General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bampton Pharmacy Ltd, Barnhay, Bampton, Devon, EX16 9NB

Pharmacy reference: 9012349

Type of pharmacy: Community

Date of inspection: 09/09/2024

Pharmacy context

The pharmacy is an established business which has recently relocated to a new premises, adjacent to a medical practice. The pharmacy dispenses NHS and private prescriptions. It sells medicines over the counter to treat a range of common minor health problems. The pharmacy team offers advice to people about minor illnesses and long-term conditions. The pharmacy offers services including flu vaccinations, the NHS New Medicine Service (NMS) and the Pharmacy First Service. The pharmacy team offers the NHS Hypertension Case Finding Service and a private ear wax removal service. The pharmacy supplies medicines in multi-compartment compliance packs to people who need help to remember when to take them. And it supplies prescribed medicines to the residents of two nearby care homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.8	Good practice	Pharmacy team members know how to protect the safety of vulnerable people and take prompt action to raise safeguarding concerns.
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 provides its services safely and effectively. It has suitable systems in place to identify and manage the risks associated with its services. Team members record any mistakes they make and review them to identify the cause. The pharmacy team then makes the necessary changes to stop mistakes from happening again. The pharmacy has written procedures in place to help ensure that its team members work safely. And these procedures are reviewed and updated regularly. The pharmacy asks people for their feedback on its services and responds appropriately. It has the required insurance in place to cover its services. And it keeps all the records required by law. The pharmacy keeps people's private information safe. Pharmacy team members know how to protect the safety of vulnerable people and take prompt action to raise safeguarding concerns.

Inspector's evidence

The pharmacy had processes in place to identify, manage and reduce its risks. This included standard operating procedures (SOPs) which reflected the way the team worked. The pharmacy team reviewed the SOPs regularly to ensure they were appropriate and that the team were following them. The pharmacy team could describe the activities that could not be undertaken in the absence of the responsible pharmacist (RP). Team members had clear lines of accountabilities and were clear on their job role. The pharmacy had risk assessments in place to cover its activities. And it had a written business continuity plan.

Pharmacy team members recorded any mistakes they made which were picked up during the final accuracy check, known as near misses, on paper logs. They were recorded promptly by the person who had made the mistake. Dispensing errors that reached the patient were reported in a more detailed way using an online reporting tool. When errors occurred, team members considered why the mistake had happened and learned from their mistakes. The RP discussed errors with the person that had made them. And they also made the wider team aware of common themes. The pharmacy team took appropriate action to prevent the reoccurrence of errors including separating medicines that looked or sounded alike.

The pharmacy team worked closely with the adjacent medical centre to ensure people received their prescriptions in a timely manner. The pharmacy dispensed most prescriptions using the electronic repeat dispensing system. Following a patient safety review, the team had identified that when changes were made to people's medicines, old batches of prescriptions were not always deleted by the medical centre. So they now proactively contacted the medical centre to ensure this happened, leading to less likelihood of dispensing medicines that had been stopped or changed. .

The pharmacy had a documented procedure in place for handling complaints or feedback from people. There was information for people displayed in the retail area about how to provide the pharmacy with feedback. Any complaints were passed straight to the SI to deal with. The RP made sure to pass any compliments received to the team. Public liability and professional indemnity insurance were in place.

The pharmacy kept a record of who had acted as the RP each day. The correct RP notice was prominently displayed. Controlled drug (CD) registers were in order. Balance checks were completed regularly and any discrepancies were promptly rectified. A random balance check was accurate. Patient

returned CDs were recorded in a separate register and were destroyed promptly.

The pharmacy kept adequate records of private prescriptions using an online register. The pharmacy kept appropriate records of any emergency supplies it made through the Pharmacy First service. The pharmacy kept records of the receipt and supplies of unlicensed medicines ('specials'). Certificates of conformity were stored with all required details completed.

All team members completed yearly training on information governance and general data protection regulations. Patient data and confidential waste were dealt with in a secure manner to protect privacy and no confidential information was visible from customer areas. The pharmacy had a privacy policy which was available to people on request. Team members used their own NHS smart cards. Verbal consent was obtained before summary care records were accessed and a record of access was made on the person's PMR.

