General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bridgnorth Pharmacy, 2 Mill Street, BRIDGNORTH, Shropshire, WV15 5AL

Pharmacy reference: 1123786

Type of pharmacy: Community

Date of inspection: 17/01/2020

Pharmacy context

The pharmacy is located in the centre of the busy market town of Bridgnorth. It dispenses prescriptions and sells a range if over-the-counter (OTC) medicines. The pharmacy provides some medicines in multi-compartment compliance aid packs, to help make sure people take them at the correct time. It also supplies medicines to a local nursing home and it offers a home delivery service. Additional services also available include Medicines Use Reviews (MURs) and a substance misuse treatment 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 suitably identifies and manages risks. It keeps the records it needs to by law and asks for feedback on its services to help make improvements. Pharmacy team members are clear about their roles and they are comfortable discussing when things go wrong, so that they can learn and improve. Team members understand how to keep people's private information safe and escalate concerns to protect the wellbeing of vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) covering operational tasks and activities. A log sheet at the front of the procedures indicated that some had been recently reviewed, but individual version controls were not completed. So, it was not always possible to demonstrate that all procedures were up-to-date and reflected current practice. Most of the procedures defined the responsibilities of individual team members, who had signed to confirm their acknowledgement. The locum pharmacist said that he had previously read some of the procedures and one dispenser was still completing training on the procedures after five months of employment. Through discussion she demonstrated a clear understanding of her role and accurately described the activities which were permissible in the absence of a responsible pharmacist (RP). The professional indemnity insurance displayed had expired, but the superintendent pharmacist subsequently provided confirmation that the policy had been renewed with no break in cover.

The pharmacy had a near miss log, and entries were usually recorded by the pharmacist, but did not always record the details of individuals involved, so individual learning needs may not always be identified. A discussion regarding near misses took place at the time of the event and they were also discussed during performance reviews. A dispenser said that if the pharmacist noticed that a near miss happened more than once, this would be discussed as a team. The locum pharmacist discussed the information that he would capture if a dispensing incident were reported and incidents were escalated to the superintendent pharmacist for review. Records of previous incidents were maintained as an audit trail.

The pharmacy had a complaint procedure and a notice near to the door advertised the ways in which concerns could be raised. Ongoing feedback was sought through an annual Community Pharmacy Patient Questionnaire (CPPQ). Feedback was usually positive, and a dispenser discussed how the team were trying to support patients with recent changes that had been made to repeat prescription ordering in the area.

The correct RP notice was conspicuously displayed near to the medicine counter. The RP log was generally in order, but there was a missing entry for 6 January 2019, so it was not fully compliant. Private prescription and emergency supply records were maintained and the specials procurement records which were available provided an audit trail from source to supply. Controlled drugs (CD) registers kept a running balance and a patient returns CD register was available. Previous destructions had been signed and witnessed.

Some pharmacy team members had completed an update on data protection following the introduction of the General Data Protection Regulation (GDPR). They discussed how people's information would be kept private and completed prescriptions were stored out of public view. Team members segregated and shredded confidential information on an ongoing basis. Both dispensers had an NHS smartcard, but the cards were not functioning on the day and the smartcard of the superintendent pharmacist was being used to access the NHS spine. This may demonstrate that cards are not suitably secured when not in use and is not in keeping with the terms of user agreement. This was highlighted to the team.

The locum pharmacist had completed safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE), and a dispenser had also completed some training. Team members discussed the types of concerns that might be identified, and the contact details of local safeguarding agencies were available to support the escalation of concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members work together well and can provide feedback and raise concerns. They are suitably trained for the jobs that they do, and they get some feedback on their development. But protected training time is not routinely provided, so some individuals may find it more difficult to keep their knowledge up to date.

Inspector's evidence

On the day of the inspection a locum pharmacist was working alongside two dispensers, one of whom was completing training. The regular pharmacist, who was also the superintendent pharmacist was on leave. The pharmacy also employed two delivery drivers and a part-time trainee had recently worked a few shifts in the pharmacy as part of an induction. The trainee was due to be enrolled on an appropriate training programme, in line with GPhC requirements, upon completion of the trial period. The team managed the workload adequately during the inspection and there was no backlog in the dispensing workload. Leave was restricted to one team member at a time in order to maintain suitable staffing levels. And the superintendent pharmacist's wife, who was also a registered pharmacist, provided additional support if required.

Sales were discussed with a dispenser who identified the questions that she would ask to help make sure that sales were safe and appropriate. The dispenser demonstrated an understanding of restrictions around the supply of codeine-based preparations and the team discussed a previous problem where a patient had been referred following repeated requests for these medications.

A dispenser was enrolled on a training course with Buttercups. Most course work was completed outside of working hours as protected training time was not routinely available in the pharmacy. The team received some access to additional ongoing learning. A dispenser had previously attended training courses, when they were available. An example provided was a healthy living training event. But pre-planned and structured ongoing training was limited. The team had development reviews every six months, where they were provided with feedback on their performance and any issues were identified and addressed. The team were unsure about whether records of reviews were maintained.

Pharmacy team members were happy to approach the regular pharmacist with any concerns. They worked together closely and supported one another well during the inspection. A dispenser was aware of how anonymous concerns could be raised but said that the need had never occurred. The locum pharmacist said that he had never been set any targets for professional services and briefly discussed how he would identify people who were suitable for services such as MURs.

Principle 3 - Premises ✔ Standards met

Summary findings

Overall, the pharmacy is maintained to a suitable standard and it has a consultation room to facilitate private and confidential discussions. But the pharmacy lacks space, which impacts on general organisation and may detract from the overall appearance.

