General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Biscot Pharmacy, 157A Biscot Road, LUTON, Bedfordshire, LU3 1AW

Pharmacy reference: 1110108

Type of pharmacy: Community

Date of inspection: 04/09/2019

Pharmacy context

This is a 100-hour community pharmacy located on a busy road in a residential area of Luton in Bedfordshire. The pharmacy dispenses NHS and private prescriptions. It offers some services such as Medicines Use Reviews (MURs), the New Medicine Service (NMS) and travel vaccinations, including the ACWY vaccine for meningitis. And, it supplies multi-compartment compliance aids to people if they find it difficult to take their medicines on time.

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

Overall, the pharmacy manages risks in an adequate manner. Members of the pharmacy team protect people's private information appropriately and they maintain most of their records in accordance with the law. Pharmacy team members deal with their mistakes responsibly. But, they are not always recording or formally reviewing them. This could mean that they may be missing opportunities to learn from their mistakes and prevent them happening again.

Inspector's evidence

The pharmacy held a range of documented standard operating procedures (SOPs) to support the provision of its services. They were last reviewed in 2018, the team's roles and responsibilities were defined within them and existing staff members had read and signed the SOPs. There was also a new sign-off sheet that was in the process of being filled out by newer members of the team. Trained members of the team understood their roles and responsibilities, staff in training were being appropriately supervised and the correct notice for the responsible pharmacist (RP) was on display. This provided details of the pharmacist in charge of operational activities on the day.

The pharmacy was relatively organised and clean. Staff dispensed prescriptions from a separate part of the main workbench or used a separate table for multi-compartment compliance aids and the RP accuracy-checked medicines from a separate area. This helped to reduce the likelihood of errors happening. Team members explained that when medicines were involved in incidents or were similar in some way, such as amlodipine and amitriptyline, they were separated. However, staff were not routinely recording or reviewing their near misses. This reduced their ability to demonstrate effective learning from mistakes.

There was a documented complaints process in place and incidents were usually handled by pharmacists. The superintendent pharmacist was present during the inspection and his process was generally in line with the policy although details about the incidents were not always being documented. The last incident involved valsartan and verapamil being inadvertently mixed up and supplied, this was not taken incorrectly, the team was informed, and the two medicines were subsequently separated. There was a box in the retail space for people's comments and suggestions although there were no details to inform people about the pharmacy's complaints procedure. This was discussed at the time as it meant that people may not have been able to raise their concerns easily.

The pharmacy displayed details about how it maintained people's privacy and it was registered with the Information Commissioners Office. Staff segregated confidential waste before it was shredded and sensitive details on dispensed prescriptions awaiting collection could not be seen from the retail space. The RP had accessed Summary Care Records for queries about allergies and he obtained people's consent to do this verbally.

Staff could identify signs of concern to safeguard vulnerable people and referred to the RP in the event of a concern. The RP stated that he last completed training on safeguarding about five years ago by attending a course. He was advised to update his knowledge during the inspection. There were also no relevant contact details available about the local safeguarding agencies. This could lead to a delay in alerting the appropriate authorities if a situation required escalating. Ensuring relevant contact details

were in place was discussed at the time.

The pharmacy's indemnity insurance was through Numark and this was due for renewal after January 2020. Records for the maximum and minimum temperatures for the pharmacy fridge were kept daily to verify that medicines were appropriately held here. Records for controlled drugs (CDs) that were returned to the pharmacy to be disposed by the team were maintained, although there were several gaps seen in the past where details about their destruction had not been entered. The RP record, a sample of registers seen for CDs and some records of emergency supplies were maintained in line with statutory requirements. Balances were seen to be checked regularly with CDs and on randomly selecting CDs held in the cabinet, the quantities held, matched the balance in the corresponding registers. However, there were missing prescriber details seen in the electronic private prescription register.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members understand their roles and responsibilities. They are provided with resources to help keep their skills and knowledge up to date.

