General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Torphins Pharmacy Limited, The Square, 1 Beltie Road, TORPHINS, Aberdeenshire, AB31 4JP

Pharmacy reference: 1041693

Type of pharmacy: Community

Date of inspection: 20/11/2019

Pharmacy context

This is a community pharmacy in a village. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it supplies medicines to care homes. The pharmacy offers a repeat prescription collection 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. The superintendent pharmacist works as the responsible pharmacist four days per week.

Overall inspection outcome

✔ **Standards 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 met	1.8	Good practice	The pharmacy identifies vulnerable people, takes appropriate action and can demonstrate positive outcomes.
2. Staff	Standards met	2.2	Good practice	The pharmacy provides regular structured training for all team members on relevant topics. This ensures they all have the knowledge to provide effective pharmacy services.
		2.3	Good practice	The pharmacy team regularly makes interventions which benefit people.
		2.4	Good practice	Pharmacy team members are enthusiastic about their role and the help they give people. They are comfortable sharing incidents and learning.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy provides effective advice to people, identifying care issues, leading to positive outcomes. Team members manage high risk dispensing activities well, limiting distractions. They monitor repeat prescriptions, intervening appropriately.
		4.3	Good practice	The pharmacy manages medicines stock well, minimising the chance of errors with insulin. The team screens person returned medicines and deals with them appropriately, including minimising waste from care homes.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team members follow written processes for all services to ensure that they are safe. They record mistakes to learn from them. They review these and make changes to avoid the same mistakes happening again. Team members listen to feedback from people and use it to improve the 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 vulnerable people in various ways including delivering emergency first aid training to other people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. But they were old, with some dating from 2008 and others 2014. Processes scrutinised were as per the SOP. The superintendent pharmacist explained that she was in the early stages of reviewing SOPs. She was enlisting the help of an experienced dispenser. Pharmacy team members had read SOPs, 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. 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. They also recorded errors reaching patients to learn from them. The pharmacists explained that team members made very few errors. They were accurate dispensers and checked their work before passing for the final accuracy check. They explained that the process followed for dispensing helped accuracy. The pharmacy kept records of errors reaching people. Team members documented them fully, discussing possible causes. They were more likely to make mistakes when the pharmacy was busy. So, they had been reminded to take their time when dispensing, even at times of high volume. The pharmacy did not undertakle regular formal reviews. A pharmacist explained that this was going to be done in the future. The team had separated items involved in incidents with similar sounding names. These included tramadol and trazadone. And team members had fixed labels to shelves to highlight amlodipine and amiloride. They had made a note on a person's medication record (PMR) that they were prescribed ramipril tablets as there had been a few near misses with capsules dispensed.

The pharmacy had a complaints procedure and welcomed feedback. It had received feedback that some people were unable to get to the pharmacy to collect their medication. So, team members had started delivering medicines to people with a need. The pharmacy ordered items it did not usually stock, on request, for people.

The pharmacy had indemnity insurance provided by Zurich, expiring 01 Oct 20, and it displayed the certificate. 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.

Pharmacy team members were aware of the need for confidentiality and had read a policy. They discussed the topic frequently, being mindful of the challenges of a small rural community. 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 pharmacist was PVG registered. Team members described several examples of raising concerns about potentially vulnerable people. These included contacting the GP who had visited a patient and had him admitted to hospital. The delivery driver who also worked in the pharmacy reported anything unusual to the pharmacist, such as people not looking well, or not answering the door as expected. Team members monitored a few people, discussing their welfare and demeanour amongst themselves. This had resulted in GP referrals and some people being provided with multicompartment compliance packs to help them take their medicines regularly.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. Team members have access to training to ensure they have the skills they need. The pharmacy gives them time to do this training. They can make decisions and use their professional judgement to help people. Team members share information and can raise concerns to keep the pharmacy safe. They discuss incidents and learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: two pharmacists, the owner working four days per week and a regular locum working two days per week; two part-time dispensers one working four days and the other working 2.5 days providing a half day overlap; one full-time medicines counter assistant; one Saturday only trainee medicines counter assistant and one retail assistant also delivers medicines. Typically, there were three team members and a pharmacist working. They had all worked in the pharmacy for several years. Team members were able to manage the workload. The pharmacy displayed their certificates of qualification. The locum pharmacist also worked in two GP practices and she was a prescriber, specialising in respiratory conditions.

