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: 22/06/2021

Pharmacy context

This is a community pharmacy beside other shops in a residential area. 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 also dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. This pharmacy was inspected during the COVID-19 pandemic.

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

The pharmacy suitably identifies and manages the risks with its services, including reducing the infection risk during the pandemic. The pharmacy team members follow written processes for the pharmacy's services to help ensure they provide them safely. The pharmacy keeps all the records that it needs to by law, but some are incomplete. Team members record some but not all mistakes, but they do not routinely review these. They could be missing opportunities to learn and make improvements.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter and hand sanitiser at the premises entrance. The pharmacy had tape on the floor to encourage people to socially distance. It allowed three people on the premises at any time. Most people coming to the pharmacy wore face coverings and team members all wore masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points several times during the day. A team member cleaned the consultation room immediately after use. The superintendent pharmacist had carried out a personal risk assessment with each team member to identify any risk that may need to be mitigated in the pharmacy. No such risks had been identified.

The pharmacy had standard operating procedures (SOPs) which were followed. The superintendent pharmacist had reviewed them and implemented some new ones since the previous inspection 18 months ago. But some were for 'old' processes such as the minor ailments service and chronic medication service. Pharmacy team members had read them, and the pharmacy kept records of this. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. All dispensing team members were able to carry out all tasks and followed a rota that they had suggested to the pharmacist. And they swapped tasks with each other to avoid tiring or boredom. This ensured that team members were 'fresh' and concentrating on the task. 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.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. But they did not record all these errors, meaning that they did not have much data and they did not review it. They recorded errors that had been identified after people received their medicines. No examples were described. The team members and pharmacists explained that dispensing was generally accurate, partly because of the dispensing robot. But they acknowledged that they could record more incidents and make records more meaningful. They discussed individual errors as they occurred. And they discussed how they could reduce errors by taking their time and reading prescriptions more carefully.

The pharmacy had an indemnity insurance certificate, expiring 30 April 2022. The pharmacy displayed the responsible pharmacist notice and had an accurate responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. But some detail that was legally required was not recorded, such as prescribers' addresses. It kept

unlicensed specials records, a CD destruction register for patient returned medicines and controlled drugs (CD) registers with running balances maintained and regularly audited, every three months as per the SOP. At the previous inspection the SOP had stated weekly running balance audits, but this was not achievable. So the superintendent pharmacist had changed it when he had reviewed the SOPs. Three-monthly audits could result in a lengthy investigation if a discrepancy was discovered, and delay identification of an error. 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.

Pharmacy team members were aware of the need for confidentiality. They had all read and signed 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. The locum pharmacists were registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. They are trained and competent for their roles and the services they provide. The pharmacy gives them time for training during the working day. And it makes adjustments to support team members enabling them to continue their role safely. Team members make decisions within their competence to help provide safe services to people. And they use their professional judgement to help people. They feel comfortable to make suggestions and raise concerns if they have any to keep the pharmacy safe.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager (the superintendent pharmacist), four regular locum pharmacists, two trainee part-time pharmacy technicians, four part-time dispensers, one full-time and two part-time medicines counter assistants, four Saturday only team members and a part-time delivery driver. Typically, there were one or two pharmacists, four dispensing team members and two medicines' counter assistants working at any time. Team members were able to manage the workload. Part-time team members had some scope to work flexibly providing contingency for absence. There were two pharmacists working two days per week, and when the superintendent was off, or ahead of local holidays the pharmacy increased this. During the pandemic the pharmacy had faced some staffing challenges with absence for a variety of reasons. The pharmacy had put strategies in place to support people during this time, an example being providing a stool, and changing tasks for a team member with an injury.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development. And it provided team members undertaking accredited courses with additional time to complete coursework. A new team member had started this week in the pharmacy so had not been registered on a course yet. But she knew that she would have to complete training and expected to have time during the working day. Team members had annual development meetings with the superintendent pharmacist to identify their learning needs. They used this as an opportunity to make suggestions and offer feedback. An example described how filling the dispensing robot was very time consuming, so the process was reviewed and changed. Team members were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The pharmacist was observed to supervise the medicines' counter, listening to conversations between people and team members, intervening as appropriate.

