General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pilning Community Pharmacy, Northwick Road, Pilning, BRISTOL, Avon, BS35 4JF

Pharmacy reference: 1106927

Type of pharmacy: Community

Date of inspection: 30/10/2019

Pharmacy context

This is a community pharmacy in the village of Pilning in South Gloucestershire, north of the city of Bristol. The pharmacy is attached to a doctors' surgery. A wide variety of people use the pharmacy. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy supplies medicines in multi-compartment compliance aids to help vulnerable people to take their medicines. It also supplies medicines to the residents of a small local care home.

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. The pharmacy is appropriately insured to protect people if things go wrong. It mostly keeps the up-to-date records that it must by law. The team members keep 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. The last error at the pharmacy was said to have been some time ago but the staff would do a full root cause analysis and complete an incident report form. Near misses were recorded but insufficient information was documented to allow any useful analysis, such as, a Sukkato strength error. It had not been documented what was on the prescription and what was picked. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. General trends could be identified. But, in September 2019, the majority of mistakes were form errors and no actions had been put in place to reduce the likelihood of recurrences. The staff did however say that any prescriptions for ramipril tablets were highlighted at the time of labelling to reduce the likelihood of picking capsules.

The main dispensary was spacious and organised. There were labelling, assembly, waiting to be checked and checking areas. There was a separate room for the assembly of multi-compartment compliance aids. This was also spacious and organised with separate assembly and checking benches.

Coloured baskets were used and distinguished prescriptions for patients who were waiting, prescriptions for collection and those for delivery. 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), 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. Local guidelines for medicine sales advice was displayed by the till but the questions that the staff should ask customers requesting to buy medicines were not. The pharmacy had a newly appointed medicine counter assistant trainee who would benefit from having these to-hand. A NVQ2 trained dispenser said that she would check the electronic prescription medication record of anyone asking to buy medicines but, also taking any prescribed medicines. If she was unsure about the suitability of the over-the-counter medicine requested, she would refer the person to the pharmacist. She was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as chloramphenicol eye drops and Beconase Nasal Spray and referred requests for these to the pharmacist. All the staff would refer any sales for young children and pregnant women to the pharmacist.

The staff knew 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. 15% of people had given feedback about having medicines in stock. Because of this, the pharmacy had a poster displayed in the window about the recent stock problems facing pharmacies. The staff said that they had a good relationship with the adjacent surgery and that they did their best to get prescriptions

changed, such as recently, for hormone replacement therapy patches, to items that were available.

Current public liability and indemnity insurance was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, specials records, fridge temperature records and date checking records were all in order. Private prescriptions were recorded electronically and several seen did not include the prescriber details.

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 generally stored securely. At the time of the visit, prescriptions were stored in an unlocked cabinet in an unlocked room. Later that day, the pharmacist sent an email stating that these had been moved to the dispensary. Confidential waste paper information was shredded. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had done 'Virtual Outcomes' e-Learning 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. They are encouraged to keep their skills up to date and they do this in work time. But, those team members who are in training don't have dedicated learning time. And, the team members do not have regular performance appraisals. So, any gaps in their skills or knowledge may not be identified and supported.

Inspector's evidence

The pharmacy was in the village of Pilning in South Gloucestershire, north of the city of Bristol. The pharmacy was attached to a doctors' surgery. They mainly dispensed NHS prescriptions, with the majority of these being repeats. Due to the location of the pharmacy, there were several acute 'walk-in' prescriptions. Several domiciliary patients and a few care home patients received their medicines in compliance aids. Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, one full-time European qualified pharmacist but working as a dispenser to increase her English language skills, two part-time NVQ2 trained dispensers (one not seen and both enrolled on the NVQ3 technician course), one part-time medicine counter assistant (MCA) and one part-time MCA trainee. A qualified technician was on maternity leave. The pharmacy had struggled to get a replacement and so employed an additional part-time counter assistant. The person who mainly covered the counter (not seen) had been enrolled on the technician course to address the skill mix at the pharmacy whilst the technician was on maternity leave.

The staff, all part-time, were flexible and generally covered any unplanned absences. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time. If necessary, locum dispensary help would be obtained. The staff worked well together as a team. Staff performance was said to be monitored, reviewed and discussed informally throughout the year. But, there had been no formal performance appraisals since the change in superintendent pharmacist about 18 months ago.

The staff were encouraged with learning and development and completed 'Virtual Outcomes' e-Learning, such as recently on the surgery referral service. They said that they spent about 30 minutes each month of protected time learning. However, staff enrolled on accredited courses, such as the NVQ3 technician's course, were not allocated dedicated learning time towards their courses. All the dispensary staff reported that they were supported to learn from errors. The pharmacist seen, said that all learning was documented on her continuing professional development (CPD) record.

