General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Steeple Pharmacy, 152 High Street, MONTROSE, Angus, DD10 8JB

Pharmacy reference: 1041762

Type of pharmacy: Community

Date of inspection: 14/11/2019

Pharmacy context

This is a community pharmacy on a town high street. 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 provides substance misuse services, a smoking cessation service and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use and supplies a range of over-the-counter medicines.

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 does not follow documented processes for all activities such as failed medicines deliveries and the management of controlled drugs.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough team members to safely deliver its services and undertake all necessary tasks.
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 manage all instalment dispensing safely including multi-compartment compliance packs and serial prescriptions.
		4.3	Standard not met	The pharmacy does not store all medicines appropriately with date expired medicines and prescriptions available for supply. This includes a medicine that was identified date expired three years previously.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy team follows written procedures for most processes. But team members do not follow a process when people are not in to accept their delivery of medicines. This means some people may not have the medicines they need. And they do not follow the controlled drugs procedure. Team members record mistakes to learn from them. The pharmacy keeps all the records that it needs to by law. And it keeps people's information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for its processes. Pharmacy team members had read them and signed a sheet listing SOPs. They ticked the ones they had read. They were not following the controlled drugs SOPs which applied to dispensers as well as pharmacists. The dispensers did not handle controlled drugs meaning the locum pharmacist had to dispense and self-check. The delivery driver who had started his role two months previously had not read any SOPs. The SOPs did not include the name of the person who had prepared them or the date of preparation. Most had a review date of 2020 with previous dates obliterated with correction fluid. 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 closed for lunch, so this seldom occurred. 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 pharmacist who had left six weeks previously reviewed these and spoke to the team. But team members did not know if she documented anything. The inspector did not find evidence of review. Recent trends included incorrect strengths and forms. And two documented errors reaching people over the past two months were an incorrect form. Team members described separating similar items in the past. And they circled quantities on some packs which were identical e.g. diclofenac 28 and 84. The pharmacy had a complaints procedure.

The pharmacy had an indemnity insurance certificate, expiring 30 Sept 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. 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 a policy which formed part of their contract of employment. They explained this had included safeguarding. Team members did not know how to raise safeguarding concerns but would discuss with the pharmacist. The locum pharmacist explained that he would look on the internet for details if the need arose. He was PVG registered and had supplied his registration details to the pharmacy superintendent. The delivery driver was a trained first-aider from previous employment. He described speaking to neighbours when a person did not answer the door as expected. The warden of the housing complex investigated and there was no issue. The driver put cards through people's doors if they did not answer the door and told the pharmacist. As there had been no regular pharmacist recently, the team did not know if there

had been any follow-up. One person had not answered the door for three consecutive weeks. The pharmacy had contacted the prescriber who told the team to withhold further supplies.

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

Summary findings

The pharmacy does not have enough team members to safely provide its services. Team members are rushing. This causes them to make mistakes. And they do not have time to undertake all their tasks which means medicines are not always ready when people expect them. They have access to training material and sometimes read this at home. They do not have time at work to do this. And the material is not related to what they or the pharmacy need.

Inspector's evidence

The pharmacy had the following staff: two full-time dispensers (one still in training), three part-time dispensers (16, 9, 8 hours per week) and a part-time delivery driver. The pharmacy displayed their certificates of qualification. The pharmacist had left around six weeks previously and locum/relief pharmacists were covering daily. Typically, a pharmacist and three team members worked at most times. And Saturdays had two team members with a third team member alternate weeks. Team members sometimes worked overtime to cover absence. They got authority from head office prior to doing this. But not all absence could be covered. At the time of inspection there was a locum pharmacist (who had worked in the pharmacy once before) and two dispensers. A full time (45 hours per week) trainee dispenser was on annual leave.

Team members were not able to manage the workload. They were visibly stressed and struggling. At times during the inspection no-one was dispensing because the two team members were having to serve at the medicines counter and take phone calls. There were constantly people at the medicines counter trying to collect dispensed medicines, hand in prescriptions and seek over-the-counter medicines and advice. And there were several phone calls. Most people trying to collect medicines were told politely that they were not yet ready. The prescriptions from the previous day had not been dispensed. The pharmacy was still working on multi-compartment compliance packs due out the following day. Previously team members would have assembled these the week before they were required to avoid pressure. The pharmacy was busy. Dispensing volume had increased by over 60% around six months previously and been sustained at this level each month since then. The inspector saw dispensing data for the year. After the inspection the superintendent checked this data and explained that there had not been this increase. He was investigating the reason for the data seen. The volume six months ago was like that seen at the previous inspection. At the previous inspection there had been similar dispensing hours and additionally a full-time medicines counter assistant and two ‘after-school’ and Saturday only medicines counter assistants. Team members described changes to other local pharmacies that had contributed to the increased work load. Other examples of the team struggling with workload included ‘near-miss’ dispensing errors being made due to rushing and interruptions; date expired items on shelves; date expired prescriptions and dispensed medicines waiting to be supplied; a minor ailments request being refused, then offered later in the day; team members running; uncollected instalment medicines not being queried including important medicines such as olanzapine and furosemide e.g. should have been supplied 16.10.19, 30.10.19, 31.10.19. Team members were aware of these and stated that they knew they were not providing good patient care. As there had been no regular pharmacist for several weeks there was a lack of leadership e.g. tasks undertaken by the pharmacist had not been delegated or explained to other team members e.g. stock for balances was not all ordered, resulting in partially assembled prescriptions taking up a large area of dispensing bench; team members were unaware of the valproate pregnancy prevention programme;

team members were not trained to deliver the smoking cessation service and did not know where documentation for this was.

