General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Catrine Pharmacy, 8 Ford Street, CATRINE, Ayrshire, KA5 6RW

Pharmacy reference: 1041813

Type of pharmacy: Community

Date of inspection: 27/11/2019

Pharmacy context

This is a community pharmacy in the village of Catrine, Ayrshire. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including a home delivery service and a minor ailments service. It supplies medicines in multi-compartment compliance packs to people living in their own homes.

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 generally identifies and manages the risks associated with the services it provides to people. And it keeps people's private information secure. The team members openly discuss and record any mistakes that they make when dispensing. So, they can learn from each other. And they implement changes to minimise the risk of similar mistakes happening in the future. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children. The pharmacy generally keeps the records it must have by law. And it has a set of written procedures for the team members to follow. But it doesn't review these procedures regularly. And it doesn't have procedures for all the services it provides. So, the team may not be working in the safest and most effective way.

Inspector's evidence

The pharmacy had a spacious retail area which led to the dispensary. The pharmacy counter prevented access from the retail area to the dispensary. The pharmacist on duty used a dispensary bench that was closest to the retail area to complete final checks on prescriptions. So, he could over see any sales of medicines and listen to any conversations the pharmacy's team members were having with people who used the pharmacy.

The pharmacy had a set of written standard operating procedures (SOPs). They included ones for responsible pharmacist (RP) regulations and dispensing. But there was not a SOP for dispensing medicines into multi-compartment compliance packs. And so, the team members may not know how to carry out the process in the safest and most effective way. There was an index, so it was easy to find a specific SOP. The SOPs were versions used by the pharmacy's previous owners. And there was no evidence of the SOPs having been reviewed to make sure they were up to date and reflected the pharmacy's current practices. Each team member had read and signed the SOPs that were relevant to their role.

The pharmacy recorded near miss errors made while dispensing onto a paper near miss log. The team member who made the error was responsible for entering the details of the error. The team members explained this helped them take ownership and responsibility for their errors and helped with their learning. Previously, the pharmacy used a basic log to record the details of the near misses. These included the nature of the error, the date and the team members involved. From November 2019, the pharmacist changed the log to a more comprehensive version. The new log recorded the date and time of the error, the type of error and any learning points. But the team members did not always record why an error might have happened. And so, they may have missed out on the opportunity to make specific changes to their practice. The pharmacist on duty explained that the team was not always recording every near miss, but the introduction of the new log had helped the team record more detail which had helped him analyse the near misses for any trends or patterns. Following a recent analysis, the pharmacist noticed several labelling errors had happened. The pharmacist explained the reason was because the computer software often encouraged the person labelling the prescription to use the directions from the last time the medicine was dispensed. And so, the team members sometimes failed to notice if the directions had changed. The team discussed what they could do to prevent similar errors happening again. They talked about making sure they were always dispensing from the prescription and

not the generated dispensing labels. And ensuring they did not accept the suggested directions without double checking them against the prescription. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. And some examples were seen. The team described a recent incident where two people had picked up each other's medicine bags after they had rested them on the pharmacy counter while they were speaking with the pharmacy's team members. The pharmacist explained that the pharmacy previously secured the bags by attaching the person's repeat prescription slip to the front of the bag. However, the person's details on the slips were small and hard to read from a distance. And this may have contributed to the mix up. The team discussed how they could prevent something similar from happening again. And they decided to start using printed bag labels to secure the bags, in place of the repeat prescription slips.

The pharmacy had a complaints procedure available for the team to refer to. But it did not advertise to people how they could give feedback or raise any concerns or complaints. It collected basic feedback from people through verbal conversations, but the team was not proactive in doing so. The team members could not demonstrate any examples of improvements they had made to the pharmacy's services following any feedback from people.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept records of private prescription supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock when new stock arrived or when stock was dispensed. A physical balance check of Longtec 5mg tablets and Shortec 20mg capsules matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines, but some were not completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team members were aware of the need to keep people's personal information confidential. And they were seen offering the use of the consultation room to people to discuss their health in private. The team members explained this was important as people often congregated close to the pharmacy counter and so any conversations that took place near the pharmacy counter could be overheard. They were seen moving to the back of the dispensary to take any telephone calls. They had all undertaken general data protection regulation (GDPR) training. Records containing personal identifiable information were held in areas of the pharmacy that only the team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a shredder.

The pharmacist was PVG registered. The team members gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. A team member explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage and report a concern. And the contact details of the local support teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate skills to provide the pharmacy's services safely. They work well together to manage their workload and to ensure people receive an efficient service. The pharmacy team members complete some ongoing basic learning to keep their knowledge and skills up to date. And they discuss and set personal development goals. They feel comfortable to make suggestions to improve the pharmacy's services. And they can raise professional concerns when necessary. The pharmacy doesn't always enrol its team members on the required qualification training in a timely manner.

