General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Charles Michie, 287 Rosemount Place, ABERDEEN, Aberdeenshire, AB25 2YB

Pharmacy reference: 1041633

Type of pharmacy: Community

Date of inspection: 21/08/2019

Pharmacy context

This is a community pharmacy on a main road in a suburb. People of all ages use the pharmacy. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs and provide substance misuse services.

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

Pharmacy team members follow processes for all services to ensure that they are safe. The pharmacy reviews these and makes changes to keep improving services. The pharmacy team record mistakes to learn from them. It reviews these and makes changes to avoid the same mistake happening again. The pharmacy asks people for feedback. Team members discuss this and make changes to improve pharmacy services. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. The folder included additional information including GPhC guidance for responsible pharmacists, safeguarding information, examples of pharmacy paperwork used and some other guidance documents. They were well filed and stored in an accessible manner. Pharmacy team members had read SOPs, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs and a 'roles and responsibilities' SOP further clarified this. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy displayed this information on the dispensary wall as a reference for team members. An inexperienced team member was very clear on the limitations of her role. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. It had a list of phone numbers displayed in the dispensary including other pharmacies, medicine wholesalers, surgeries and the National pharmaceutical Association. It also had a folder with a comprehensive list of contacts that could be used to signpost people to other services as well.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors periodically. The pharmacist explained that there was typically no pattern or recurring issue. But recently strength of medication had been a recurrent error. The pharmacist had reminded team members to doublecheck their dispensing before passing for the final check. She explained that similar packaging often contributed to this.

The pharmacy had a complaints procedure and welcomed feedback. It had questionnaires on the medicines counter for people to complete. Feedback was always very positive and several 'thank-you' cards were observed from people. The pharmacy also used mystery shoppers. It had received a low score several months previously which had been reviewed. The pharmacy team had identified the situation and team member and put strategies in place to improve this.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. Team members signed any

alterations to records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost. The pharmacist had downloaded information from the General Medical Council website regarding advice on doctors self-prescribing. A European private prescription was observed without a prescriber name and address, which was a legal requirement. The pharmacy kept and archived other records including records of medication deliveries, evidence of date checking and controlled drug cabinet key access log.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. Pharmacy had a list of child protection phone numbers on the dispensary wall for reference. It had a chaperone policy in place and displayed a notice telling people. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough qualified and experienced staff to safely provide its services. The pharmacy compares staff numbers to how busy the pharmacy is and makes changes when possible. This ensures that appropriately skilled and qualified staff provide pharmacy services. Team members are encouraged to attend relevant training events. They discuss incidents and learn from them to avoid the same thing happening again. They can make suggestions to help improve services.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one full-time dispenser, one part-time medicines counter assistant (mornings only, and all-day Friday when the pharmacy was busier) and a Saturday only pharmacy student. The pharmacist explained that she tried to always have the same locum pharmacist for her day off to provide continuity. The regular locum pharmacist developed relationships with people and regularly saw a smoking cessation client. At the time of inspection, the dispenser was off and was replaced by a pharmacy student from another branch. Team members were able to manage the workload. But they were very busy as there were a lot of requests to speak to the pharmacist. Some of these requests were accessing the 'pharmacy first' patient group directive involving supply of medicines for common infection. These consultations were time-consuming. Part-time team members could sometimes cover absence.

