General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bromham Pharmacy, Avoca House, Molivers Lane, Bromham, BEDFORD, Bedfordshire, MK43 8JT

Pharmacy reference: 1105565

Type of pharmacy: Community

Date of inspection: 16/10/2023

Pharmacy context

This pharmacy is located in a small village in Bedfordshire. The pharmacy dispenses both NHS and private prescriptions. And it delivers medicines to people's homes. It also provides medicines in multi-compartment compliance packs to people who need help managing their medicines. And people can get their flu vaccination and COVID-19 vaccination at the pharmacy.

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 met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy does not have adequate clear work surfaces to safely assemble and check prescriptions.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not effectively check the expiry dates of its medicines or devices or separate date-expired items from in-date stock. This increases the chances that medicines which are not fit for purpose are supplied to people.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures to make sure its team members know how to complete tasks safely. And its team members generally follow these. The pharmacy makes records when mistakes happen during the dispensing process. But sometimes it doesn't record enough information about these mistakes. This may make it harder to respond to queries regarding mistakes that occur. Pharmacy team members take the necessary steps to protect people's private information and are aware of how to protect vulnerable people. And the pharmacy keeps the records it needs to by law.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) that had been reviewed in April 2023. Training records were available to show most pharmacy team members had read and understood them. An SOP which covered data protection and confidentiality was in place but only the pharmacy superintendent (SI) had signed to say they had read and understood the contents. The SI confirmed that pharmacy team members had read the SOPs and would ask them to sign the training records. The dispenser was able to explain the steps they took to protect people's personal information. They provided an example of separating confidential waste and shredding it in the pharmacy. Team members were also observed having discrete conversations in the dispensary so not to be overheard by people.

Pharmacy team members made records of mistakes that occurred when dispensing medicines, also known as near misses. The pharmacist would highlight the mistakes to the team member involved and they would make a record in a near miss log so that they could reflect on it. Regular reviews of near misses were not completed so common causes of mistakes may not be identified and appropriately addressed. But the dispenser explained they would discuss near misses when they occurred, and the action they would take to reduce the likelihood of a similar mistake happening again. Examples included the physical separation of rivaroxaban and rosuvastatin. The SI provided an example of one of the team members incorrectly selecting losartan and sertraline on multiple occasions as both medicines were available as 50mg tablet forms. They asked the team member to check prescriptions for these medicines three times so they could identify any mistakes.

The near miss log also contained records of mistakes that had not been identified by the pharmacist before they were handed out to people, also known as dispensing errors. Two errors had been recorded where people had been given the incorrect medicine. Details of the people who received the incorrect medicine, if any harm was caused or the team members involved in the dispensing process were not recorded. This would make it harder to review these incidents fully and respond to any queries that may arise. The SI had an incident reporting form which they were going to use in future.

The pharmacy offered both flu and COVID-19 vaccinations to people who required these. The services were provided using patient group directions (PGDs). The PGDs were signed by the SI and the pharmacist who was administering vaccinations to people. The pharmacy had professional indemnity insurance in place to cover the services they were providing, including the vaccinations services.

On the day of inspection, a pharmacy team member was unexpectedly absent from work. This left the pharmacist and one trained dispenser to manage the workload. Work was prioritised based on urgency and the pharmacist was observed taking a mental break before checking prescriptions they had dispensed. The dispenser was seen referring sales of medicines to the pharmacist to make sure the

supply was safe. When questioned, they explained that the sale of any pharmacy medicines would be referred to the pharmacist. They were also aware of what they could and could not do if the responsible pharmacist (RP) had to take a short leave of absence. The correct RP notice was on display allowing people to see who the pharmacist on duty was.