The pharmacy provided the team member undertaking accredited training with time at work to complete her coursework. All team members had time at work to read product information and other literature that was received into the pharmacy. From time to time the pharmacy had learning lunches when other healthcare professionals were invited in to deliver training e.g. inhalers. The medicines counter assistant attended these sessions which she described as useful. Training had included head lice and respiratory conditions recently. And a meeting planned over the next few weeks was focusing on non-steroidal anti-inflammatory drugs (NSAIDs) with the elements of the new care bundle in mind. The team discussed new products and did not get them into the pharmacy until all team members were knowledgeable. Recently the pharmacists had attended a diabetes training and information was in the pharmacy to cascade to other team members. All team members attended training events when they were available e.g. RPS meetings, trainings on hormone replacement therapy, indigestion and NHS services. Recently the non-steroidal anti-inflammatory drugs (NSAIDs) care bundle had been relaunched and NHS Education for Scotland had delivered training which all team members attended. This enabled the pharmacy to provide quality advice and work with prescribers when interacting medicines were prescribed – known as triple WHAMMY (ARBs, ACEIs and diuretics). The practice pharmacist had already reviewed many people, but pharmacy team members reviewed all people when they were labelling prescriptions. They considered quantities prescribed, smoking status, age, and whether stomach protection medicines were prescribed. They recorded outcomes and interventions on the patient medication record (PMR). The pharmacy had recently changed its labelling software. Team members had basic training to use it, but the pharmacy was trying to get more advanced training to ensure that they were making the most of the functions available e.g. how to manage serial prescriptions better. The pharmacists were part of a learning group which encouraged shared learning across all pharmacists in the geographic area.

The various individuals were observed going about their tasks in a systematic and very professional manner. They demonstrated enthusiasm for their work and provided quality counselling and advice to people. The pharmacist counselled every patient as she supplied their prescribed medicines. This

stimulated conversation, encouraged people to ask other questions and helped to identify care issues e.g. difficulty swallowing tablets. Team members had a lot of communication with the GP practice to confirm doses and clarify any ambiguities. They recorded all these interventions on people's records e.g. clarification for a vulnerable patient who explained she was on a reducing dose. 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. Team members constantly shared relevant information with their colleagues. This included information about people's medicines, their health and processes in the pharmacy.

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 manager or area manager. They gave appropriate responses to scenarios posed. The pharmacy team discussed incidents and how to reduce risks. The team had lunchtime meetings approximately every three months. These usually had a training element and time to discuss other issues. Team members sometimes had social events which helped them get to know each other well which contributed to the trust and good communication observed.

