General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Blenheim Pharmacy, 9A Blenheim Crescent, LUTON, LU3 1HA

Pharmacy reference: 1111687

Type of pharmacy: Community

Date of inspection: 29/08/2019

Pharmacy context

The pharmacy is in separate premises located at the entrance to a health centre in a residential area. 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 prescription delivery, substance misuse, stop smoking, meningitis ACWY and seasonal flu vaccinations.

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	1.2	Good practice	The introduction of the new computer system has improved the safety and quality of services.
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 safe and effective. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy manages risk well and keeps people's information safe. The pharmacy has written procedures to make sure the team works safely. The pharmacy generally keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team members understand how they can help to protect vulnerable people.

Inspector's evidence

Near misses were recorded and reviewed but were reduced by the introduction of a computer system which was being trialled. Scanning the prescription barcode showed the prescription items on a screen. The barcodes on the selected medicine packaging were then scanned. If the medicine selected and scanned did not match what was on the prescription, the system highlighted the item and alerted staff resulting in reduced near misses due to picking errors. The annual patient safety review highlighted identifying near miss trends with two types of inhaler with similar name and actions taken to address the selection errors. Learnings were shared during monthly staff meetings and maintaining an electronic communication book for daily staff reference, so they were aware of safety concerns.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. Scanning the barcode on a prescription showed the prescription and medicines on the computer screen which was clinically checked by the pharmacist. Interactions between medicines were highlighted. A 'pick' label with a barcode was generated. When medicines were picked and scanned they were cross referred with the prescription and incorrectly selected medicines were highlighted. The final check was completed by the pharmacist and the dispensing audit trail reflected by the staff logged in at the time. At the end of the process, scanning the dispensing label bar code confirmed the prescription was correctly completed and a bag label was generated. Scanning the bag label and shelf label bar codes confirmed the location of the completed prescription in retrieval and prompted a text to the patient if required.

The information was transferred to a hand-held device which showed the prescription, patient details including exemptions from prescription charges, any counselling needs including high-risk medicines and whether the prescription was in retrieval or had been given out. When the patient visited the pharmacy and enquired about their prescription staff could refer to the hand-held device. There was a procedure for dealing with outstanding medication. The original prescription was retained, and a record of the owing was retained on the computer screen and the hand-held device. For "manufacturer cannot supply" items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance aids were prepared for a number of patients both domiciliary and in nursing or care homes. The pharmacy did not re-order prescriptions on behalf of patients but sent a reminder text to patients to prompt them to order their prescriptions in a timely manner. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance aid. Patient notes were recorded on the patient medication record (PMR). Labelling included a description to identify individual medicines and package information leaflets were supplied with each set of compliance aids. Ensuring the description included sufficient detail to identify individual medicines was discussed.

High-risk medicines such as alendronate and controlled drugs (CDs) were generally supplied separately from the compliance aid. The dates of CD prescriptions were managed to ensure supply within 28-day validity of the prescription. Levothyroxine and lansoprazole were supplied in compartments positioned to ensure it was taken before other medication or food for some people. The stability of sodium valproate was checked regularly when supplying in a compliance aid.

At the time of the visit, FP10 prescriptions for nursing or care homes were scanned and visible on the computer screen. Scanning the prescriptions caused the software to produce a pick list of medicines ordered for an individual home. The pharmacist could see all the patients' prescription details for an individual home on the computer system. As staff administered medicines and scanned the appropriate barcode on the dispensing label, the computer screen recorded the administration. This highlighted incorrect medicines, administration times or patient and a report could be generated and sent to the manager at the home.

When staff at the home re-ordered medicines, the pharmacy could prompt staff if the medicine had not run out but was in a different location at the home. The home also had a hand-held device which was updated with changes in medication which was relayed back to the pharmacy. This highlighted any occasions when the surgery had not updated their records. This reduced wastage of medicines and improved adherence to medicines.

The practice leaflet was on display and details of how to comment or complain were displayed. The annual patient questionnaire was conducted. The was a set of recently reviewed standard operating procedures (SOPs) which included responsible pharmacist, complaints and supply of high-risk medicines (including sodium valproate) procedures. There were recent staff training records. The pharmacy had recently changed the delivery procedure from a manual system to records on a hand-held device so the SOP required review to reflect the new way of working. The staff member at the medicines counter said she would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. Hydrocortisone cream would not be sold for use on the face.

To protect patients receiving services, there was professional indemnity insurance in place provided by Numark expiring April 2020. The responsible pharmacist (RP) notice was on display and the responsible pharmacist log was completed. The electronic CD and methadone registers were complete and the balance of CDs was audited regularly following a prompt by the pharmacy computer. A random check of actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. Patient returned CDs were recorded in the destruction register for patient returned CDs. Amended entries could

be audited and FP10MDA prescriptions were endorsed at the time of supply. Records for private prescriptions, emergency and special supplies were generally complete. Patient group directions (PGDs) included meningitis ACWY and erectile dysfunction and were due for renewal. Training to administer flu vaccination was due to be updated.

Staff had signed confidentiality agreements and were aware of procedures regarding General Data Protection Regulation (GDPR). GDPR guidance was displayed. A privacy notice was displayed. The pharmacy computer was password protected and regularly backed up. A CCTV notice was displayed. The Data Security and Protection toolkit had been completed. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards. Staff had undertaken safeguarding and dementia friends training and the pharmacist was accredited at level 2 in safeguarding training. There was a safeguarding folder and local contact details to report concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. The pharmacy team works effectively together and are supported in keeping their knowledge up to date. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time pharmacist, four part-time pharmacists, one full-time pre-registration pharmacist, two full-time trainee pharmacy technicians, one part-time trainee pharmacy technicians, three full-time dispensers, one part-time medicines counter assistant (MCA) and one full-time delivery person.

