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: 25/07/2023

Pharmacy context

The pharmacy is in a parade of businesses near a doctor's surgery in a residential area of Luton. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include supply of emergency hormonal contraception (EHC), prescription collection and delivery, substance misuse and treatment for malaria, meningitis ACWY and seasonal flu vaccinations. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

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’s working practices are generally safe and effective. It has adequate written instructions to help team members identify and manage risks. But they do not always follow all steps so those instructions may not fully reflect current practice. The pharmacy's team members mostly keep the records they need to so they can show the pharmacy is providing safe services. They protect people's private information and understand their role in safeguarding vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. They did not routinely record them or the lessons they learnt from them. So, they could be missing opportunities to spot patterns or trends with the mistakes they made. The responsible pharmacist (RP) explained that some medicines involved in incidents, or were similar in some way, such as amitriptyline and amlodipine, were separated from each other in the dispensary to help avoid picking errors. And segregating fast moving medicines often separated similar medicines as well as improving workflow. Member of the team had attached labels to the shelf edges warning them of similar medicines which they might pick by mistake.

When members of the pharmacy team were making up people’s prescriptions, they used baskets to separate each person’s medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were checked by the RP. Members of the team initialled the ‘dispensed’ and ‘checked’ by boxes on the dispensing labels to show who assembled the prescription. The pharmacist added warning stickers and cards to prescriptions alerting people to storage requirements or to arrange a blood test. And significant interventions were recorded for future reference. Members of the team were trained to check patient details to make sure they handed medicines out to the right people.

The RP described receiving a prescription for a controlled drug (CD) and checking its validity. First, the RP would check the prescription type such as FP10, FP10PCD, FP10MDA or private prescription. Where appropriate, the RP checked the prescription had been completed with the patient’s date of birth (DOB), name and address, NHS number and ensured the back of the prescription was completed by the patient or their representative and included identification. If there was missing information, the pharmacy would gain consent to check the summary care record (SCR). If there was missing prescriber information such as their signature, the practice number and the date of issue of the prescription, the RP would phone the surgery to verify the missing details and arrange a replacement prescription or for the prescription already received to be amended. The RP checked the date the prescription was issued to make sure the CD prescribed was supplied within the period that the prescription was valid. And that the prescription had not been issued too soon after the last time the CD was dispensed. The RP demonstrated an intervention relating to a prescription for a schedule 3 CD which had been issued too soon. The RP checked the strength of the CD and that the dose was stated in full and not ‘as directed’. The pharmacy team checked for available stock in the pharmacy before placing an order. The pharmacy had patient group directions (PGDs) to supply treatment for erectile dysfunction, malaria and the meningitis ACWY vaccination.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided although some were due for review and previous versions could be archived. The pharmacy had a complaints procedure. The SOPs for CDs have been reviewed most recently. A section of an SOP outlining dealing with CD requisitions, stocking and supplying CDs, had spaces to record names of people authorised to access CDs in the pharmacy but the names had not been recorded. The superintendent pharmacist (SI) provided a copy of the pharmacy's SOP for delivering schedule 2 CDs. The CDs were audited monthly although the SOP referred to a weekly audit. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. Their roles and responsibilities were described in the SOPs. During the visit, two team members explained that they would not sell certain products or give out a prescription if the pharmacist was not on the premises. They described why they would not sell two different over-the-counter (OTC) medicines containing codeine to the same person. And they would refer repeated requests for the same or similar products, such as medicines liable to misuse to a pharmacist.

The pharmacy had assessed the impact of risks associated with the COVID-19 virus upon its services and the people who used the pharmacy. Many of these measures put in place to help protect people against the virus had been relaxed. Each SOP had a review procedure and a section on known risks for the procedure. Completing, documenting and updating risk assessments for the pharmacy's services was discussed with the members of the team.

The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and when. It displayed a notice that told people who the RP was. The pharmacy had controlled drug (CD) and methadone registers which were generally complete, but some headers had not been filled in. And making sure the CD register showed the details of health care professionals collecting CDs on behalf of people was discussed. The stock levels recorded in the CD register were checked monthly. A check of the actual stock of two CDs matched the recorded amount in the CD register. The pharmacy supplied CDs via instalment prescriptions and the quantity supplied was correctly recorded in the register and endorsed on the prescription. The pharmacy kept records for its supplies of unlicensed medicinal products and private prescriptions. And these generally were in order. But the name and address of the prescriber were sometimes incorrectly recorded. The pharmacy provided some treatments such as meningitis ACWY vaccination via online patient group directions (PGDs).

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Its team tried to make sure people's personal information was not visible to anyone who should not see it by keeping computer screens turned away from people waiting in the public area of the pharmacy. The pharmacy SI had completed a level 3 safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members who are trained or in training. They work well together to manage the workload. They are aware of the potential to misuse certain medicines so they refer inappropriate purchase requests to the pharmacist.