The pharmacy team members sometimes attended training events locally provided by a variety of training providers. The superintendent pharmacist notified the pharmacy when courses were available. Team members had attended a course on how to prepare for an inspection. The pharmacy kept training certificates from external courses. The pharmacist had a 'first aid at work' certificate. The pharmacy had a staff handbook that all team members were aware of. This included a variety of information and policies. Team members had annual appraisals with the pharmacy manager, and the pharmacy manager had annual appraisals with the human resources manager. They did not have development plans. The team members present during the inspection went about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter. The pharmacist provided effective counselling and advice to people with a variety of symptoms. She constantly coached and provided guidance to the pharmacy student who was working.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the superintended pharmacist. The office sent emails with information on a variety of topics to the pharmacy on a regular basis. The pharmacist printed these for all team members to read and sign acknowledging understanding. The pharmacy responded positively to incidents that had occurred elsewhere to reduce the risk of similar incidents in this pharmacy. The pharmacist had highlighted prednisolone and propranolol tablets to reduce the risk of these being mixed up. The pharmacy team discussed incidents as they occurred, 'on the job'. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy's services. The pharmacy team members use a private room for some conversations with people. People cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were reasonably sized premises incorporating a retail area, dispensary and back shop area including storage and staff facilities. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. There was a curtain separating the retail area from the back-shop storage area. The pharmacy protected this area with a CCTV camera which was monitored from the dispensary. The staff room was accessed from this area by a door that was kept locked.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a new consultation room with a desk, chairs, sink and bed which folded against wall. It was clean and tidy, and the door closed providing privacy. The door was kept locked to prevent unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

The pharmacy had a high step at the entrance. Some people found this difficult, but team members helped when required. It listed its services and had leaflets available on a variety of topics. And it had a community noticeboard with information about local events. The pharmacy signposted people to other services such as food parcels and meals, podiatry and a pharmacy travel clinic. It had a large screen in the window signposting some of these services. It had a hearing loop in working order and could provide large print labels for people with impaired vision. The pharmacy displayed a notice on the door welcoming helping dogs. All team members wore badges showing their name and role. The pharmacy had not identified a need for a delivery service. But occasionally this was required and the delivery driver from a branch nearby was used. The pharmacy kept records of this.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to separate people's medicines and prescriptions. The pharmacist usually labelled so that she could monitor stock levels, identify balances and undertake clinical assessments. Team members shared a lot of information verbally taking care to speak quietly. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. The pharmacy team left dispensed medicines on retrieval shelves for up to 6 months. This was observed. Analgesics dispensed in February were still waiting to be supplied. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these in advance. It stored prescriptions alphabetically and the pharmacist checked this box every two weeks or so. She recorded date of collection and next expected supply date. She did not monitor compliance but explained that for various reasons people accumulated medicines. But compliance was not thought to be a big problem. People were not very engaged with the service and pharmaceutical care issues were seldom identified when registering people. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. The dispenser assembled these two weeks before the first pack was due for supply. She attached backing sheets firmly and included basic tablet descriptions. The pharmacy kept thorough records including records of when prescriptions were ordered and batch number and expiry dates of medicines. It had dose regime templates included medicine changes with the appropriate date and the pharmacist's initials. The pharmacy supplied patient information leaflets with the first pack of each prescription.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled appropriately. The pharmacy stored all valproate preparations together with labels highlighting the information to supply to people. The

pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, and supply of chloramphenicol ophthalmic products. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. All team members delivered the smoking cessation service. Currently there was one person accessing this and the locum pharmacist was providing it.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacist was aware of the requirements and explained that equipment was on the premises, but the team had not yet been trained. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. The drawers were labelled with the contents which helped team members locate different products. The pharmacy stored diabetic medicines on separate labelled shelves to minimise the chance of these being supplied in error. The pharmacy also labelled shelves highlighting recently rescheduled controlled drugs as an aide memoir for the team. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for delivery of its services. The pharmacy looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy kept a carbon monoxide monitor maintained by the health board in the consultation room where it was used with people accessing the smoking cessation service. Team members kept crown stamped and ISO marked measures by the sink in the dispensary, and separate marked ones were used for methadone. And they had clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets. The pharmacy had a 'Keito' health care monitor which measured and recorded, weight, height, body mass index, fat percent and blood pressure. The pharmacist showed people how to use it and provided them with their personal bar-coded card to access it. She used this to support people with lifestyle advice.

The pharmacy stored paper records in the dispensary and cupboards in the consultation room which was kept locked. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left them unattended unless they were locked.

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.