General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bottisham Pharmacy, 8 High Street, Bottisham, CAMBRIDGE, Cambridgeshire, CB25 9DQ

Pharmacy reference: 1109266

Type of pharmacy: Community

Date of inspection: 12/02/2020

Pharmacy context

This community pharmacy is in the middle of the village of Bottisham. Its main activity is dispensing NHS prescriptions. Most medicines it dispenses are for people in care homes and the majority of these medicines are supplied in multi-compartment compliance packs. It also supplies medicines in multi-compartment compliance packs to many people who live at home. Three delivery drivers take medicines to people's homes and to the care homes. The pharmacist also provides Medicines Use Reviews and New Medicine Service checks. And he occasionally receives patient referrals through the Community Pharmacy Consultation Service.

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	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 identifies and manages the risks associated with its services adequately. It has made improvements to how it looks after people's information. And it uses mistakes in the dispensing process as opportunities to improve and learn from. The pharmacy keeps the records that it needs to by law. And pharmacy professionals understand their role in protecting vulnerable people. The pharmacy has written procedures which tell its staff how to complete tasks safely, and these are reviewed so they reflect current practice. But, not all members of the pharmacy team have signed the procedures. This could make it harder to be sure that all members of staff are aware of and are following the procedures correctly.

Inspector's evidence

The pharmacy was reviewing and strengthening its processes for managing confidential information. A new set of procedures had been introduced by the superintendent (SI), who was also the named Data Protection Officer. The regular pharmacist was studying these procedures. The pharmacist was aware of previous concerns and failings identified in relation to how confidential waste had been managed. He said both he and the SI had identified further improvements that the pharmacy needed to make following an audit of the pharmacy's information governance processes. These improvements included additional staff training on protecting sensitive information, particularly for delivery drivers, and making sure that any incidents involving the inadvertent disclosure of data were recorded appropriately. Changes had already been made to how confidential waste was destroyed. It was collected in the dispensaries and transferred to designated secure containers for disposal by specialist waste contractors. There was evidence that these containers were collected and replaced each month. A notice telling people about how their information was handled and giving the name of the Data Protection Officer was displayed in the pharmacy. There was no confidential information visible to people visiting the pharmacy. Staff were seen removing patient identifiers from waste medicines before disposing of them.

There was a set of written procedures for other pharmacy activities. These had been reviewed by the current SI in 2019 and most of them had been signed by those members of staff to whom they applied. However, a member of staff recruited in November 2019 and the part-time pharmacist who covered the care home dispensary had not signed the written procedures.

The pharmacy kept the records that were required by law and these were generally complete. The notice about the responsible pharmacist (RP) was displayed but it was behind some medicines, so the details were somewhat obscured. The position was changed during the inspection. A record was kept of the RP's shift times and this was complete. Records about private prescriptions were made electronically. Most of these were accurate though the date prescribed on a recent entry was incorrect; the pharmacist said he would be more vigilant about this in future. Emergency supplies were very rare and there were no recent records to view. Records about controlled drugs (CDs), including patient-returned CDs, were made in an electronic register. The entries viewed were complete. Running balances were kept and checked regularly. Patient-returned CDs were recorded on receipt. The pharmacy displayed a certificate showing that it had current professional indemnity and public liability insurance.

Mistakes which dispenser made during the dispensing process which were spotted by the pharmacists were recorded in a near miss record. There was evidence that near misses were recorded regularly. Staff members said that the pharmacists would make them aware of their mistakes and ask the member of staff to correct them. The RP said he would discuss incidents with the individual to try to stop a similar mistake in future. The records were made by the pharmacists. There was a good level of detail about the items involved and who was responsible for the near miss but there was no information about how the mistake had been made or other contributing factors. This could make it harder for the team members to spot any patterns or trends or put in place specific improvement actions. Dispensing errors which had left the pharmacy were recorded and reported to the National Reporting and Learning System. There was some evidence that these were reviewed to identify what had gone wrong and preventative actions taken though the information recorded was brief.

When asked, an assistant who worked in the pharmacy and who had not completed any accredited pharmacy training said they always referred requests for Pharmacy (P) medicines to the pharmacist. They also said that they didn't do any dispensing and did not put away stock in the dispensary. Pharmacists accuracy checked all prescriptions before the medicines were supplied. And there a clear audit trail on all dispensed medicines to identify who had been involved in dispensing and checking each item.