Inspector's evidence

The pharmacy team consisted of the superintendent pharmacist (the RP) who covered weekdays with another pharmacist and a locum pharmacist who provided cover at the weekends. On the day of the inspection, the RP was supported by a full-time dispensing assistant, a part-time healthcare assistant and a full-time medicines counter assistant. The RP explained that the pharmacy team also included two full-time apprentices, two pharmacy students and two delivery persons. The RP was signposted to GPhC guidance on Requirements for the education and training of pharmacy support staff (Oct 22). The pharmacy provided newly recruited team members with induction training which included confidentiality, SOPs and their roles in the pharmacy team. Members of the pharmacy team had completed or were undertaking accredited training relevant to their roles. The pharmacy team relied upon each other to cover absences.

Team members worked well together serving people and processing their prescriptions. During the COVID-19 pandemic, the pharmacy had closed during lunchtime to help manage the workload. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy team members followed an OTC sales and self-care procedure which described the questions they needed to ask people when making OTC recommendations. And they knew when to refer requests to a pharmacist. During the inspection visit, the team members serving on the medicines counter were observed referring to the RP regarding requests for medicines which were liable to misuse such as painkillers and medicines to help people sleep. They knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally safe, secure and suitable for the provision of pharmacy services. The pharmacy prevents people accessing its premises when it is closed so that it keeps its medicines and people's information safe.

Inspector's evidence

The registered pharmacy premises were bright and secure. And steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a retail area with a medicines counter and access to a small consultation room where people could have a private conversation with a team member. And people attending the pharmacy to be supervised consuming CDs could use the consultation room. The consultation room was not locked when not in use but equipment was generally stored in high level cabinets. And there were handwashing facilities. The dispensary was located on the same level as the retail area. Since the previous visit, the dispensary had been partially re-fitted to optimise storage and available workspace. Some items were stored on the floor at the time of the visit. Worksurfaces in the dispensary could become cluttered when the pharmacy was busy. The pharmacy team was responsible for keeping the pharmacy’s premises clean and tidy.

The website included an A-Z health information guide. It also offered GSL and P medicines for sale. This service was provided by a third-party pharmacy registered with the GPhC. The pharmacy did not advertise details of this third-party provider prominently on its website. But information was available upon check-out of baskets when people purchased medicines. And further information about the arrangement was set out within the 'terms and conditions' section of the website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy stays open later than usual and people can easily access the pharmacy's services. It gets its medicines from reputable sources to protect people from harm. Members of the team store medicines securely at the correct temperature so that medicines are safe to use. They don't always do enough to make sure that people have all the information they need to use their medicines safely. Team members know what to do if any medicines or devices need to be returned to the suppliers to protect patient safety.

Inspector's evidence

The pharmacy had a manually operated door. Its entrance was level with the outside pavement. The pharmacy had a notice that told people when it was open as it had recently changed its opening hours. The pharmacy had seating for people who wanted to wait. Members of the pharmacy team could understand or speak Urdu, Polish, Hindi and Bengali to assist people whose first language was not English. And they signposted people to another provider if a service was not available at the pharmacy. The pharmacy provided the meningitis ACWY vaccination which was required for Hajj and a positive outcome for people wishing to perform Hajj as not many doctors offered the service.

The pharmacy provided a delivery service to people who could not attend its premises in person. The pharmacy created a spreadsheet and audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The delivery driver returned items which were not successfully delivered to the pharmacy and posted a 'failed delivery slip' through the door to let the recipient know.

The pharmacy used a disposable pack for people who received their medicines in multi-compartment compliance packs. The pharmacy team checked whether a medicine was suitable to be re-packaged. It provided a brief description of each medicine contained within the compliance packs. But it did not always provide patient information leaflets. So, people did not always have the information they needed to make sure they took their medicines safely. Members of the pharmacy team generally initialled dispensing labels to show which of them prepared a prescription. And highlighted some prescriptions where the RP needed to speak to the person about the medication or check the date of the prescription to make sure a CD was to be handed out when the prescription was valid. Team members were aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices in their original manufacturer's packaging. The team members checked with other suppliers for stock of short supply medicines. They were in a local WhatsApp group of pharmacies to share information. The dispensary benches did become cluttered when it was busy but the pharmacy team members kept tidying them. The pharmacy team checked the expiry dates of medicines and marked short-dated medicine packs. No expired medicines were found on the shelves. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees

Celsius. And it stored its CDs securely in line with safe custody requirements. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people’s private information safe.

Inspector's evidence

The pharmacy had measures for use with liquids, and some were used only with certain liquids. The pharmacy team had access to up-to-date reference sources. The pharmacy had refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the refrigerators. The adrenaline injector devices to teat anaphylaxis were in date. The pharmacy's sharps and clinical waste containers were collected regularly for safe disposal. The pharmacy team collected confidential waste for safe disposal. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. And its team members were using their own NHS smartcards

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.