The pharmacy generally kept the records it needed to by law. A paper RP record was available and completed each day. A private prescription record was made when a private prescription was dispensed, and this was completed correctly. Registers for controlled drugs (CDs) were available and in most cases had completed headers. A register for methylphenidate 5mg tablets did not have its headings fully completed which could increase the chance of entries being made in the wrong register. Running balances of CDs were recorded but there was no indication that these balances were checked as per the written procedures in place. The SI explained they checked the balance of CDs during the dispensing process, but no entry was made in the register to confirm this. This could mean the balances of CDs not frequently dispensed are not checked for extended periods of time. Spot checks of the physical stock against the recorded balances were carried out and two discrepancies were found. The SI managed to resolve one discrepancy during the inspection and subsequently informed the inspector that the second discrepancy was rectified shortly after the inspection was completed. CDs returned to the pharmacy for destruction were recorded in a returns register and this was signed when the items were destroyed.

The pharmacy did not have a written procedure about safeguarding people who may be considered vulnerable. But the dispenser was aware of the signs to look out for and explained they would refer any concerns to the pharmacist. The SI confirmed that they didn't have any safeguarding concerns but had the details of the local safeguarding contacts if needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload effectively. Team members complete appropriate training so that they can carry out their roles and responsibilities. And support is provided to those on training courses to help them progress. Team members communicate effectively with each other and can raise concerns if they need to.

Inspector's evidence

The pharmacy team consisted of a regular RP, who was also the SI, one qualified dispenser, one trainee dispenser and one part-time delivery driver. Only the regular RP and qualified dispenser were present during the inspection due to an unexpected absence. The pharmacy team members were observed working well together and communicated clearly to make sure people could access the pharmacy services on offer.

The team members explained that they organised workload based on when people required their medicines to help them manage the jobs that needed to be completed. The dispenser explained their role was to serve people on the counter and assemble prescriptions, which had been labelled, ready for the pharmacist to check. They were also aware of over-the-counter medicines that may be considered high-risk and the need to ask additional questions to supply these to people safely. Medicines containing codeine were provided as an example and the dispenser highlighted a time when they had to refuse a supply of this medicine to someone who was buying them on a regular basis. A discussion with the pharmacy team members had taken place so that everyone was aware of the incident.

Team members did not receive a formal appraisal or review of their performance but when questioned, the dispenser felt comfortable to raise any concerns and provide feedback. Team meetings did not take place, but the SI updated the team informally if any information needed to be shared. The pharmacy did not set any targets or incentives for its team members.

A trainee dispenser was undertaking training to become a qualified dispenser to help make sure they could work safely. The training was organised through a recognised training provider. Support from the provider was available and the SI explained they offered support when it was needed.

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

Summary findings

The pharmacy has very little clear work surface space for prescriptions to be assembled and checked in a safe manner. And there are areas which are untidy and disorganised. This increases the risks of mistakes happening. However, it is clean and it has a consultation room which is suitable for the services it offers.

Inspector's evidence

Overall, the pharmacy was clean, but the dispensary area was disorganised and untidy. Work surfaces used to assemble and check prescriptions were untidy and cluttered so limited the amount of space that was available for the workload to be completed in a safe and effective manner. Baskets containing prescriptions that were waiting to be checked by the pharmacist were piled on the floor which could increase the risk of medicines intended for one person falling into a basket for someone else. The pharmacist was seen checking prescriptions from the pile of baskets due to the lack of space. The fixtures and fitting were suitable for medicines to be stored securely. A clean sink was available with both hot and cold water which was used to prepare medicines that required mixing before handing out to people.

The pharmacy had a consultation room available to provide the services it offered. The entrance was wide enough for people with a wheelchair or a pram to enter. The room was clean, tidy, and professional in appearance. It was large enough to provide flu and COVID-19 vaccinations safely.

The pharmacy was secured overnight. It also had suitable lighting for the services it provided, and the room temperature was appropriate. The dispensary area was situated behind the front counter which restricted unauthorised access.

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

Summary findings

The pharmacy obtains its medicines and devices from licensed suppliers. But it doesn't effectively check the expiry dates of these medicines and devices or always separate date-expired items from other stock. This increases the chances that it provides people with medicines that are not safe to use. However, the pharmacy stores its medicines securely and at the required temperatures. And its team provides additional advice to people who are supplied high-risk medicines. It delivers medicines to people's homes, but it does not retain an audit trail for this service. So, it may be harder for the pharmacy to respond to any queries about its delivery service.