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. Other people cannot hear 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. The premises had benefited from a refit a few years previously which had provided a larger dispensary. The dispensary now had a defined area to undertake higher risk activities such as the management and assembly of multicompartment compliance packs, with no distraction. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, and toilet area. 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 a consultation room with a desk, chairs, and computer which was clean and tidy, and the door closed providing privacy. All team members used this room to have private conversations with people. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. And pharmacists ensure all people know how to use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and team members helped people with the door if required. It listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as flu vaccination. It welcomed helping dogs and could provide large print labels to help people with visual impairment. All team members wore badges showing their name and role. The pharmacy delivered urgent medicines required by people who were unable to visit the pharmacy.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. The team member labelling prescriptions marked them with any new items or changes and checked dates of previous supplies. Team members contacted the GP practice if the medicine had been requested early or if there were concerns about compliance. Sometimes people had requested medicine early to cover holidays or other events, and often prescribers noted this on prescriptions. Another team member usually gathered the stock which was scanned for the falsified medicines directive (FMD) process, then labelled, checked and passed to the pharmacist for the final check. There were not many mistakes identified, and this was attributed to this dispensing process. 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. It received twice daily stock deliveries so was able to obtain medicines quickly e.g. palliative care items for care homes. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these as people requested them and kept records of date of supply and expected supply date. Team members had occasionally identified compliance issues which they shared with the GP as well as discussing with the person as appropriate. The pharmacy was actively registering people for this service. Sometimes the GP identified people. The pharmacists used a laminated bespoke form which it had devised from the NHS pharmacy care record to ask relevant questions and identify care issues. They often discussed smoking and encouraged people to access the smoking cessation service. All team members had read a new service level agreement for 'medicines: care and review' (M:C&R) which was the new service replacing CMS. The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. People were assessed using the NHS assessment form before starting to receive packs. Team members used a dedicated area of the dispensary where they were not disturbed to assemble these. A team member labelled and gathered stock which the pharmacist checked for accuracy. The pharmacy had a process in place to identify checked medicine which a team member then assembled into packs. They provided patient information leaflets and included tablet descriptions on labels. The pharmacy stored completed packs in individual baskets labelled with people's name and date of supply. The team ordered prescriptions after the last pack had been supplied, and this gave

ample time to receive prescriptions and assemble packs before they were required. The pharmacy kept robust records of changes and other interventions. The pharmacy also provided pharmaceutical services to care homes. It divided the dispensing workload over a four-week period, assembling medicines on alternate weeks and undertaking paperwork on the other weeks. The homes ordered items they required using the medicines administration record (MAR) charts. A pharmacy team member checked requirements then ordered prescriptions. The care home staff checked prescriptions before they were returned to the pharmacy for dispensing. A pharmacy team member monitored medicines returned from homes and returned them to the home if they were still required and had been reordered. The pharmacy had a very organised process for this to minimise waste. It kept records of all items returned to the pharmacy and those returned to the homes. The pharmacy supplied medicines to the homes in original packs with MAR charts. The pharmacy supplied a variety of other medicines by instalment. Team members dispensed these in entirety and stored medicines in individual bags in baskets labelled with people's names and days of collection. They kept records of collection. The pharmacy also supplied medicines to people on the medicines' management service. The pharmacy had reviewed this recently and now provided MAR charts for topical medicines as care staff could not administer these if there were not on the chart.

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 them appropriately. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle second phase, with 'triple WHAMMY' (described above). Team members provided written and verbal information to people supplied with these medicines over-the-counter, or on prescriptions. They also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. The pharmacist discussed how to take medicines with everyone. And sometimes this helped her to identify pharmaceutical care issues e.g. someone who was unable to swallow capsules, so she wrote an urgent prescription for a liquid formulation. 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. It empowered team members to deliver the minor ailments service (eMAS) within their competence 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.

The pharmacy supplied gluten-free foods on prescription to several people. It had recently received a prescription for a product range that the team was not familiar with. A team member contacted the company for information on this product range. This resulted in the pharmacy receiving literature and samples on the range. The team member had learned how to use some of the products and was sharing this knowledge with service users. The pharmacy was distributing samples to people who would find them useful. The pharmacists usually delivered the smoking cessation service and could describe recent successes. They often identified people suitable for the service when they were registering them for CMS including vulnerable people that could access the extended programme.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It complied with the requirements of the Falsified Medicines Directive (FMD). Medicines were scanned when dispensed and scanned again when supplied. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. 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. The pharmacy did not stock a large quantity of items requiring cold storage such as insulin. Pharmacists discussed how best to manage prescriptions when people were prescribed insulin. So, people ordered prescriptions in time to enable the pharmacy to order the stock as required. This ensured that insulin did not go out of date and helped with accuracy. 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 the delivery of its services. Team members look 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 equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. It had a carbon monoxide monitor maintained by the health board . And it had several demonstration/placebo inhalers used to help people learn to use their inhalers correctly. The team kept a lot of topical material and leaflets in the co0nsultation room. 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 the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored 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.