General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Largue Pharmacy, 10-12 Gordon Street, HUNTLY, Aberdeenshire, AB54 8AJ

Pharmacy reference: 1041670

Type of pharmacy: Community

Date of inspection: 28/09/2022

Pharmacy context

This community pharmacy is in the large town of Huntly. The pharmacy provides a range of services including dispensing NHS prescriptions, seasonal flu vaccinations, a travel clinic, the NHS Pharmacy First service and an ear wax removal service. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines.

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	2.5	Good practice	The pharmacy encourages team members to share ideas on how to improve the delivery of services through regular meetings. And they actively engage in providing feedback on any changes that may affect their ways of working.
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 identifies and manages the risks associated with its services well. It has up-to-date written procedures that the pharmacy team follows. And it completes all the records it needs to by law. Team members suitably protect people's confidential information. They respond competently when errors occur and take appropriate action to prevent future mistakes. Team members demonstrate a clear understanding of how to safeguard the safety and wellbeing of children and vulnerable adults. And they respond promptly and suitably when concerns arise.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The team had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure for managing errors that were spotted during the dispensing of prescriptions known as near miss errors. The team member involved was invited to identify their error so they could reflect on why it happened. The pharmacy kept an electronic record of the near miss errors. A sample found that the details recorded enabled the team to identify patterns, learn from the error and take action to prevent the error happening again. The pharmacy had a process for managing errors identified after a person had received their medicine, known as dispensing incidents. The team recorded the dispensing incidents and detailed what contributed to the error along with the actions taken by the team to prevent the same error from happening again. The team discussed their errors and shared ideas on how to prevent errors from reoccurring. The actions taken by the team included a process to highlight prescriptions for people with similar names and addresses. The team members asked a colleague to complete a second check of the controlled drug (CD) they'd picked when dispensing a prescription, to ensure the correct product had been selected. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services and it displayed a poster informing people on how to raise a concern or provide feedback. The pharmacy website provided people with information on how to contact the team.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The CD registers were kept electronically and linked with the pharmacy's patient medication record (PMR). The system captured the current stock balance for each CD register and prompted the pharmacists when a stock check was due. The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. The pharmacy website displayed a privacy notice. The team members had completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding onsite.

The pharmacy had safeguarding procedures, training and guidance for the team to follow. It displayed a poster advising people that it provided a safe space for people to use. The RP was registered with the protecting vulnerable group (PVG) scheme and team members acted appropriately when safeguarding concerns arose. They had a good working relationship with the healthcare team at the nearby medical

centre and shared any safeguarding concerns with them.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an experienced team with the qualifications and skills to support its services. It encourages an open and honest culture where team members work very well together. Team members share ideas on how to improve the delivery of services through regular meetings. And they actively engage in providing feedback on any changes that may affect their ways of working. They benefit from identifying areas of their own practice they wish to develop, and the pharmacy helps them to achieve this.

Inspector's evidence

The Superintendent Pharmacist (SI) covered the opening hours along with regular pharmacist support. The pharmacy on most days had two pharmacists on duty to support the delivery of its services especially for the travel clinic and seasonal flu vaccination service. The pharmacy team consisted of six qualified dispensers, one whom was an accuracy checker and three medicines counter assistants (MCAs). There were usually three dispensers on duty of a morning and three of an afternoon. Two of the pharmacists were qualified independent prescribers. And all the pharmacists had been trained to provide the travel clinic that had been running for a few months. New team members were enrolled onto a combined MCA and dispenser course so they could support the dispensary team. All the trainees had protected time at work to do their training and received support from experienced colleagues who they could ask questions of.

The SI provided training to the team members and sought their feedback when new services and procedures were introduced. After the introduction of a new software package that included an electronic CD register the SI had provided training to the team. The team had raised concerns about some elements of the new software and had discussed them with the SI. The team discussed with the SI their ideas on how they could adapt some of their processes to fit around the new system which were agreed and implemented.

The team members accessed online training modules to keep their knowledge up to date. They were informed of new training modules and usually had some protected time at work to complete the training. The pharmacy provided team members with informal feedback on their performance and supported those who wished to progress and develop their skills. The accuracy checker had been enrolled on to the course after expressing an interest in further developing their skills.

The pharmacy regularly held meetings where team members discussed a range of matters and suggested changes to processes and new ways of working. It had a communications book and notice board to capture key pieces of information for all the team to be aware of. The pharmacy had a whistleblowing policy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has good and varied facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy had undergone a significant refit which provided more storage space and work benches for the team. The refit was completed to a high standard and the layout enabled the team to easily engage with people presenting at the pharmacy counter. The pharmacy was tidy and hygienic, it had separate sinks for the preparation of medicines and hand washing. The pharmacy supplied disposable gloves to the pharmacists when providing services such as the flu vaccinations. In response to the COVID-19 pandemic the pharmacy team wore face masks and the pharmacy had installed clear plastic screens on the pharmacy counter. The pharmacy maintained a one-way system for people to follow when presenting at the pharmacy counter. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had a defined professional area and items for sale in this area were healthcare related.

The pharmacy had two large soundproof consultation rooms which the team used for private conversations with people and when providing pharmacy services. One of the rooms had a clinical bed and plenty of space for the pharmacist to manage incidents when a person felt unwell. The pharmacy also had a separate entrance that provided privacy to people receiving their medication as a supervised dose. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy actively supports local and national NHS healthcare initiatives to help people access a range of services to meet their needs. It manages its services well to help people receive appropriate care and to make sure they receive their medicines when they need them. The pharmacy gets its medicines from reputable sources and it stores them properly. The team carries out checks to make sure medicines are in good condition and appropriate to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance and an automatic door. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And the team provided people with information on how to access other healthcare services when required. The team wore name badges detailing their role so people using the pharmacy knew who they were speaking to.

