General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Glevum Pharmacy, Glevum Way, Abbeydale, GLOUCESTER, GL4 4BL

Pharmacy reference: 1110212

Type of pharmacy: Community

Date of inspection: 16/01/2020

Pharmacy context

This is a community pharmacy interconnected with a doctors' surgery in the south-eastern suburbs of the city of Gloucester. It is open every day and for extended hours. A wide variety of people use the pharmacy. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy also supplies a large quantity of medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines.

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's working practices are generally safe and effective. It is appropriately insured to protect people if things go wrong. The pharmacy mainly keeps the up-to-date records that it must by law. The pharmacy team keep people's private information safe and they know how to protect vulnerable people. But, they could be better at recording and learning from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team identified and managed most risks. Any dispensing error or incident would be recorded, reviewed and appropriately managed. But, the staff said that there had not been an error for a long time. Near misses were recorded but insufficient information was documented to allow any useful analysis, such as a recent near miss regarding erythromycin. It had not been recorded what was on the prescription and what was picked. The near miss log had no learning points or actions taken to reduce the likelihood of similar recurrences. General trends could be identified but these were not documented and not discussed with the staff.

The dispensary was spacious and organised. The pharmacy dispensed many items and 95% of these were picked by a robot. The dispensing areas were divided into two distinct areas, the main labelling and assembly area and a checking area. A separate bench in the second area was used for the assembly of the multi-compartment compliance aids. Coloured baskets were used and distinguished prescriptions for patients who were waiting, acute electronically transferred prescriptions or acute green FP10 prescriptions, other electronically transferred prescriptions and prescriptions 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. All prescriptions checked by the accuracy checking technician had been previously clinically checked by the pharmacist and there was an audit trail demonstrating this.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions, 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. A NVQ2 trained dispenser said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. She was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as chloramphenicol eye drops and Ella One and referred requests for these to the pharmacist. All the staff were aware that fluconazole capsules should not be sold to women over the age of 60 for the treatment of vaginal thrush.

The staff were clear about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey but the staff were not sure about the results of the 2019 survey. This also had not been uploaded onto the nhs.uk website. However, the staff did say that most complaints they received involved a surgery not sending prescriptions that a patient had requested online. The staff explained this to the patient and also contacted the surgery to enquire about these.

Public liability and professional indemnity insurance provided by the National Pharmacy Association

(NPA) and valid until 9 March 2020, was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, emergency supply records, specials records, fridge temperature records and date checking records were all in order. Private prescriptions were recorded electronically and several did not include the prescriber details.

An information governance procedure was in place and the staff had completed training on the general data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was shredded. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had read the company procedures on the safeguarding of both children and vulnerable adults. The pharmacist and technician had also completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers to escalate any concerns relating to both children and adults were available online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. They are actively trying to recruit more staff and the company provides support when team members are on holiday or off sick. The team members feel comfortable about raising concerns and making suggestions to their managers. But, there are no formal appraisals and so any gaps in their skills or knowledge may not be identified. Those members in training are not allocated dedicated learning time, so it may take them longer than anticipated to complete their courses.

Inspector's evidence

The pharmacy was a busy 100-hour pharmacy interconnected with a surgery. They mainly dispensed NHS prescriptions with the many of these being repeats. But, due to its location, they did dispense several acute prescriptions. A large number of domiciliary patients received their medicines in compliance aids.

The current staffing profile was two pharmacists, working two shifts, usually 8am to 5pm and 2pm to 11pm, one full-time accuracy checking technician (ACT), two full-time NVQ2 trained dispensers, one part-time NVQ2 trained dispenser, three full-time NVQ2 trainee dispensers and one full-time apprentice working on the medicine counter. The pharmacy was actively trying to recruit further trained dispensing staff. A trained dispenser was always on duty with the pharmacist. The extended opening hours of the pharmacy meant that they were able to keep on top of their extensive workload. And, there was generally a three-hour crossover with double pharmacist cover. This allowed time for services and other general duties.

There was only one part-time member of staff and so limited flexibility to cover either planned or unplanned absences. The ACT was not replaced with someone of the same qualification when she was off. Locum dispensers were however engaged. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time.

