) or 'general sales list' (GSL) switches, such as chloramphenicol eye drops and Nexium and referred requests for these to the pharmacist. The staff 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, 100% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback about the seating for people who were waiting. Because of this, a further chair had been obtained.

Public liability and professional indemnity insurance provided by Numark and valid until 30 September 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. The pharmacy supplied some medicines to a local surgery. The pharmacist did not know if the pharmacy had valid wholesale dealer authorisation (WDA) from the Medicines and Healthcare products Regulatory Agency (MHRA). He said that he would ask the superintendent about this.

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. Confidential information was stored securely. Confidential waste paper information was disposed of appropriately. No conversations could be overheard in the consultation room when the door was closed. But, the door to this room contained clear glass which meant that patient confidentiality could not be guaranteed in here (see under principle 3).

The staff understood safeguarding issues and had read the company's policy on the safeguarding of both children and vulnerable adults. The pharmacist had also 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. The team members are encouraged to develop and keep their skills up to date and they are given time to do this at work. Those team members who are in training are supported with their courses. But, the pharmacy could have better procedures when people are on holiday or off sick so that the team are not put under pressure or fall behind with their work.

Inspector's evidence

The pharmacy was in a shopping area in the village of Alveston, close to the town of Thornbury. They mainly dispensed NHS prescriptions with the majority of these being repeats. Several domiciliary patients received their medicines in multi-compartment compliance aids and the number of these had increased in the last few months with no change in staffing or layout of the premises (see further under principle 3 and 4). However, the staff said that they were not behind with their workload.

The current staffing profile was one pharmacist, one full-time NVQ3 qualified technician (recently completed the course but not yet on the register), two full-time NVQ2 qualified dispensers and one part-time medicine counter assistant (MCA) trainee. The staffing profile allowed little flexibility to cover either planned or unplanned absences. The staff said that they could try to get help from the other branches but usually they just had to cope. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time.

The staff worked well together as a team and they were all clearly well known to their customers. 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. The staff were encouraged with learning and development and completed regular e-Learning such as recently on incontinence. They said that they spent about an hour each month of protected time learning. Staff enrolled on accredited courses, such as the MCA course were allocated further time for their courses. 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 knew how to raise a concern and reported that this was encouraged and acted on. There were weekly staff meetings where the staff were able to raise any issues. The pharmacist was set targets, such as for Medicine 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 generally looks professional and is suitable for the services it provides. But, it could make better use of the space for the compliance aids to provide clear, separate, dedicated work areas. The pharmacy signposts its consultation room well, so it is clear to people that there is somewhere private for them to talk. But, the door to this room contains clear glass and so people's privacy in here cannot be guaranteed.

Inspector's evidence

The pharmacy was well laid out and generally presented a professional image. The main dispensary was limited in size and some baskets waiting to be checked were stored on top of one another. This increased the risk of errors. A separate area at the back of the dispensary was used for the assembly of the compliance aids. Best use of this space was not made in this area and there were no separate assembly and separate checking areas. And, the compliance aid services had increased over the last few months. The premises were clean and well maintained.

The consultation room was small but the door opened outwards and so access by the emergency services, if necessary, should not be impeded. The pharmacy did offer a flu vaccination service and so this was a possibility. The room was well signposted but the door contained clear glass which meant that patient confidentiality could not be guaranteed. It contained a computer and a sink. 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.

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

Most people can access the services that the pharmacy offers. But, some people with specific mobility needs may have difficulty entering the pharmacy. The pharmacy generally manages the 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. 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. The pharmacy disposes of its medicines safely.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room via a portable ramp. There was a step up to the pharmacy. But, there was no bell on the front door alerting the staff to anyone who may need assistance entering the pharmacy. The staff could access an electronic translation application for use by non-English speakers. They 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, emergency hormonal contraception (EHC), the Community Pharmacy Consultation Service (CPCS) and seasonal flu vaccinations. The latter was also provided under a private scheme. 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.

A few substance misuse patients had their medicines supervised. There was a dedicated folder for these patients where any relevant information was kept. The patients were offered water or engaged in conversation to reduce the likelihood of diversion.

A large proportion of the business at the pharmacy was the assembly of medicines in compliance aids for domiciliary patients. And, the number of these had increased greatly in the last few months. The monthly compliance aid prescriptions were assembled in a separate area at the back of the dispensary. There was no clear assembly and checking area despite there being two separate benches. One bench was only being used for the compliance aids. The other bench was mainly taken up with the storage of files and other general items. The pharmacist said that he would try to re-locate these items so that there was a clear assembly bench and checking bench. In addition, he said that he would look at utilising the shelves above these benches, for items waiting to be checked, in order to keep the benches as clear as possible. The monthly compliance aids were assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There were dedicated poly-pockets for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. But, there was not a concise chronological audit trail of these for easy reference by the pharmacist at the checking stage. The weekly compliance aids were assembled on a small space at the back of the main dispensary. Procedures were 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.

There was a good audit trail for all items dispensed by the pharmacy. Green ‘see the pharmacist’ stickers were used. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. International normalised ratios (INR) were asked about. The pharmacist clearly knew his patients well and was seen to counsel all ‘walk-in’ patients. He also counselled patients 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. The pharmacy had no ‘at risk’ patients.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. The pharmacist reported that he frequently identified issues with inhaler technique, especially with some of the new types of inhalers, during MURs. He also identified timings of medicines. Many of his patients had read in the press about taking anti-hypertensive medicines at night. Some of these included diuretics and some patients had stopped taking these because of having to get up in the middle of the night. The pharmacist gave the patients advice about this and advised that they saw their doctor.

Medicines and medical devices were obtained from AAH, Alliance Healthcare, Lexon, Ethigen and Phoenix. Specials were obtained from Ethigen Specials. Invoices for all these suppliers were available. Some unlicenced medicines, such as calcium and ergocalciferol were seen on the dispensary shelves. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. But, there were many out-of-date CDs. These were clearly labelled and separated from usable stock but were occupying valuable space in the cabinet. Appropriate destruction kits were on the premises. The dispensary shelves had many boxes containing mixed batches of drugs. On 26 February 2020, the pharmacist sent an email stating that all the dispensary shelves had been tidied and that all mixed batches of drugs had ben removed. Fridge lines were correctly stored with electronic 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 13 February 2020 about gliclazide 40mg. 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 it provides. And, the team members make sure that they are clan and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (5 - 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.

The fridge was in good working order and maximum and 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 disposed of appropriately. 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.