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 were observed sharing information with each other, discussing issues and asking for second opinions. They explained they could make suggestions and raise concerns to the pharmacists or pharmacy superintendent. The pharmacy team discussed incidents and how to reduce risks. Team members described working on the same activity for long periods as a potential risk. They had previously introduced a rota which helped address this, and they often offered to take over from colleagues when they noticed someone with a heavy workload. The two regular locum pharmacists present at the time of inspection described the team as efficient and competent with team members

working well together.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for the services it provides. It has good facilities for people to have conversations with team members in private.

Inspector's evidence

These were reasonably sized premises incorporating a retail area, dispensary, storage area and staff facilities. The premises were clean, hygienic and well maintained. Team members cleaned surfaces and touch points frequently. A new team member was observed to do this and brush the floor during the inspection. Cleaning rotas were observed but had not been completed recently. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available.

People were not able to see activities being undertaken in the dispensary. There was a distinct area to the side of the dispensary that was used for the management of multi-compartment compliance packs as there was unlikely to be interruption or distraction in this area. The pharmacy had a dispensing robot in the front dispensary where team members carried out most routine dispensing. The pharmacy had two consultation rooms. One was accessed from the dispensary and the computer was often used by the pharmacists to view patient medication 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 were clean and tidy, and the doors closed providing privacy. Currently team members did not use these rooms as often as they did before the pandemic. But they could manage social distancing and they cleaned the room immediately after use. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services which it provides safely. Team members follow written processes relevant to the services they provide. They support people by providing them with suitable information and advice to help them use their medicines. And they provide extra written information to people taking higher risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. Team members know what to do if medicines are not for purpose.

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. But it was well known in the community that the pharmacy did not provide these services and the team members present could not recall any requests or prescriptions. The pharmacy had a hearing loop in working order and could provide large print labels to help people with visual impairment. It provided a delivery service which had been popular during the pandemic. Team members generated two bag labels and attached one to a sheet for the driver. The pharmacist undertaking the final check placed bags of dispensed medicines straight into a delivery box labelled for the relevant day.

Pharmacy team members followed a logical and methodical workflow for dispensing, using the dispensing robot for most items. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. And they followed a rota as noted elsewhere, working in pairs to improve the efficiency of some dispensing. There were dedicated areas in the dispensary for different activities, ensuring that complex dispensing was undertaken in areas with little interruption. And pharmacists could supervise the medicines counter and check different prescription types safely. 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. Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these when people requested them. Team members kept records of all medicines supplied so they could see any compliance issues when the person next ordered their medicines. But the pharmacy was not pro-actively monitoring compliance or reconciling medicines.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle in a designated area of the pharmacy where equipment and sundries were stored, and team members were not disturbed. They assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. They followed a robust process and kept records of medicine changes and other interventions. Prescribers completed a change form to inform the pharmacy and this was retained. The pharmacy did not include tablet descriptions on backing sheets, so it would be difficult for a person to identify their tablets. It supplied patient information leaflets monthly. Following the prescribers' written request, the pharmacy supplied four packs at a time to a few people. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details

and date of supply. They were stored alphabetically in individually named baskets on labelled shelves.

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. The pharmacy did not supply valproate to anyone in this group. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care, smoking cessation, and the Pharmacy First service including two recent additions. Some pharmacists were in the process of completing the training and paperwork required for these and others had completed it. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. 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, recording personal details and symptoms on a template. During the pandemic the pharmacist had delivered some services remotely by phone. This had ensured service delivery while minimising footfall on the premises. Services delivered in this way included smoking cessation and urinary tract infection (UTI) treatment. The pharmacist carried out the consultation remotely and if appropriate, the team prepared medication ready for collection when the person came to the pharmacy. The pharmacists delivered the smoking cessation service and some other team members had recently completed training to enable them to participate, which would enable more people to access the service.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. And team members used space well to segregate stock, dispensed items and obsolete items. The pharmacy stored items requiring cold storage in two fridges and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action 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 Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety 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 to deliver its services. The pharmacy looks after this equipment to ensure it works. Team members act appropriately to address any malfunctions.

Inspector's evidence

The pharmacy had resources 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 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. The pharmacy team members were not using this equipment during the pandemic to avoid spreading infection. Team members kept crown-stamped measures by the sink in the dispensary and kept clean tablet and capsule counters in the dispensary. They did not have a separate one for cytotoxic tablets as methotrexate tablets were supplied in blister packaging. The pharmacy used a dispensing robot for much of the routine dispensing. It had a maintenance contract including routine servicing. And team members knew how to access support in the event of any malfunction or query. Often a video call was enough for an engineer to address the issue.

The pharmacy stored paper records in the dispensary inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave 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.