Inspector's evidence

At the time of the inspection the regular pharmacist was on duty. And he was supported by a full-time accuracy checking technician (ACT) and a part-time counter assistant. The pharmacist was relatively new to the business and worked three days a week. The ACT had also only recently been employed and was not completing any final accuracy checks during the inspection. The ACT explained that she wanted to familiarise herself with the basic dispensing process for the first few weeks of her employment before she would start completing any final accuracy checks. Another team member was observed dispensing during the inspection, but the team member was not a trained dispenser or enrolled on a suitable training course. This was discussed with the pharmacy’s superintendent pharmacist, who was present during the inspection. Following the inspection, the superintendent pharmacist enrolled the team member onto an appropriate dispensing training course. And evidence was seen by the inspector. The pharmacy’s staffing rotas were organised in advance to ensure enough support was available during the its busiest periods. The team members were observed managing the workload well and had a manageable workflow. The pharmacy assistant was seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. The team members mostly acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. They felt they had enough staff to manage the workload efficiently, especially when all the team members were available to work. They felt they could speak to the pharmacy’s owner if they needed extra support and they often received additional support if they felt they were falling behind with their workload. This helped to make sure they provided the high quality of service they aimed to achieve. The team members often worked additional hours to cover absences and holidays. They did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The pharmacy did not have a formal training process in place for its team members. The superintendent pharmacist explained she had recently enrolled each team member onto the NPA online training portal but had not yet briefed the team members on how they could utilise it. The portal consisted of several online healthcare related modules that the team could choose voluntarily in response to a learning need. The team members got some time to read various training material that the pharmacy received through the post when the pharmacy was quiet. But this was not done regularly. And no records of completed training were kept. The pharmacy did not have a formal performance appraisal process, but it was looking to implement a process over the coming months. Currently the team members had open conversations with the pharmacist to discuss which aspects of their role they were doing well in and where they could improve. The conversations were also an opportunity for the team members to

discuss their own personal development goals. A pharmacy assistant had recently discussed and set a goal to complete training to qualify as a pharmacy technician. The team attended ad-hoc, informal meetings and discussed topics such as company news and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members felt comfortable to give feedback or raise concerns with the regular pharmacist or the superintendent pharmacist, to help improve the pharmacy's services. The pharmacy had a whistleblowing policy. And so, the team members could raise concerns anonymously. The team was not set any specific targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and kept secure. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and was professional in its appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was tidy and well organised during the inspection and the team had ample bench space to organise the workflow. Floor spaces were kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. It had hot and cold running water. There was a WC which had a sink, but it did not have hot running water. So, the team used the dispensary sink for handwashing. The pharmacy had a sound-proofed consultation room which contained two seats, so people could sit down with the pharmacist to speak privately. The room was smart and professional in appearance and was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. The team members take steps to identify people taking high-risk medicines. And they provide these people with appropriate advice to help them take these medicines safely. The pharmacy provides medicines to some people in multi-compartment compliance packs to help them take them correctly. And it suitably manages the risks associated with the service. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately. But it doesn't keep a full audit trail when it delivers medicines to people's homes. And so, the team may find it difficult to resolve any queries.

Inspector's evidence

The pharmacy had level access from the street to the entrance door. Which allowed people with prams and wheelchairs to enter the pharmacy unaided. The pharmacy could supply people with large print dispensing labels if needed. The pharmacy advertised its services and opening hours in the main window and on the pharmacy's website. It stocked a wide range of healthcare related leaflets in the retail area, which people could select and take away with them. The pharmacy had an eye-catching display of healthcare related leaflets and posters, for example promoting regular eye screening. The team members described how several people had engaged with the information on display. And how they then had an opportunity to speak to people about their health and give healthy living advice.

The team members regularly used various stickers during dispensing, and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people's prescriptions from getting mixed up. They used CD alert stickers to attach to medication bags. This system helped the team members check the dates and helped prevent them from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept records of the delivery of medicines it made to people. The records did not always include a signature of receipt. So, there wasn't a complete audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy provided a minor ailment service (eMAS). The team members had completed the relevant training to provide the service. 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 pharmacist was seen advising several people who wanted treatment for various minor ailments. The pharmacist was observed recommending various treatments and given appropriate advice.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The

team was responsible for ordering people's prescriptions. And this was done around a week in advance to give the team members the time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the medication on a bench furthest away from the retail area. This was to minimise distractions. The pharmacy managed the workload across four weeks. And it kept all documents related to each person on the service in separate wallets. The documents included master sheets which the team members used to check off prescriptions and confirm they were accurate. They also kept details of any changes in people's medicines. The packs were supplied with information which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used alert stickers attached to people's medication bags to remind them that the bag contained a high-risk medicine. The pharmacist gave the person collecting the medicine additional advice if there was a need to do so and checked they were having regular blood tests before they supplied the person with the medicine. The pharmacist was observed discussing the dosage regime of a housebound patient who was prescribed warfarin. The pharmacist explained he was ensuring the persons INR levels were within the correct ranges and they had been prescribed enough warfarin for the dose they were required to take. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. No-one had been identified.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy stored its medicines in the dispensary tidily. The pharmacy had a process to check the expiry dates of its medicines to make sure none had expired. But the team members did not carry out the process regularly. Records seen showed that the process had not been fully completed since 2018. Twenty medicines were randomly checked, and two expired medicines were found. The implications of not following the process was discussed with the pharmacist and superintendent pharmacist. Following the inspection, the pharmacy completed a full date check of all its medicines. And evidence was seen. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had not received training on how to follow the directive and the pharmacy did not have the correct type of scanners installed. The pharmacy did not have a timescale to become compliant with the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. It had one CD cabinet in place. And it was secured and of an appropriate size. The medicines inside were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services provided. And it keeps the equipment well maintained. The team mostly uses the equipment and facilities in a way that protects people's privacy.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team members used tweezers and rollers to help dispense multi-compartment compliance packs. The fridges used to store medicines were of an appropriate size. And the medicines inside were organised in an orderly manner. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private. Some confidential material was stored in the consultation room, for example some prescriptions. But the room was kept closed when it was not in use and the material was moved away from sight when it was in use.

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.