Inspector's evidence

The pharmacy had a ramp leading to a double door entrance making it easier for people with a wheelchair or pram to enter. The door to the consultation room was wide enough for people with limited mobility to access. The pharmacy advertised its opening times and services in the window using posters. A wall of health advice leaflets faced the entrance for people to access additional information.

The pharmacy delivered medicines to people's homes if they were unable to collect these from the pharmacy. A record of the deliveries due was created each day but these were destroyed when the delivery driver had completed the route. And there was no other record kept about deliveries that had been made. This could make it harder for pharmacy team members to respond to any queries they received regarding the pharmacy delivery service.

The pharmacy obtained its medicines and medical devices from multiple licensed sources and stored them appropriately to prevent unauthorised access. But some medicines stored on shelves, in the fridge, and in the CD cabinet were untidy and disorganised. This could lead to incorrect medicines being selected during the dispensing process. The expiry dates of medicines and devices were said to be checked every four to five months, but no records of these checks were made. When a selection of medicines was checked, some had gone past the expiry date (three packs of Optive plus eye drops, one bottle of pilocarpine 2% eye drops, four packs of Optive eye drops, four packs of Optive Infusion eye drops and seven bottles of Fortijuice liquid). The SI said that a full date check would be completed, and a record made to show this had been done.

Medicines that required cold storage were stored within the required temperature range and the temperature was recorded daily. Drug alerts and recalls were received by email. The team printed these and checked them against the stock on the shelves. And they annotated the print-outs with a tick but omitted the date and who checked them. This could make it harder to follow up any queries following a recall.

The pharmacy had two CD cabinets; one contained stock that was used to fulfil prescriptions and the second contained CDs that people had returned to the pharmacy. This made sure the returns were separated from the stock to reduce the risk of mistakes happening. But CD stock was not stored in an organised manner; this could lead to mistakes when assembling prescriptions.

The pharmacy accepted medicines that were no longer needed by people, and these were kept secure and separated from stock, pending destruction.

The pharmacy team were observed assembling prescriptions ready for people to collect. Baskets were used to separate prescriptions for different people. Notes were made on the prescription to highlight urgency or if a CD or fridge item was needed. And the pharmacist would make a note on the prescription if they needed to speak to someone about their medication. The team members were aware that prescriptions marked 'CD' had a 28-day validity and should not be handed out to people after this time. Medicines were picked according to the prescription and dispensing labels were attached to the medicine boxes. A dispenser was seen marking the dispensing label with a dot once they had attached it to the medicine box. But the SOP for dispensing indicated labels should be annotated with the dispenser's and checker's initials. Only using a dot would make it harder to identify who was involved in the dispensing process.

A handful of people who required additional support with taking their medicines were supplied their medicines in multi-compartment compliance packs. These packs were provided either on a weekly or monthly basis. And the pharmacy provided patient information leaflets so that people could access additional information about their medicines. The packs also had descriptions of the medicines contained in them so that people could easily identify their medicines.

The pharmacist was aware of when they would need to provide additional advice to people taking medicines containing sodium valproate, and checked if women of childbearing age were on the Pregnancy Prevention Programme. A recent audit had been completed and found that the pharmacy didn't currently supply to any people who were in the at-risk group. Educational materials were not readily available but the warning cards on the original packs of sodium valproate-containing medicines were provided.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the equipment it needs to provide its services effectively. And it uses its equipment in a way which helps protect people's personal information.

Inspector's evidence

The pharmacy had clean, calibrated conical measures which were used to measure liquids. Counting triangles were also available. The pharmacy had patient medication record (PMR) systems, one of which was on the front counter to help team members locate people's prescriptions. Access to these systems was restricted using a username and password. Information on computer screens wasn't visible to people, to maintain confidentiality. And cordless phones were being used to keep conversations private. Electrical equipment looked to be in good working order but had not undergone any safety testing. The pharmacist was able to access a range of resources online such as the BNF and Drug Tariff.

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.