All staff were trained to an appropriate level on safeguarding. The pharmacists and the pharmacy technician had completed the Centre for Postgraduate Pharmacy Education (CPPE) safeguarding training to the required level. And all other members of the pharmacy team had completed appropriate training on safeguarding. Local contacts for the referral of concerns were available. Team members described multiple examples of how they had raised safeguarding concerns, often liaising with the medical practice to ensure people's safety.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs enough people to manage its workload. Team members are trained to deliver their roles and keep their skills up to date by completing regular learning activities. They are confident to suggest and make changes to the way they work to improve their services. Team members communicate effectively and support each other well. And they work well together to deliver the pharmacy's services.

Inspector's evidence

The owners of the pharmacy were two pharmacists, both of whom worked regularly in the pharmacy. One of them was the superintendent pharmacist (SI). Both were present during the inspection. There was also a pharmacy technician, two dispensers and a trainee medicines counter assistant (MCA).

The pharmacy team were coping with the workload well and dispensing was up to date. It was clear that the team worked well together and supported each other. They had a good rapport and knew the people that used the pharmacy well. There was a strong community feel to the pharmacy.

The team were encouraged to discuss concerns and give feedback to the owners. Team members were confident to make suggestions for changes which would improve how the pharmacy operated. Team members were aware of the internal escalation process for concerns and a whistleblowing policy was in place.

Team members were seen to give appropriate advice to people in the pharmacy. And they referred to the pharmacist for further clarification when needed. When questioned, one of the dispensers knew what tasks could not be completed if the RP was not in the pharmacy.

Team members were given time during working hours to learn. Recent learning had included completing learning about the upcoming flu and COVID-19 vaccination services. The pharmacy team encouraged each other to learn and helped each other. The trainee MCA was given plenty of time to learn at work and they were able to ask questions of the pharmacist. Each team member had regular appraisals where they could discuss their progress.

The pharmacists used their clinical judgement and ensured all services provided by the pharmacy were appropriate for the person requesting them. There were no targets or incentives set.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, well-organised and present a professional image to people. The pharmacy has enough workspace for the team to work effectively. The pharmacy has a suitable consultation room which it uses to provide services to people whilst maintaining their privacy and confidentiality.

Inspector's evidence

The pharmacy had recently relocated to a new purpose-built premises next to the medical centre in Bampton. There was a carpark outside. A large, nicely laid out, retail area led to the healthcare counter. There were chairs available for people who needed to wait for prescriptions or services.

The pharmacy had a well-equipped consultation room. It could be accessed both from the dispensary or the retail area. No conversations could be heard from outside the consultation room.

The dispensary was well organised and tidy. There was plenty of shelving and workbench space for dispensing. Medicines were stored neatly on the shelves. Pharmacy medicines were stored behind the medicines counter.

There was a daily cleaning rota on display in the dispensary and the team cleaned the pharmacy regularly to ensure their environment was hygienic. Cleaning products were available, as was hot and cold running water. The fire alarm was tested each week. The lighting and temperature were appropriate for the storage and preparation of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy supplies medicines to people safely. And it ensures it gives appropriate advice to people to make sure they use medicines correctly. The pharmacy team make sure that people with different needs can access its various services. Team members take steps to identify people prescribed high-risk medicines to ensure that they are given additional information. The pharmacy obtains its medicines from reputable suppliers. It stores them securely and makes regular checks to ensure that they are still suitable for supply. The pharmacy accepts unwanted medicines and disposes of them appropriately.

Inspector's evidence

The pharmacy had step-free access and was wheelchair accessible. It had an automatic door. Parking was available outside. The pharmacy provided additional support for people with disabilities, such as producing large print labels. A range of health-related posters and leaflets were displayed. Team members explained that if a person requested a service not offered by the pharmacy at the time, they referred them to other nearby pharmacies or providers, calling ahead to ensure the service could be provided there. Up-to-date signposting resources and details of local support agencies were accessed online.

The pharmacy had a clear flow to ensure prescriptions were dispensed safely. Team members used baskets to store dispensed prescriptions and medicines to prevent transfer between patients as well as to organise the workload.