Inspector's evidence

The pharmacy was located inside an old traditional building in the centre of the town and it was in a suitable state of repair. Repair work to address any maintenance concerns was arranged by the superintendent pharmacist and the pharmacy team carried out general housekeeping duties. The pharmacy was generally clean on the day, although some shelves in the retail area were dusty. There was adequate lighting throughout and the temperature was suitable for the storage of medicines.

The pharmacy had a small retail area which offered a range of suitably healthcare-based products for sale. Pharmacy medicines were secured from self-selection behind the medicine counter. There were some health promotion materials displayed and chairs were available for use by people waiting for their medicines. On the day there were some empty tote boxes being stored to the side of the medicine counter, due to limited storage space, which may cause a trip hazard. At the end of the medicine counter, was a small unit used for accuracy checking by the pharmacist, a small raised privacy screen surrounded the work unit to help reduce the risk of confidential information being seen. Off the retail area was a small consultation room, which was signposted. The room had a desk and two chairs but was compact in size. The space available was further reduced by several boxes being stored in the room, which may also detract from the overall professional appearance.

The dispensary was also small. There was a work station with a small area for dispensing, which was shared by both dispensers. Shelving units provided space for the storage of medicines, but there were some items which were temporarily being stored on the floor, which may cause a trip hazard. A small kitchenette area off the dispensary had a sink for the preparation of medicines and suitable cleaning materials were available. The staff WC was also appropriately maintained.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are generally accessible and suitably managed, so people receive their medicines safely. The pharmacy sources medicines suitably and carries out some checks to help make sure that they are fit for supply.

Inspector's evidence

The pharmacy had a small step at the front entrance. A note was displayed encouraging people to take care with entry. Staff provided assistance where possible, but a ramp facility was not available to help people with mobility issues. The pharmacy could provide large print labels to assist people with visual impairment and offered this to at least one regular patient. The pharmacy opening times were advertised and a service leaflet was available on the medicine counter. Several health promotion leaflets were displayed, and pharmacy team members had access to information to support signposting.

Prescriptions were dispensed using coloured baskets to keep them separate and prioritise the workload. Pharmacy team members signed ‘dispensed’ and ‘checked’ boxes as an audit trail for dispensing. The pharmacy did not routinely identify all prescriptions for high-risk medicines, such as warfarin. The pharmacist used stickers to highlight any prescriptions where it was felt additional counselling was needed. The locum pharmacist had an awareness of the risks of the use of valproate-based medicines in people who may become pregnant and the pharmacy had some counselling cards available for supply. The pharmacy highlighted some prescriptions for CDs, but did not include those which were not subject to safe custody requirements and an expiring prescription for pregabalin was found on the day, which may increase the risk that a supply could be made in excess of its valid 28-day expiry date.

The pharmacy team were permitted to order medications of behalf of people who used one local surgery and for other more vulnerable people, who had difficulties managing their medicines. Team members kept an audit trail to enable unreturned prescriptions to be identified and followed-up. Prescriptions for people on compliance aid packs were reviewed against the patient medication record (PMR) system and previous medication administration record (MAR) sheets to identify changes to medications. Completed packs were labelled with patient details and an audit trail. And descriptions were present enabling individual medicines to be identified. There were some packs which contained pain medications such as paracetamol that were prescribed on a when required basis, which may make it more difficult to people to manage their medicines and choose whether pain relief is necessary. Signatures were not routinely obtained for deliveries which were made to patients, which may make it more difficult to resolve any queries arising. The delivery driver indicated on a record sheet that medications had been handed to the patient and failed deliveries were returned to the pharmacy. Occasional entries were marked with the word ‘letterbox’. A dispenser confirmed that checks would take place to ensure that no children or pets were at the premises to manage the risks associated with this but was unsure whether records of this were kept.

Medications for nursing home residents were ordered by the nursing home team, who sent the request to the pharmacy, enabling them to keep an audit trail of requests that had been sent. Supplies were made using original calendar pack dispensing and the pharmacy team were made aware of any interim items which were required for patients.

Stock medications were obtained from licensed wholesalers and specials from a licensed manufacturer. Stock was generally organised and stored in the original packaging provided by the manufacturer. The pharmacy kept date checking records, but the sheet had not recently been updated. A dispenser believed that some recent checks had been carried out and examples were seen where short dated medicines had been highlighted. One expired medicine was identified during random checks of the dispensary shelves. This was immediately removed and placed for disposal. Obsolete medicines were placed into medicines waste bins and some hazardous waste guidelines were displayed. There were a small number of bags of returned medicines which required sorting. The pharmacy had the necessary equipment to enable compliance with the requirement of the European Falsified Medicines Directive (FMD), but they were not actively verifying and decommissioning stock medications on the day. Alerts for the recall of faulty medicines and medical devices were received via email, which was accessed daily, and an audit trail of alerts was maintained.

CDs were stored appropriately, with expired CDs clearly marked and segregated from stock. The pharmacy fridge was fitted with a maximum and minimum thermometer and the temperature was checked and recorded each day. The temperature was within the recommended temperature range on the day.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services and team members use equipment in a way that protects people's privacy.

Inspector's evidence

The pharmacy team had access to paper-based reference materials including the British National Formulary (BNF). Internet access was available to enable further research. The pharmacy had a range of ISO approved glass measures. Separate measures were marked for use with CDs, but these had not been cleaned following their last use, which risked cross-contamination. The locum pharmacist advised that he would do this before using the measures again. Other equipment, including counting triangles for loose tablets were suitably maintained and a separate triangle was marked for use with cytotoxic medicines.

Electrical equipment was in working order and computer systems were password protected. Screens were located out of direct public view and a cordless phone was available to enable conversations to take place in private.

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.