The pharmacy did not provide protected learning time for team members to undertake regular training and development. They had been told it was their personal responsibility to make time for training, so team members were taking magazines home to read. The pharmacy stored pharmacy magazines in a box for team members to access. This was not structured, and some magazines had training modules in them. Team members had training folders but there was very little information in them. They had recorded a variety of topics but not recently e.g. 6/18, 9/18, 4/19. Some team members had had appraisals with the previous pharmacy manager. They had actions to complete accredited courses. This was historic and there was nothing current.

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. 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. 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. The premises were clean and hygienic but looked old-fashioned and 'tired'. At the time of inspection, the exterior was being painted in the corporate colour. 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 the detail of activities being undertaken in the dispensary. But they could see team members running. The pharmacy had a consultation room with a desk and chairs, which was clean and tidy, and the door closed providing privacy. All team members used this room e.g. when measuring people for stockings. And the pharmacist used it to supervise methadone consumption. Temperature and lighting were comfortable.

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

Summary findings

The pharmacy helps people to ensure they can use its services. The pharmacy team mostly provides safe services. But team members are dispensing under pressure which could lead to mistakes. And they do not manage instalment prescriptions including multi-compartment compliance packs as they should. The pharmacy gets medicines from reliable sources and mostly stores them correctly. But it has date expired items on shelves and in cupboards.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and team members assisted with the door if they saw people having difficulty. It had leaflets available on a few topics including smoking cessation in the consultation room. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

Pharmacy team members followed a logical and methodical workflow for dispensing. But at the time of inspection it was somewhat chaotic as they were working on the previous day's prescriptions as well as those received earlier that day. When the pharmacy received prescriptions from the surgery a team member arranged them alphabetically. This helped team members locate people's prescriptions efficiently if they were requested before they had been assembled. This occurred frequently. One team member was labelling the current day's prescriptions in the consultation room. And she was looking after the medicines counter. So she was interrupted continually to serve at the counter and answer the phone. The other team member was assembling the previous day's prescriptions and those for people walking in. Both team members were under a lot of pressure. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. The pharmacy collected prescriptions from the surgery each morning. It had previously done this twice a day, but team members did not have time to go twice now. They tried to go twice on Mondays and Fridays as there were more prescriptions these days. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy was storing many bags containing dispensed medicines on the floor as the retrieval shelves were full. The pharmacy usually assembled owings later the same day or the following day. But previously the pharmacist had overseen this and ensured all stock was ordered. Team members did not have the time to do this and locum/relief pharmacists were not aware of this need. So, sometimes stock was not ordered in a timely manner. And part-assembled prescriptions were accumulating on a dispensing bench. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these the week before required. It kept records of supply date, next expected supply date and date of dispensing. The computer flagged when these were due. Team members explained that they were not aware of any compliance issues. But they described phoning the surgery if people had not collected their medicines after two months when the next instalment was due. This meant that people may have no medicine for up to two months. The pharmacy was registering people for this service. But people filled in their own assessment forms and no pharmaceutical care issues were identified. The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. Team members were assembling these packs for supply the following day. They did not supply patient information leaflets, which was a legal requirement. They included tablet descriptions on backing sheets. But they did not attach backing sheets to the packs, so they would easily become separated. Then people would not know the identity of tablets in the pack. The

pharmacy supplied a lot of other medicines by instalment. Team members dispensed prescriptions in entirety when they were received. They wrote the date of supply on bags containing medicines. But they did not monitor these, and several examples were observed of medicines that should have been supplied a few weeks previously. The pharmacy had not contacted people or notified prescribers.

The locum pharmacist undertook clinical checks and described providing appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. The valproate information was stored beside the tablets. But team members were not aware of this. The locum pharmacist was familiar with the programme and could provide advice and information. Team members did not know if a search had been undertaken to identify patients in the 'at-risk' group, or if the pharmacy supplied valproate to any people in this group. The pharmacy had 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. 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.

Pharmacists delivered the smoking cessation service. But the locum pharmacist could not find people's records when two people attended the pharmacy for their routine appointment. The other team members did not know where these were stored. The pharmacy no longer provided the local NHS palliative care service due to there being no regular pharmacist.

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 they were dispensed, then scanned again (de-commissioned) when supplied. The system was not linked to prescriptions so did not include accuracy checking. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in two 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 the inspector checked dates of medicines on one shelf only and found three date expired items. 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. 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 its smoking cessation service. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate one for cytotoxic tablets.

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 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.