The RP had completed level two training about safeguarding vulnerable people provided by the Centre for Pharmacy Postgraduate Education. He knew how to find contact details for local safeguarding bodies. He said that, in practice, if he had any safeguarding concerns, he would discuss these with the SI to agree the best course of action. When asked, the delivery driver explained that if had concerns about anyone he delivered medicines to he would refer this information back to the pharmacist. The pharmacy routinely followed up with people if they couldn't deliver medicines as expected.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. It can alter its staffing arrangements to cope with changes in its workload. And pharmacy professionals can exercise their professional judgement to act in people's best interests. The pharmacy could do more to make sure its staff are enrolled promptly on the required accredited training for the roles they carry out. And the lack of a structured approach to ongoing training may make it harder for trained staff to keep their skills and knowledge up to date and to identify any additional training needs.

Inspector's evidence

At the time of the inspection there was the responsible pharmacist (the regular pharmacist), a second pharmacist working in the upstairs dispensary, the pharmacy manager (a trained NVQ level dispenser), one untrained counter assistant, one trained dispenser and two dispensers in training. There had been some delay in enrolling one of the trainee dispensers on accredited training; this had just been done despite the person being in role for around a year. The pharmacy manager was reminded of the training requirements for pharmacy support staff.

The team appeared to be managing the workload adequately. The pharmacy manager explained that the hours could be increased on weeks where the dispensing workload was heavier. Information was shared amongst the team during meetings or one-to-one discussions. There was also a staff notice board in the dispensary where information was recorded about previous meetings. The current information displayed was pointing out the need for dispensers to be careful about the form of a medicine to reduce selection errors.

There was no structured training or specific time set aside for staff to do ongoing training. However, staff members said they received on the job coaching and feedback from the pharmacists. And the RP said staff were able to do training at work at quieter times when needed. There was no formal appraisal process for staff.

The SI visited the pharmacy regularly and the RP said he felt able to raise any concerns with the SI. The RP felt able to exercise his professional judgement and said he would be supported by the SI in doing so. There was a whistleblowing policy for staff. The second pharmacist was aware of the authorisations that were required for the covert administration of medicines to people and would look for documented evidence of this before making supplies or offering advice to care home staff about this.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides its services from suitable premises. The pharmacy has enough space to safely provide its services, and it has appropriate security arrangements to protect its premises.

Inspector's evidence

The pharmacy was made up of four main areas; the retail space which had a small a consultation room, the downstairs' dispensary, a separate upstirs dispensary for dispensing care home prescriptions, and staff facilities. All areas were reasonably clean and tidy though the downstairs' dispensary was a little cluttered in places. The premises could be secured appropriately. Pharmacy medicines could not be self-selected by members of the public and the dispensaries were protected from unauthorised access. The consultation room was just large enough to accommodate two chairs and a table. It would have been difficult to accommodate a chaperone in this space but there was a window in the door which could have allowed someone to view from the outside. The RP was asked to consider how this window might be obscured if a patient required more privacy.

The workbenches were largely tidy and there was enough space to complete dispensing tasks safely. There were separate parts of workbenches reserved for checking prescriptions to reduce risks from distraction and clutter. There was adequate heating and lighting throughout the pharmacy; room temperatures were monitored. There was a portable air-conditioning unit available if needed during warmer months. The pharmacy had hot and cold running water available with separate handwashing facilities for staff.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services effectively. The pharmacy obtains its medicines from reputable suppliers and generally stores them appropriately. It understands how to respond to alerts about the safety of medicines. But it does not keep a record of what it has done about these. So, it is harder for the pharmacy to show it has taken the right action to remove affected medicines from circulation. And it doesn't always highlight prescriptions for medicines which are higher risk. This could increase the chances of some medicines being handed out when the prescription isn't valid. And some people may not get the advice they need to take their medicines safely.

Inspector's evidence

There were two small steps up into the pharmacy which made it difficult for people in wheelchairs to use the pharmacy. There was no bell at the entrance for people to attract attention, but staff said they would watch out for people who might need assistance at the door. There were practice leaflets available in the retail area and these gave people information about the pharmacy's services and how to raise a concern about the pharmacy. Most of the medicines dispensed by the pharmacy were delivered to people. And some people were supplied their medicines in multi-compartment compliance packs to help they take their medicines at the right times.

Dispensers used baskets to make sure prescriptions were prioritised and medicines remained organised. Computer-generated labels contained relevant warnings and were initialled by the dispenser and checker to provide an audit trail. Prescriptions were kept with checked medicines awaiting collection so the pharmacist could readily refer to these when the medicines were handed out. Prescriptions for most CDs were highlighted using stickers so the pharmacy could check prescription dates to make sure these medicines were supplied while prescriptions remained valid. These stickers weren't usually applied to prescriptions for zopiclone. The RP said he would review this process to include all appropriate CDs.

The pharmacy provided medicines in multi-compartment compliance packs to people living at home and to people living in care homes. However, an increasing number of medicines were now being supplied to care homes as the original packs. The supplies to care homes were assembled and checked in the upstairs dispensary. And the packs for people living at home were prepared in the dispensary downstairs. To make sure that supplies for both types of destination were ready on time, the pharmacy had work matrices to spread the workload across four-week cycles.