Staff were enrolled on or had completed accredited training for their rolls. The delivery person had undertaken a Numark eLearning module in delivery procedures. Staff had completed children's oral health and risk management training. Introduction of the new computer system and reducing errors in the dispensing process had been risk managed. Staff had undertaken stop smoking training for supply of nicotine replacement therapy and industry representative training in topics including Nurofen.

The RP/superintendent pharmacist (SI) was pre-registration tutor and the pre-registration pharmacist attended regular pre-registration Buttercups training days. Training topics included British National Formulary (BNF) chapters and calculation. There were 13 weekly appraisals to monitor progress in pre-registration training. Other staff appraisals were due to be conducted. Staff were able to provide feedback and had suggested a new way of managing compliance aid stock ordering and preparation. Staff had suggested extending the MCA hours. There was a whistleblowing policy. Targets and incentives were not set.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally clean and suitable for the provision of its services. The consultation room is used regularly so people can have a conversation in private. The pharmacy prevents people accessing the premises when it is closed.

Inspector's evidence

The premises were generally clean including dispensary benches and sink. Lavatory facilities were clean and handwashing equipment was provided. The consultation room was located to one side of the medicines counter and removal of some clutter was discussed to improve its appearance. Patient privacy was protected. Cabinets were lockable to secure documents and equipment. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy services. The pharmacy generally provides services safely. The pharmacy gets its medicines from reputable sources to protect people from harm. The pharmacy team takes the right action if any medicines or devices need to be returned to the suppliers. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safely and effectively. The pharmacy's team members are helpful and give advice to people about where they can get other support. They also make sure that people have all the information they need so that they can use their medicines safely.

Inspector's evidence

There was wheelchair access and large font labels could be printed to assist visually impaired patients. Staff could converse in Punjabi, Hindi, Urdu, Bengali, Lithuanian and Polish to assist patients whose first language was not English. Large font labels could be printed to assist visually impaired patients. People were signposted to other local services including needle exchange, the local walk-in centre and NHS 111.

The pharmacists were aware of the procedure for supply of sodium valproate to people in the at-risk group and information on the pregnancy prevention programme (PPP) would be explained. The pharmacists explained the procedure for supply of isotretinoin to people in the at-risk group. Although prescriptions were issued locally for 28 days' supply, the prescriber would be contacted regarding prescriptions for more than 30 days' supply of CD. Interventions were recorded on the patient medication record (PMR) of checks that medicines were safe for people to take and showing appropriate counselling was provided to protect patient safety.

Prescriptions were highlighted on the hand-held device to indicate that the pharmacist would provide counselling on high risk medicines. Prescriptions were scanned again before transfer showing counselling needs. For schedule 4 CDs the date was highlighted so the CD was supplied within the 28-day validity of the prescription. When supplying warfarin to people, their record of INR along with blood test due dates had been recorded on the prescription. Advice was given about side effects of bruising and bleeding. Advice was given about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were reminded about the weekly dose and when to take folic acid. People were advised to seek medical advice if they developed an unexplained fever.

The pharmacy healthy living status was to be updated but there were health campaigns to raise public awareness of stroke and stopping smoking through a stop smoking clinic. Audits were conducted including for referral for prescription of a proton pump inhibitor for gastric protection while taking a non-steroidal anti-inflammatory drug (NSAID) and both phases of the sodium valproate audit, owing

medicines and referring diabetic patients for flu vaccination. Training in sepsis for the Pharmacy Quality Scheme was undertaken.

Medicines and medical devices were delivered outside the pharmacy and records were maintained via Pro Delivery Manager tracking system Patients signed the screen upon safe delivery. Data was protected and special notes could be added regarding that patient or their medicines.

Medicines and medical devices were obtained from Alliance, AAH, Phoenix and Colorama. Floor areas were mostly clear, and stock was stored on the dispensary shelves. Stock was date checked and recorded. Short-dated stock was highlighted. No date expired medicines were found in a random check. Liquid medicines were generally marked with the date of opening and medicines were generally stored in original manufacturer's packaging. Some de-blistered tablets and capsules were removed from stock. There was a discussion about storing medicines in original manufacturer's packaging to ensure stability of the medication and so the pharmacy could identify stock affected by drug alerts or date checks. Cold chain items were stored in two medical fridges. Uncollected prescriptions were cleared from retrieval every three months. Waste medicines were stored separate from other stock in the lavatory area due to space constraints. Falsified medicines directive (FMD) hardware and software had been installed but was not operational at the time of the visit. A record of responses to drug alerts and recalls was maintained on the pharmacy computer system.

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 keeps people’s private information safe.

Inspector's evidence

Current reference sources included BNF Ap and online reference sources. There were standard stamped glass measures to measure liquids including separate marked measure for methadone. The medical fridges were in good working order. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinet was fixed with bolts. Stop smoking equipment was supplied and maintained by Live Well Luton. The blood pressure monitor was due for recalibration. There were two sharps bins on the floor in the consultation room and there was a discussion about ensuring they were stored securely because of the risk of biohazard or accidental injury to people.

The pharmacy computer was password protected and regularly backed up. A CCTV notice was displayed. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards.

What do the summary findings for each principle mean?

✔ **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.