Each person who received regular medicines from the pharmacy had a written card containing details of their current prescription. Different coloured cards were used to highlight people prescribed CDs, items requiring refrigeration and high-risk medicines. The pharmacists described that they checked if patients receiving lithium, warfarin and methotrexate had had blood tests recently, and gave additional advice as needed. And they usually made records of this advice on the PMR.

The pharmacy offered a range of additional services including flu vaccinations. The pharmacy team had reviewed and signed the patient group direction for the upcoming flu vaccination service. The pharmacy had recently been approved to act as a COVID-19 local vaccination centre and the team were completing the required preparation and training. The pharmacists had completed the required training on injection technique, anaphylaxis and resuscitation. The pharmacy supplied opioid replacement medicines to a small number of people. The pharmacists liaised with the drug and alcohol team and the person’s key worker in the event of any concerns or issues.

The pharmacy offered the NHS New Medicines Service. The pharmacists contacted people prescribed new medicines to check how they were getting on and to offer any advice needed. The pharmacy was actively providing the new NHS Pharmacy First service. The team had supportive information available to support the safe delivery of this service, including current versions of the national patient group directions. And there were checklists available to support team members in triaging people attending for the service.

Multi-compartment compliance aids were supplied by the pharmacy for people living in their own homes. Each person requesting compliance aids was assessed to ensure it was the most appropriate

solution for their needs. The workload was organised and well planned. A sample of compliance aids was inspected. Each compliance aid was clearly labelled and contained a description of the tablets included so that they could be easily identified. Patient information leaflets (PILs) were supplied each month. 'When required' medicines were dispensed in boxes and team members were aware of what could and could not be placed in trays. A record of any changes made was kept on a patient information sheet, which was available for the pharmacist during the clinical checking process.

The pharmacy dispensed medicines for the residents of two care homes. They were supplied in original packs rather than multi-compartment compliance aids. Either a paper or an electronic medicines administration record (MAR) sheet was supplied for each person to allow the care home staff to record administration of medicines. Medicines were delivered approximately one week before the start date. Any medicines that were urgently required were usually delivered on the same day. The pharmacy also kept stocks of medicines used in palliative care so that they could be supplied promptly.

The pharmacy team was aware of the risks associated with people becoming pregnant whilst taking sodium valproate and topiramate as part of the Pregnancy Prevention Programme (PPP). The pharmacy team took care not to apply labels over the warning cards on the boxes of valproate products when dispensing. They were aware of the recent updates to guidance about supplying valproate safely to those who had the potential to become pregnant whilst taking it. The pharmacists had regular conversations with the people at risk who were prescribed valproate to ensure they were on adequate contraception. And records were made on the PMR.

The dispensary stock was generally arranged alphabetically on shelves. It was well organised. Date checking was undertaken regularly and records were kept. Spot checks revealed no date-expired medicines or mixed batches. Prescriptions containing owings were appropriately managed and the prescription was kept with the balance until it was collected. Stock was obtained from reputable sources. Records of recalls and alerts were actioned promptly. Relevant alerts were printed and stored with any quarantined stock. Dedicated bins for the disposal of waste medicines were available and seen being used for the disposal of medicines returned by patients.

CDs were stored in accordance with legal requirements in approved cabinet. A denaturing kit was available so that any CDs awaiting destruction could be processed. Expired and patient-returned CDs were clearly marked and segregated in the cabinet. The pharmacy had a separate register for patient-returned CDs and they would be destroyed promptly in the presence of a witness. The dispensary fridges were clean, tidy and well organised and records of temperatures were maintained. The maximum and minimum temperatures were within the required range.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities to provide its services. It keeps these clean, tidy and well-maintained. The pharmacy uses its equipment in a way that protects people's confidential information.

Inspector's evidence

The pharmacy had up-to-date reference resources available including the British National Formulary (BNF). Team members had access to the internet to support them in obtaining current information. The pharmacy's computer system was password protected. And information displayed on computer monitors was suitably protected from unauthorised view.

The pharmacy had clean equipment available for counting and measuring medicines. It highlighted equipment for measuring and counting higher-risk medicines. This helped to reduce any risk of cross contamination.

A range of consumables and equipment to support the services provided by the pharmacy was available within the consultation room. Electrical equipment was visibly free of wear and tear and in good working order.

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.