General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Stauros, 53 Clerkhill Road, PETERHEAD, Aberdeenshire, AB42 2XF

Pharmacy reference: 1041683

Type of pharmacy: Community

Date of inspection: 26/11/2019

Pharmacy context

This is a community pharmacy beside other shops in a residential area of a town. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It dispenses private prescriptions and supplies medicines to ships. The pharmacy team advises on minor ailments and medicines' use. And it supplies a range of over-the-counter medicines. The pharmacy offers services including smoking cessation, blood pressure measurement and diabetes and cholesterol testing. It does not provide substance misuse services or emergency hormonal contraception. The superintendent pharmacist works four days per week in the pharmacy.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy team does not follow standard operating procedures for all processes.
		1.2	Standard not met	The pharmacy does not record errors identified in the pharmacy. So team members cannot learn from them. And they do not make changes to avoid the same mistakes happening again.
2. Staff	Standards not all met	2.2	Standard not met	Some part-time team members have not had training in line with GPhC minimum standards. And team members do not undertake ongoing training or development to ensure they are knowledgeable about the services the pharmacy delivers.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy does not deliver all services safely due to team members not following SOPs, inadequate dispensing audit trails, and pharmacists having insufficient information to carry out clinical assessments.
		4.3	Standard not met	The pharmacy does not always supply medicines safely as team members are not aware of some patient safety initiatives and date expired medicines are available for supply. The pharmacy does not have a wholesale dealer's licence but wholesales medicines to ships.
5. Equipment and facilities	Standards not all met	5.2	Standard not met	The pharmacy does not calibrate equipment and diagnostic test strips are out of date.

Principle 1 - Governance **Standards not all met**

Summary findings

Pharmacy team members do not always follow written processes for services so there is a risk of mistakes. The pharmacy has made some mistakes, and these are not all recorded. So, the team are missing learning opportunities. The pharmacy does not review these so cannot identify learning points. The pharmacy considers using feedback to improve services. The pharmacy keeps people's information safe and keeps the records that it needs to by law.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) dated 2015 and signed by team members in January 2016. So, there was no evidence of team members employed since then reading them. The delivery driver who had worked in the pharmacy for three years had not read or signed the delivery SOP or any others. SOPs were not detailed enough e.g. 'Review of CD SOPs' SOP states that these SOPs should be regularly reviewed, and the fridge temperature SOP states that fridge temperatures should be recorded in a pocket diary or on a record sheet, and if the temperature was out of range, tell the pharmacist who will take appropriate action. It did not specify what that action was. The controlled drug (CD) disposal SOP refers to the area team. But the pharmacy team and the inspector did not know what the area team was. The pharmacy team did not follow all SOPs e.g. the delivery SOP stated that the pharmacy phoned patients to arrange delivery date and time and that records of deliveries were kept – but the pharmacy did not phone patients and records of failed deliveries were not kept. And fridge temperatures were recorded electronically, not as per the SOP. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. They followed a rota to ensure that they were all competent at all activities and did not become bored or complacent. The rota covered the management of multicompartment compliance packs, working in the front dispensary, working in the back dispensary and managing stock and filling the dispensing robot.

Team members did not record near misses. This was despite failing the standard (1.2) at the previous inspection. A near miss log book was available in the pharmacy and had been used following the previous inspection. But there had been no entries for the past 18 months. There was no evidence of review or learning from incidents. And there was no evidence of strategies introduced to reduce errors.

The pharmacy had a complaints procedure. A team member described feedback from people that their prescriptions were not always ready as they expected. She had been discussing with colleagues the possibility of changing the time between ordering prescriptions and receiving medicines from 2 to 3 days. But this had not been implemented yet.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. The pharmacy displayed the responsible pharmacist notice and the following records were observed: unlicensed specials records and a controlled drug (CD) destruction register for patient returned medicines. At the time of inspection there was no access to the internet, so the following records could not be used and were not seen: responsible pharmacist log; private prescription records and controlled drugs (CD) registers. Team members described how they were used.

Pharmacy team members were aware of the need for confidentiality. Those who were working in the

pharmacy in January 2016 had read and signed an SOP on the subject, but more recently joined team members had not. They segregated confidential waste for secure shredding. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding in 2016. The superintendent pharmacist had talked to the delivery driver and medicines counter assistant about confidentiality and safeguarding. The pharmacist was PVG registered. The delivery driver explained that she told the pharmacy team if people were looking unwell. This did not happen often and there were no examples of intervention. If people did not answer the door for delivery a few times the pharmacy would contact the GP but there were no examples of this happening.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough qualified and experienced staff to provide its services. But some team members working a few hours per week are not trained. The pharmacy does not identify team members' training needs and they do not have access to ongoing training and development. This could affect how well they care for people and the advice they give. Team members can share information and raise concerns to keep the pharmacy safe. They make suggestions to improve services. And they discuss incidents as they occur to learn from them.