Team members explained the questions they asked when selling over-the-counter (OTC) products and when they referred to the pharmacist. They monitored requests for OTC medicines that were liable to misuse and liaised with the pharmacy team at the other pharmacy in Huntly when concerns arose. The NHS Pharmacy First service was popular and the team was able to provide people with a range of medicines to treat minor ailments. The pharmacist had access to a range of NHS Patient Group Directions (PGDs) to support the supply of medicines classed as prescription only medicines within the service. The team worked well with the pharmacist when people presented for treatments for minor ailments to ensure their request fitted the criteria of the service. The team asked appropriate questions of the person to discuss with the pharmacist.

The pharmacy had recently started a travel clinic led by NHS Grampian. The clinic offered people a travel vaccination and advice service provided by the pharmacists who had received specific training to support the service. The pharmacy had up-to-date PGDs issued by NHS Grampian. These gave the pharmacists the legal authority to administer the appropriate travel vaccines to the person. A record of the vaccination administered was recorded on the person’s GP system. The pharmacists kept up-to-date adrenaline injections in the consultation rooms to promptly administer to a person who experienced an anaphylactic reaction to the vaccine. The pharmacists providing the ear wax removal service had access to an audiology team to answer any questions.

The pharmacy provided multi-compartment compliance packs to help around 48 people take their medicines. To manage the workload the team members divided the preparation of the packs across the month. And they kept a record of the completion of each stage of the dispensing of the packs. So, everyone had this information available if queries arose. The team usually ordered prescriptions two weeks before supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the record and queried any changes with the GP team. The team recorded the descriptions of the products within the packs and supplied the manufacturer’s packaging information leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The team dated each completed pack and marked them with the week of supply e.g. one of four, before storing them banded together in a dedicated section.

The pharmacy supplied medicine to several people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet in baskets labelled with the person's name. The pharmacist checked the prepared doses at the time the supply was made to the person and the person was asked to confirm the dose they were expecting. This helped to ensure the person received the correct dose. The pharmacy provided several people with their medicines from NHS instalment prescriptions. The team dispensed the instalments in advance and stored them in baskets labelled with the person's name. The team marked the bag with the date of supply and how many weeks from the instalment prescription were left so they could advise the person when a new prescription was required. The team completed a check of the medicines dispensed against the instalment prescription at the point of supply.

The team members provided a repeat prescription ordering service. They used an electronic system to remind them to request the prescription and as an audit trail to track the requests. The team usually ordered the prescriptions a few days before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team provided people with clear advice on how to use their medicines. The pharmacy used 'speak to the pharmacist' stickers to prompt the pharmacist to have a conversation with the person when they collected their medication. The stickers included brief information on the reason for the conversation such as a new medicine or dose. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacist spoke to people prescribed valproate who met the criteria and provided them with the relevant PPP information. The computer on the pharmacy counter had access to the pharmacy's electronic patient records (PMR). So, when a person presented the team member could check what stage the dispensing of their prescription was at.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The team used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription and a sample found the team completed the boxes. The pharmacist completed a clinical check of the prescription to enable the accuracy checker to complete their task. The team used different coloured baskets to indicate the prescriptions the accuracy checker could complete as she wasn't involved with accuracy checking of CDs and compliance packs. The pharmacy used clear bags to hold dispensed CDs and fridge lines particularly insulin products. This allowed the team at the point of supply to complete a further check of the dispensed items. The team members used CD and fridge stickers on bags and prescriptions to remind them when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The pharmacy kept a record of the delivery of medicines to people. Completed prescriptions were stored in a dedicated retrieval area waiting to be supplied. And the team scanned prescriptions into a particular area using a barcode attached to the shelf. When the person came to collect their prescription, the team used barcode scanning to identify within which area the prescription was held and to check the correct prescription had been picked. This helped to reduce the number of hand-out errors. The pharmacy had a text messaging service to advise people when their prescription was ready to collect.

The pharmacy obtained medication from several reputable sources. The team members regularly shared and discussed medicines that were out of stock especially when there was a long-term manufacturing supply issue. So, they could take appropriate action such as contacting the prescriber to arrange an alternative medicine. The pharmacy team checked the expiry dates on stock and kept a record of this. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening. This meant the team could assess if the medicines

were still safe to use. The team checked and recorded fridge temperatures each day. A sample of these records found they were within the correct range. The team members recorded the action they'd taken when the temperature went outside the range. The pharmacy had medicinal waste bins to store out-of-date stock and patient-returned medication. And it stored out-of-date and patient-returned CDs separate from in-date stock in CD cabinets that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team members actioned the alert and kept a record of their response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It makes sure it uses its equipment appropriately to protect people’s confidential information.

Inspector's evidence

The pharmacy had reference resources and access to the internet to provide the team with up-to-date clinical information. It had equipment available for the services provided that included a range of CE equipment to accurately measure liquid medication. The pharmacy had two large fridges to store medicines. The fridges had glass doors that enabled the stock to be viewed without prolong opening of the door. The pharmacy completed safety checks on its electrical equipment. It's computers were password protected and the computers on the pharmacy counter were positioned in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view and it held private information in the dispensary which had restricted public access.

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.