General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bispham Pharmacy, 2 Blackpool Road, Bispham, Blackpool, Lancashire, FY2 0HR

Pharmacy reference: 9011531

Type of pharmacy: Community

Date of inspection: 18/08/2021

Pharmacy context

This is a community pharmacy located on a parade of shops. It is situated in the residential area of Bispham, north of Blackpool town centre. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It supplies medicines in multi-compartment compliance aids for some people to help them take the medicines at the right time. The pharmacy began trading approximately 6 months ago.

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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy keeps the records it needs to by law. And members of the team understand how to keep private information safe. They record things that go wrong so that they can learn from them. But they do not always review these records, so they are missing some opportunities to improve.

Inspector's evidence

There was a current set of standard operating procedures (SOPs). Members of the pharmacy team had signed to say they had read and accepted the SOPs. The pharmacy had some systems in place to identify and manage risk, such as records of dispensing errors and their learning outcomes. These were logged on an electronic system which could be seen by the superintendent (SI) and head office. The pharmacy team said they would discuss what had happened following an error. But the pharmacy had fallen behind in completing their monthly reviews, and none had been completed this year. So any trends or underlying causes may be missed.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A trainee dispenser was able to explain what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms and had badges identifying their names and roles. The pharmacy had a complaints procedure. Any complaints were recorded and sent to the head office to be followed up. A current certificate of professional indemnity insurance was on display. The responsible pharmacist (RP) notice was displayed prominently.

Controlled drugs (CDs) registers were maintained electronically, with running balances recorded and checked at least monthly. Two random balances were checked and found to be accurate. Records for private prescriptions appeared to be in order.

An information governance (IG) policy was available. Members of the pharmacy team had each read the IG policy and signed confidentiality agreements in their contracts. When questioned, the trainee dispenser was able to describe how confidential information was segregated to be removed and destroyed by a waste carrier. A privacy notice was available describing how patient data was handled.

Safeguarding procedures were included in the SOPs. The pharmacist had completed level 2 safeguarding training. Contact details for the local safeguarding board were available. A dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist manager, a trainee pharmacy technician, and two dispensers – one of whom was in training. All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist plus two to three staff. On the day of the inspection the SI was present as the RP. The volume of work appeared to be managed. Staffing levels were maintained by a staggered holiday system. Relief staff could be called from nearby branches if needed.

Members of the pharmacy team completed some additional training, for example a dispenser had completed a first aid training course. Training records were kept showing what training had been completed. But further training was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

The trainee dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines she felt were inappropriate, and refer people to the pharmacist if needed.

Staff were seen working well together and providing support to each other when needed. The trainee dispenser said she felt a good level of support from her manager. Appraisals were conducted by the head office. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or SI. There were no performance targets in relation to professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and steps have been taken to make the premises COVID secure. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. Customers were not able to view any patient sensitive information due to the position of the dispensary. The temperature was controlled by the use of an air conditioning unit. Lighting was sufficient. The staff had access to a kettle, microwave, separate staff fridge and WC facilities.

A Perspex screen was located at the medicines counter to help prevent the spread of infection. Staff were wearing masks, and hand sanitiser was available. Signage helped to encourage members of the public to wear a mask when visiting the pharmacy.

A consultation room was available. The space was clutter free with a desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it uses technology to help manage and provide its services safely. The pharmacy team gets medicines from recognised sources and carries out regular checks to help make sure that they are kept in good condition.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was also wheelchair access to the consultation room. Various leaflets provided information about the services offered and information was also available on the website. The pharmacy opening hours were displayed and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. This had been adapted in response to current COVID guidance. The delivery driver would leave the patient's bag of medicines at the door, knock, and stand back to allow social distancing whilst the patient picked up the bag. If there was no answer the medicines would be returned to the pharmacy. An electronic record was kept as an audit trail.

The pharmacy used the Titan patient medical record (PMR) system. This used a barcode database to help with the accuracy check and audit of prescription items. Each prescription was clinically checked by the pharmacist, and this was recorded on the PMR system. High-risk medicines (such as warfarin, methotrexate, lithium or valproate) or high-risk interactions were highlighted by the PMR during the accuracy check. If the pharmacist thought the patient would benefit from counselling, he recorded notes on the PMR so that they could be passed on when the medicines were handed out.

Once the prescription had been clinically checked, the PMR permitted members of the pharmacy team to print a picking list, which was used to select the medicines required for the prescription. Once the member of staff had selected the medicine, they scanned the barcode and, if it was correct, the dispensing label was printed. If it was incorrect, the screen would flash red. The dispenser said she would attach the dispensing label as soon as it was printed to help reduce the likelihood of a mistake. Because the PMR system performed the accuracy check using the barcodes, only certain items were accuracy checked manually by the pharmacist. These included any split boxes, CDs, amended doses or manual additions of barcodes. Once the dispensing was completed, the medicines were placed in a bag and the bag was scanned to a particular shelf, which the PMR recorded the location of. When a patient came to collect their prescription, the PMR system would inform the member of staff where the prescription was, and the bag was scanned upon handout. Owing slips were used to provide an audit trail if the full quantity could not be immediately supplied. The PMR system would highlight any prescriptions which had expired, such as any 28-day CD prescriptions. It would also highlight any counselling notes recorded by the pharmacist during the clinical check. Members of the pharmacy team said they would use the notes to counsel the patient or refer to the pharmacist if needed.

The SI said the company worked closely with the PMR system providers to identify any issues or errors made. But no reviews or audits had been completed by the pharmacy to demonstrate how accurate the system was or to identify any underlying trends.

The staff were aware of the risks associated with the use of valproate during pregnancy. Educational

material was available to hand out when the medicines were supplied. The pharmacy team said they were not aware of any current patients who met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. Before a patient was started on a compliance aid the pharmacist would assess them to check their suitability. A record sheet was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information was sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Stock was date checked on a 3-month basis. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker and recorded in a diary for it to be removed at the start of the month of expiry. Liquid medication generally had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There was a clean medicines fridge with a thermometer. The minimum and maximum temperatures were supposed to be electronically recorded each day, but there were a number of days where this had not occurred. So any temperature fluctuations may not always be identified promptly. Patient returned medication was disposed of in designated bins located in the consultation room. Drug alerts were received electronically. Alerts were marked as 'actioned' with the details record of the action taken, when and by whom.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. There were no stickers attached to indicate they had been PAT tested. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had counting triangles for counting loose tablets. Equipment was kept clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required.

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.