Inspector's evidence

Staff present during the inspection included the RP who was also the superintendent pharmacist, an apprentice, two dispensing assistants and the pre-registration pharmacist. The latter's shift finished shortly into the inspection. One of the dispensing assistants was trained, the second was undertaking accredited training for the NVQ 2 in dispensing. Other staff included a part-time delivery driver, three medicines counter assistants, another dispensing assistant and two regular locum pharmacists. The staff were not wearing name badges, but their certificates of qualifications obtained were seen.

Counter staff asked relevant questions before selling medicines over the counter (OTC). They referred to the RP when they were unsure or when required and held a suitable amount of knowledge of OTC medicines. Unusual quantities or requests of some medicines with potential for abuse were monitored, and subsequent sales were referred to the RP. Staff in training completed their course material at home. To assist with training needs, the team described reading available literature or using modules from Numark. They communicated verbally or used WhatsApp and staff progress was monitored informally. There were no formal targets in place to complete services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an appropriate environment to deliver healthcare services. The pharmacy is secure, and it has a space to offer private conversations and services.

Inspector's evidence

The pharmacy premises consisted of a small retail area and a somewhat larger dispensary behind with a small kitchenette area at the very rear. A signposted consultation room was available for private conversations and services. The room was of a suitable size, it was kept unlocked but there was no confidential information accessible. The pharmacy was suitably lit and well ventilated, the retail space was presented appropriately, and the pharmacy was generally clean. Some of the fixtures and fittings in the dispensary were dated but still functional. Pharmacy (P) medicines were stored behind the front counter, staff were always within the vicinity and this helped restrict these medicines from being self-selected.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is open for longer hours than usual and its team is helpful. They make suitable adjustments so that people with different needs can access the pharmacy's services. The pharmacy generally provides its services in a satisfactory manner. It obtains its medicines from reputable sources. And, it largely stores and manages them appropriately. But, the pharmacy is not always storing compliance aids in the safest way. And, team members don't always make or record relevant checks for people with higher-risk medicines. This makes it difficult for them to show that appropriate advice has been provided when these medicines are supplied.

Inspector's evidence

The pharmacy was open for long hours and its opening hours were on display. People could enter the pharmacy at street level with a ramp outside and from a wide front door. There was some clear, open space inside the premises and a relatively wide aisle. This meant that people requiring wheelchair access could access the pharmacy's services. Staff described using representatives for people with different needs, or they showed products to them, used gestures, spoke slowly or provided verbal information. This included people who were visually impaired or partially deaf. Team members could also speak Bengali, Urdu, Arabic and Pahari if required to help converse with people from the local population. This was observed during the inspection. Some members of the public specifically asked for the pharmacist so that they could speak to him in Urdu. There were two seats available for anyone wanting to wait for their prescriptions and some leaflets available about other services.

In addition to the Essential services, the pharmacy provided travel vaccinations against Patient Group Directions (PGDs). This did not include yellow fever vaccinations. According to the RP, they mostly vaccinated people going on Hajj or Umrah with the ACWY vaccine for meningitis. The PGDs were readily accessible, pharmacists authorised to provide the services were trained through accredited routes and there was relevant equipment present. This included a sharps bin and adrenaline, required in the event of a life-threatening allergic reaction to vaccines. The pharmacy carried out risk assessments, informed people's GP's and obtained informed consent before commencing the service.

The pharmacy also provided a private GP service (Medicspot). This involved people booking an appointment online or they could come into the pharmacy. The process involved a consultation with an online GP by the person logging onto a system that was situated in the consultation room, a face to face interaction then took place by using a webcam in the room, personal details were filled in by the person, submitted by them and checked by the online GP. Diagnostic equipment was present, they were attached to the system, relevant information was uploaded to the prescriber and included a stethoscope, a blood pressure machine, Pulse Oximeter and a thermometer. Staff were trained on how to use this and described cleaning the machines after each use. According to the team, the equipment was calibrated or replaced every year. Private prescriptions were generated after the consultation and sent to the pharmacy electronically. The method of transmission used was in line with legal requirements.