Inspector's evidence

The pharmacy had the following staff: the superintendent pharmacist working four days per week, two locum pharmacists working two days per week, one trainee pharmacy technician, two trained and one trainee dispensers, three medicines counter assistants, one delivery driver, and three Saturday only and after-school assistants. Pharmacist overlap provided two days when two pharmacists were working, one day was two locum pharmacists and the other was the superintendent pharmacist and one locum. Pharmacists used these days for paperwork and overseeing the management of multicompartment compliance packs. The dispensers and medicines counter assistants worked a variety of work patterns ensuring that there were always two team members on the medicines counter and either three or four in the dispensary. The Saturday and after-school team members were not trained for dispensing or medicines counter. Two of them had worked in the pharmacy for a few years and one had started recently. He did not work with medicines. Team members were able to manage the workload. The pharmacy had recently reviewed staffing levels and employed a trainee medicines counter assistant for two or three days per week. She was not yet registered on an accredited course but was aware that she had to do this.

The pharmacy provided team members undertaking accredited courses with some time to complete coursework when not too busy. But the pharmacy was busy, and this was not always possible. And a locum pharmacist was providing coaching to team members undertaking NVQ 3 and NVQ 2 training. Pharmacists supervised trainees, and this was observed during the inspection. Team members were not undertaking any other training or development. They had annual appraisals with the superintendent pharmacist but did not have development plans.

The various individuals were observed going about their tasks in a systematic and professional manner. Team members supported each other, and example being one taking over labelling from another during a busy time. The trainee NVQ 2 dispenser was observed to identify an incorrect dose on a prescription. She highlighted this to the pharmacist who confirmed the dose was wrong and contacted the GP. Team members asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests, usually referring to the pharmacist. A medicines counter assistant provided examples of this.

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. But as noted above they did not record or review these, limiting learning outcomes. They were observed to share a lot of information and discuss a variety of relevant topics

during the inspection. Team members knew how to raise concerns and gave appropriate responses to scenarios posed. They had suggested to the superintendent pharmacist over a period of months that employing another medicines counter assistant would relieve pressure on the dispensary. This had resulted in the recent recruitment. Team members had some autonomy to make changes to improve processes. An example was described of discussing a better way of managing some paperwork amongst themselves. The team then suggested this to the superintendent pharmacist who accepted it. It had been a team suggestion to introduce a rota to ensure that all team members undertook all tasks. Team members appeared to work well together, and they described a happy working environment which they believed helped their patients.

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 private rooms for some conversations with people. Other 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 space and staff facilities. There was a distinct area to the side of the dispensary that was used for the management of multicompartment compliance packs as there was unlikely to be interruption or distraction in this area. Pharmacy had installed a dispensing robot and island style dispensing bench had been removed to accommodate this. There was still adequate dispensing space. 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.

People were not able to see activities being undertaken in the dispensary. The pharmacy had two consultation rooms. One was accessed from the dispensary and the computer was often used by the pharmacists to access patient records. The pharmacy team used this room for most consultations. It had a desk, chairs, computer and equipment required for the delivery of pharmacy services. The other consultation room was used for urinary tract infection (UTI) consultations, and other consultations when the other room was in use. Both rooms clean and tidy, and the doors closed providing privacy. Temperature and lighting were comfortable.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy helps people to ensure they can all use its services. It does not always provide services safely and effectively. This is due to not following SOPs, incomplete dispensing audit trail and missed opportunities for interventions. Pharmacists do not have all the information they need to carry out clinical assessments. Team members do not always give people the information that they need to use their medicines safely. This includes written information usually supplied with high risk medicines. The pharmacy gets medicines from reliable sources and stores them properly. But some out of date medicines are available for supply. The pharmacy wholesales some medicines without the appropriate licence but this is being addressed.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and a power assisted door. It listed its services and had leaflets available on a variety of topics. And it displayed community information. The pharmacy signposted people to other services such as emergency hormonal contraception and substance misuse services. It had a hearing loop in working order and could provide large print labels to help people with visual impairment. The pharmacy provided a delivery service and people signed to acknowledge receipt of controlled drugs. Team members generated two bag labels and attached one to a sheet for the driver. The pharmacist placed bags of dispensed medicines straight into a delivery box.

Pharmacy team members followed a logical and methodical workflow using a dispensing robot for dispensing. They assembled collection service prescriptions at the rear of the dispensary behind the robot where there was little interruption. Team members worked in pairs with one labelling and one dispensing. They used baskets to separate people's medicines and prescriptions. They left baskets in this area for a pharmacist to check medicines when there were two pharmacists working. When there was one pharmacist working, she or he took baskets to the dedicated checking bench at the front of the dispensary. This enabled the pharmacist to check prescriptions for people waiting and supervise the medicines counter. Team members dispensed walk-in prescriptions at the front of the dispensary where they labelled and assembled then placed on the checking bench. They placed large cards in baskets highlighting that people were waiting. The pharmacy did not have a process in place for team members to share information with the pharmacist such as new medicines or changes, or relevant dates of previous supplies. A team member described a situation that had been highlighted of a person not having a blood pressure medication for the past three months. He had not been ordering it and the pharmacy team had not noticed. Pharmacists initialled dispensing labels to provide an audit trail of who had checked all medicines. But other team members did not so there was no audit trail of who had dispensed. Dispensed medicines were placed on retrieval shelves and some had been there for over two months e.g. co-codamol, salbutamol inhaler, amitriptyline.