The staff knew how to raise concerns or other issues. They said that this was encouraged and acted on. There were monthly staff meetings which were recorded. The staff were aware of the pharmacy's whistle-blowing policy. The pharmacist said that she was not set any specific targets for advanced and enhanced NHS services. She said that she tried to do two Medicine Use Reviews (MURs) each day and any appropriate New Medicine Service (NMS) reviews.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally looks professional. There is good signposting to the consultation room so it is clear to people that there is somewhere private for them to talk. But, some aspects of security in the pharmacy could be better.

Inspector's evidence

The pharmacy was well laid out and generally presented a professional image. The electrics were exposed on a wall in the dispensary. The staff said that they were safe but that they were waiting for a door to be fitted. A piece of trim to a dispensary bench in the compliance aid room was missing. The dispensing benches were uncluttered and the floors were clear. The premises were clean.

The consultation room was spacious and well signposted. It contained a computer, a sink and three chairs. The chairs were covered in fabric which may make them difficult to clean. The room was unlocked and a fridge in this room, also unlocked, contained flu vaccinations and insulin. Later, on the day of the inspection, the pharmacist seen, sent an email stating that the fridge had been re-located to the compliance aid room. Conversations in the consultation room could not be overheard. A room where the out-of-date and patient-returned medicine bins were stored was also unlocked. These had also been re-located to the compliance aid room later on the day of the inspection.

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. 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

Most people can access the services that the pharmacy offers. But, some people with specific mobility needs may have difficulty entering the pharmacy. The services are effectively managed to make sure that they are provided safely. The pharmacy team members make sure that people have the information that they need to use their medicines correctly. They intervene if they are worried about anyone. The pharmacy gets its medicines from appropriate sources. The medicines are generally stored and disposed of safely. The team members make sure that people only get medicines and devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room but no bell on the front door to alert staff to anyone who may need assistance entering the pharmacy. There was access to Google translate on the pharmacy computers for use by non-English speakers. The staff also spoke several foreign languages. 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) and seasonal flu vaccinations. The latter was also provided under a private scheme. The services were well displayed and the staff were aware of the services offered. The pharmacy had also taken part in a pilot General Practitioner referral scheme. All medicines offered under this scheme could be bought.

The regular pharmacist (not seen) had completed suitable training for the provision of seasonal flu vaccinations including face-to-face training on injection technique, needle stick injuries and anaphylaxis. The pharmacy did not offer the free NHS EHC service. The staff said that all their patients were also the patients at the surgery and they would refer any patients needing EHC to the surgery.

Several domiciliary patients and a few care home patients (residential) received their medicines in compliance aids (blister packs). These were assembled and checked in a separate organised room. The domiciliary blister packs 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. There was clear concise audit trail of any changes and other issues which gave the checking pharmacist a clear clinical picture of the patient. These were referred to at the checking stage. The pharmacy ordered the prescriptions on behalf of these patients and there was a clear audit trail of what had been ordered. The assembled blister packs were stored tidily on the shelves above the assembly and checking areas.

Similar organised procedures were in place for the medicines supplied to a small local care home. 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 ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. Medicines were delivered by volunteers and the service was run by

the community. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Green 'see the pharmacist' stickers were used. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were recorded. She also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. All the staff were aware of the new sodium valproate guidance. The pharmacist said that whilst most patients were well informed about their medicines, she sometimes identified during MURs, that patients were sometimes non-compliant with their medicines, such as, not taking furosemide if they were going out or taking their statins because of side effects. She said that they often felt more comfortable speaking to her that to their doctor. The pharmacist escalated any concerns, with the patient's permission to their doctor.

Medicines and medical devices were obtained through the e-CASS2 Cambrian alliance, mainly from AAH, Alliance Healthcare, Phoenix and Colorama. Specials were obtained from Thame Laboratories. Invoices for all these suppliers were available. A scanner was used to check for falsified medicines as required by the Falsified Medicines Directive (FMD). This was aligned to labelling and so reduced the likelihood or picking errors. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were a large quantity of patient-returned CDs and some 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. Fridge lines were correctly stored with electronic records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins and bags were available for medicine waste and used. But, these were located in an unlocked room. And, two strips of Gedarel 30/150mcg were seen to have been placed in the ordinary yellow waste bag. There was no dedicated separate bin for cytotoxic and cytostatic substances, of which Gedarel is one. There was a list of such substances that should be treated as hazardous for waste purposes. The pharmacist gave assurances that the staff would be trained on the contents of the list. She also sent an email on the day of the visit to say that the waste bins and bags had been re-located to the compliance aid room and that the Gedarel had been appropriately separated.

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 23 October 2019 about Avonex 30mcg/0.5ml solution. The pharmacy had none 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 clean and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10-100ml) and ISO stamped straight measures (100ml). There were four tablet-counting triangles, one of which was kept specifically for cytotoxic substances and one capsule counter. These 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 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.