People were supplied with compliance aids after the pharmacist or staff assessed their suitability for them. Prescriptions were then sent by people's GP practice automatically every month and staff explained that they cross-referenced details against people's individual records or records on the

pharmacy system to identify any changes or missing items. This was confirmed with the prescriber and records were maintained. All medicines were de-blistered into the compliance aids with none left within their outer packaging. Patient information leaflets (PILs) were supplied routinely. Mid-cycle changes either involved retrieving the compliance aids, amending, re-checking and re-supplying them or providing new ones. However, the pharmacy did not always provide descriptions of the medicines within the compliance aids. This meant that people may not have had all the information needed to identify their medicines. In addition, the compliance aids were also seen to be left unsealed overnight.

The pharmacy delivered medicines to people's homes and maintained records to verify this. CDs and fridge items were highlighted, checked prior to delivery and signatures were obtained from people when they were in receipt of CDs. Failed deliveries were brought back to the pharmacy with notes left to inform people about the attempt made. Staff explained that medicines were sometimes posted through people's letterboxes, but they checked relevant risks before delivering such as whether pets or children were present, and they did not deliver in these cases. Other than for CDs, the driver ticked people's records rather than routinely obtaining signatures from people once they had delivered their medicines.

Staff were aware of risks associated with valproate and there was literature available to provide to females at risk, upon supply of this medicine. People prescribed higher-risk medicines were not always identified and only sometimes asked about relevant parameters, if for example, the dose on their prescription was unclear. There were no details recorded to verify the checks that had been made. This included information about the International Normalised Ratio (INR) level for people prescribed warfarin.

The team used baskets to hold prescriptions and medicines to prevent any inadvertent transfer. Staff involvement in these processes was apparent through a dispensing audit trail that was used. This was through a facility on generated labels.

The pharmacy obtained its medicines and medical devices from licensed wholesalers such as Alliance Healthcare, AAH, Phoenix, Colorama, Trident and Doncaster. Colorama and Target HealthCare were used to obtain unlicensed medicines. The pharmacy was not yet complying with the European Falsified Medicines Directive (FMD), it was registered with SecurMed although staff were not yet trained on the decommissioning process.

Medicines were stored in an organised manner. There were no date-expired medicines seen and short-dated medicines were identified. The team date-checked medicines for expiry every three to six months and a schedule was in place to help verify this. Liquid medicines with short stability, were marked with the date upon which they were opened. CDs were stored under safe custody. Keys to the cabinet were maintained during the day and overnight in a manner that prevented unauthorised access. Medicines were generally stored evenly within the fridge. Drug alerts were received by email, stock was checked, and action taken as necessary. An audit trail was available to verify this process. However, there were some mixed batches seen and the occasional poorly labelled container. This was discussed during the inspection.

The pharmacy used designated containers to hold medicines returned by people for disposal. They were collected in line with the pharmacy's contractual arrangements and included containers for hazardous or cytotoxic medicines. However, there was no list available for the team to identify these medicines. People returning sharps for disposal were referred to the local council. Returned CDs were brought to the attention of the RP, details were entered into the CD returns register, they were segregated and stored in the CD cabinet prior to destruction.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities it needs to provide its services safely. Its equipment is usually kept clean and helps to protect the privacy of people.

Inspector's evidence

The pharmacy was equipped with current reference sources, counting triangles and a range of clean, crown stamped, conical measures for liquid medicines. There were also designated measures for measuring methadone. The dispensary sink used to reconstitute medicines was clean with hot and cold running water available with hand wash present. However, some of the triangles could have been cleaner. The blood pressure and blood glucose machine were described as not being used. The CD cabinet was secured in line with statutory requirements. Medicines requiring cold storage were stored at appropriate temperatures within the fridge. Computer terminals in the dispensary were positioned in a manner that prevented unauthorised access.

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.