The pharmacy usually assembled owings later the same day or the following day. Some people received medicines from chronic medication service (CMS) serial prescriptions. A locum pharmacist wrote a SOP less than two years previously, but this was not signed by team members, only the superintendent pharmacist. The pharmacy dispensed these on request. Team members had previously dispensed medicines when they were due, but that system had not worked. They recorded date of supply and expected date of next supply. They did not monitor for compliance and would not know if medicines

were not requested. The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time the week before first supply. Team members used a designated area of the pharmacy where they were not disturbed. They stored all equipment and sundries in this area. A team member checked prescriptions for completeness then generated backing sheets and gathered stock into individual baskets. A pharmacist carried out a clinical assessment and checked the accuracy of the stock. After a team member had assembled trays a pharmacist carried out the final accuracy check. Team members left packaging to facilitate this. And they supplied PILs with the first tray of each supply. The pharmacy supplied all four trays at the same time to several people after first assessing if this was appropriate and suitable. The pharmacy contacted the GP who signed an authorisation template for each patient. A pharmacist explained that people were monitored and assessed to ensure this continued to be appropriate. Pharmacy kept robust records of changes and other interventions along with a dose regime template. GPs used a bespoke form to request changes and the pharmacy retained these forms in patients records. The pharmacy supplied patient information leaflets monthly. It did not put tablet descriptions on backing sheets.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. Locum pharmacists had discussed high risk medicines a few days previously ensure they were giving advice. Team members were not aware of valproate pregnancy prevention programme and the pharmacy did not seem to have literature to be shared with people receiving this medicine. A locum pharmacist planned to order this from the manufacture. The team did not know if a search for patients in the high-risk group had been undertaken. Team members were also not familiar with sick day rules or the non-steroidal anti-inflammatory drug (NSAID) care bundle. Pharmacists were aware of these schemes but suggested that the were not in current use. This meant that people may not be getting important information to help them manage their illness and use their medicines safely. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, and supply of chloramphenicol ophthalmic products. Team members referred requests for the minor ailments service to the pharmacist. Pharmacist described examples of positive referrals to the out of hours service. People sometimes returned to the pharmacy share positive outcomes.

Pharmacists delivered other services such as the smoking cessation service, blood pressure measurement, cholesterol testing and diabetes testing.

The pharmacy did not provide emergency hormonal contraception due to the superintendent pharmacist's Biblical beliefs. He had requested that locum pharmacists also did not supply this. The locum pharmacists did provide the service when working in other pharmacies. People in the community knew that the pharmacy did not provide the service, so it was seldom requested. A locum pharmacist said she had been asked for it once some time ago and signposted the person to another pharmacy nearby. The pharmacy also did not provide substance misuse services. The health board was aware of this. The local community knew that the service was not available, so it was never requested.

The pharmacy filled medicines' chests for class B ships and occasionally class A ships which were larger. It had around 40 registered for this service and the chests required to be filled every two years. The pharmacy also supplied replacement medicines that had been used at other times for ships. These were wholesale transactions, but the pharmacy did not hold a wholesale dealer's license.

The pharmacy obtained medicines from licensed wholesalers such as AAH, Alliance and Aver. It complied with the requirements of the Falsified Medicines Directive (FMD). Medicines were scanned as they were dispensed, and bag labels were scanned at the time of supply. The pharmacy stored

medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in 2 fridges with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Team members sometimes checked expiry dates of medicines, but no evidence was seen. And a date expired controlled drug and some very short dated items were observed. 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 not all met**

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. But it may not be fit for purpose as it is not regularly calibrated, and sundries are date expired. The pharmacy team members raise concerns when utilities such as internet are not working to minimise disruption to services.

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. But at the time of inspection the internet down so team members and the inspector were unable to access records. The pharmacist reported the fault and an engineer arrived the pharmacy soon afterwards.

Pharmacy had installed a dispensing robot around 18 months previously. Team members described training at that time. They knew how to access support in the event of any malfunction or query. An engineer could be on site within three days of being called. But the remote support was usually adequate, and the team used FaceTime to enable the engineer to see any problem. The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor which was maintained by the health board; a blood pressure meter but the team did not know how old it was or if it had ever been calibrated, and blood testing equipment with no evidence of calibration. Blood glucose test strips (0ne open and one sealed pack) were out-of-date. Cholesterol strips were out-of-date the following week. The pharmacy had alcohol gel rub and gloves. Team members kept crown stamped measures by the sink in the dispensary. The pharmacy team kept clean tablet and capsule counters in the dispensary. As methotrexate tablets were supplied in blister packaging there was no longer a separate counter kept for these.

The pharmacy stored paper records in a filing cabinet in the dispensary inaccessible to the public and in a filing cabinet in a consultation room. Pharmacy team never left people alone in consultation room. The pharmacy 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.