There were no formal staff appraisals and the pharmacist manager had recently left. The pharmacy was trying to recruit a replacement. The staff were signed up to Virtual Outcomes e-Learning but had mostly not completed any learning for several months. They reported that any learning was done in their own time and not at work. Those staff members who were enrolled on accredited courses, such as the NVQ2 dispensing assistant course, were not allocated dedicated learning time. The GPhC registrants reported that all learning was documented on their continuing professional development (CPD) records.

The staff knew how to raise a concern and said that this was encouraged and acted on. There were staff meetings which used to be held each week when the manager was in place. The last meeting had been held about a month ago. The staff all said that they felt able to raise any issues to the higher management and that, if appropriate, these would be acted on.

The pharmacist seen was a locum. She said that she had not done any Medicines Use Reviews (MURs) in the time that she had been working at the pharmacy, since the manager had left. She said that generally the pharmacist who came in a 2pm, completed MURs and other services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional. The work areas are tidy, clean and organised. The pharmacy signposts its consultation room well, so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was well laid out, well fitted and presented a professional image. The dispensing benches were uncluttered and the floors were clear. The premises were clean and well maintained.

The consultation room was well signposted. It contained a computer, a sink and two chairs. It was relatively small but had a sliding door which increased the available space and also meant that access by the emergency services, if necessary, would not be impeded. Conversations in the consultation room could not be overheard. But, the door to room contained clear glass panels. This meant that patient confidentiality could not be maintained in here. The superintendent gave assurance that these panels would be obscured.

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

Everyone can access the services the pharmacy offers. It generally manages the services effectively to make sure that they are delivered safely. The pharmacy gets its medicines from appropriate sources. And, it stores them safely. The team members make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with an automatic opening front door. The staff could access an electronic translation application for use by non-English speakers. One staff member spoke Polish. 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), Community Pharmacy Consultation Service (CPCS), the Gloucestershire minor aliment scheme, the Gloucestershire urgent repeat medicine service 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 pharmacist 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. She had also completed suitable training for the provision of the new CPCS service. The staff knew where to signpost patients requiring the free NHS emergency hormonal contraception service.

A large number of domiciliary patients received their medicines in compliance aids. These were assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. Changes and other issues were not recorded. This denied the checking pharmacist or ACT a clear clinical picture of the patient. In addition, patient information leaflets were not sent with each supply as required by law. The staff said that they would send these every month in future. 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. The pharmacist seen said that she routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. She asked about INR levels. She also counselled patients prescribed amongst others, antibiotics, oral steroids, new drugs and any changes. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. Not all the staff were aware of the sodium valproate guidance relating to the pregnancy protection programme. They were not sure if they had completed an audit of ‘at risk’ patients. The ACT gave assurances that this would be addressed. All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. The pharmacy had an electronic audit trail showing when medicines had been collected. This also recorded issues like CDs and if there was more than one bag of medicines for a person.

Medicines and medical devices were obtained from AAH, Lexon, Phoenix and Alliance Healthcare.

Specials were obtained from Lexon Specials. Invoices for all these suppliers were available. CDs were stored in accordance with the regulations and access to the cabinets was appropriate. But, there was a large quantity of both patient-returned CDs and out-of-date CDs. These were clearly labelled and separated from usable stock but were occupying valuable space in the cabinets. Appropriate destruction kits were on the premises. Assurance was given that the patient-returned CD would be destroyed as soon as possible and measures would be put in place to destroy the out-of-date CDs. Fridge lines were correctly stored with electronic records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances but no list of such substances which should be treated as hazardous for waste purposes. The pharmacist said that she would print off this list and ensure that all the staff had been trained on its contents.

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 28 November 2019 about Emerade Pens. The pharmacy had two of the affected batches which were returned to the wholesaler 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 (5 - 100ml). There were two 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) 78 and the 2019/2020 Children's BNF. There was access to the internet.

The fridges were in good working order and maximum and minimum temperatures were recorded daily. The robot was subject to a service agreement. Most issues were electronic and could be dealt with over the telephone. There was a four-hour call out for other issues and the robot could be accessed manually, in emergency mode, if necessary.

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.