There were also arrangements to supply acute medicines to care home residents during the cycle, in a timely way. Patient information leaflets were supplied to all patients. Multi-compartment compliance packs for people living at home included descriptions of the contents so people could identify their medicines more easily. There were audit trails on all packs to show who had dispensed and checked them. Staff were aware of the types of medicines which were not suitable for putting into compliance packs such as those with variable doses. They checked new prescriptions against the records they had for the patients and would query any unexpected changes with care home staff, patients, or the prescribers. Notes about any changes or interventions were kept.

The pharmacy kept records about medicines that were delivered to people at home or to the care

homes. The delivery drivers updated the records using an application on a hand-held device as soon as a delivery was made. This meant the pharmacy had up-to-date information about the status of deliveries if people phoned to enquire about their medicines. When asked, a delivery driver explained the process he followed if a person wasn't at home to receive a delivery. He explained that alternative delivery locations and posting through letterboxes was only done where this had been agreed with the pharmacy, to minimise risks.

The pharmacist working in the downstairs dispensary said that he tried to check that people taking higher-risk medicines such as warfarin were having the relevant blood checks to make sure the dose they were taking was appropriate. However, prescriptions waiting to be collected were not routinely highlighted. There wasn't a robust process for making similar checks for people living in care homes. However, most people were on newer types of anticoagulant medicines which didn't require the same level of monitoring. The pharmacist was aware about pregnancy prevention advice to be provided to people in the at-risk group taking valproates. The pharmacist had most of the educational literature and safety stickers to support this advice and said he would order replacement cards as there were none of these left.

The pharmacy said it obtained its medicines from a range of licensed wholesalers and specials suppliers. It did not have a wholesale dealer's license. It used two fridges to store medicines that needed cold storage. The fridge temperatures were recorded each day to make sure the fridge stayed at the right temperatures. CDs were stored appropriately. CDs which had gone past their 'use-by' date were separated from other stock to prevent them being mixed up. Other medicines were generally stored appropriately and in their original packaging. There were some repackaged medicines which had been labelled with the original expiry date and batch number but not the manufacturer. Some tablets removed from blisters and put into bottles had been given a shorter shelf-life of eight weeks from the date of decanting, as changing the storage environment of tablets may impact their stability. But the pharmacy had not removed these from their shelves once this date had been reached.

The pharmacy checked its stock's expiry dates. It kept records about most of the checks that it had completed recently. Medicines that were approaching their expiry date were highlighted to the team. Several medicines were checked at random and were in date. The pharmacy generally put the date onto medication bottles when they were first opened but one item was found during spot checks without this information. The expiry date of this medicine was limited to one month after opening so it would be difficult for staff to determine if this item was still appropriate to supply. The medicine was subsequently destroyed when this was pointed out. Date-expired and medicines returned from care homes were separated from dispensing stock and were transferred to pharmaceutical waste bins once any confidential material was removed. These bins were kept safely away from other medicines.

The pharmacy did not yet have the equipment or software to enable it to verify the authenticity of its medicines and to comply with the Falsified Medicines Directive. The RP explained that they were still investigating the best provider for this. The pharmacy received information about recalls and safety alerts issued by the MHRA. The pharmacy manager was aware of recent alerts about products containing ranitidine and could explain the action that would be taken if the pharmacy had any stock affected by a recall. However, the pharmacy didn't keep a record of receiving safety alerts or information about the action it may have taken. That could make it harder for the pharmacy to demonstrate it has always taken the appropriate action to protect patient safety. The pharmacy manager said he would review how the pharmacy could evidence this in future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment and facilities to provide its services. It checks its equipment to make sure it is working correctly.

Inspector's evidence

The pharmacy's equipment appeared to be in good working order and was maintained adequately. There was some evidence of previous safety tests on some of the pharmacy's electrical equipment. Its computers were password protected to prevent unauthorised access to people's medication records. Staff used their own NHS smartcards to access electronic prescriptions and did not share passwords for these.

The pharmacy had a range of measuring cylinders; some of these were plastic and were not marked in any way to show they had been validated. The pharmacy manager said he would replace these with glass measures of a suitable standard. The pharmacy's team members had access to up-to-date reference sources on the internet to assist with queries and professional checks. The pharmacy fridges were equipped with maximum and minimum thermometers and the temperatures were checked daily to make sure medicines were stored in suitable conditions. The records viewed showed that the temperatures had remained within 2 and 8 degrees Celsius. The fridges were also alarmed so staff would know if the temperatures moved outside of the required range.

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.