General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newfield Dalry, 18 Main Street, DALRY, Ayrshire, KA24 5DH

Pharmacy reference: 1041820

Type of pharmacy: Community

Date of inspection: 24/10/2019

Pharmacy context

This is a community pharmacy in a residential area of Dalry, 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, the NHS minor ailments service (eMAS), the NHS Chronic Medicines Service (CMS) and the supply of medicines through the Pharmacy First service. It supplies medicines in multi-compartmental 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 identifies and manages the risks associated with the services it provides for people. And it has a set of up-to-date written procedures which the team members generally follow to help them deliver the services safely. It keeps the records it must have by law. And it keeps people's private information secure. The team members discuss and record any mistakes they make when dispensing. So, they can learn from each other. And to minimise the risk of similar mistakes happening in the future. The team members know when to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had a small retail space, which led to a small dispensary at the rear of the building. The dispensary was split into two small areas. The front of the dispensary was used to organise dispensing labels and select medicines. And for the pharmacist to complete final checks on prescriptions that were a priority. The rear area was used by the pharmacist to complete final checks of non-urgent prescriptions.

The pharmacy had a set of written standard operating procedures (SOPs) which detailed how the team members should carry out various processes. For example, the taking in and dispensing of prescriptions and services such as the Chronic Medicines Service (CMS). A separate SOP was available for the dispensing of medicines in multi-compartmental compliance packs. The SOPs did not have an index. So, it was difficult to find a specific SOP. The SOPs had been prepared in January 2019 and were due for a review in January 2020. And each team member had read the SOPs that were relevant to their role. The team members described how they would ask the pharmacist if there was a task they were unsure about or felt unable to deal with.

The pharmacy recorded near miss errors on a paper near miss log. The team recorded most, but not all, of the errors. And records dating back to January 2019 were seen. The details recorded included the date of the error and the team members involved. But the team members did not keep records of why the error might have happened. And so, they may have missed out on the opportunity to learn. The pharmacist on duty during the inspection alternated with the pharmacy’s second pharmacist to analyse the near misses each month for any trends and patterns. And they communicated their findings to each other. They then discussed their findings with the team and encouraged them to consider how to reduce the risk of similar errors happening again. For example, the pharmacist had found several errors where the team had selected the incorrect strength of diazepam. The team discussed the errors to raise awareness and remind the team members to take extra care when they dispensed diazepam. The pharmacy had a system to report and record any dispensing errors that had reached the patient. Recently the pharmacy had supplied a person with the incorrect medicine. A critical incident form was completed, and the pharmacy completed a root cause analysis. The pharmacist explained that the reason for the error was because the two medicines were similar in appearance and their names both began with ‘S’. The team members were all made aware of the error and they decided to separate the two medicines on the shelves to reduce the risk of a similar error happening again. The details of the incident were reported to the superintendent pharmacist. And they discussed the incident with the pharmacist and offered support.

The pharmacy had a formal complaints procedure in place. But it was not available for people to see. So, they may not know how to raise a complaint effectively. A team member described the complaints procedure and how she would escalate the complaint to the pharmacy's owner if necessary. The pharmacy welcomed feedback from people. And it collected the feedback through verbal conversations between people and the team members. The team members explained they had some comments about the time taken for the pharmacy to complete prescriptions for medicines they did not keep in stock. To improve, the team used a wholesaler that was able to deliver medicines to the pharmacy twice a day instead of once a day.

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 complete records of private prescription supplies. It kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. A physical balance check of two random CD items matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. It held certificates of conformity for unlicensed medicines and these were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The pharmacy team members were aware of the need to keep people's personal information confidential. And they had all undertaken some basic general data protection regulation (GDPR) training. But no records were seen. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. A third-party contractor periodically destroyed the confidential waste. The pharmacy outlined to people using the pharmacy how it stored and protected their information. The team members understood the importance of keeping people's information secure.

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 or 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 qualifications and skills to provide the pharmacy's services safely. They work well together to manage their workload and to ensure people receive a high-quality service. The pharmacy team members complete some ad-hoc training to keep their knowledge and skills up to date. They receive annual appraisals to discuss their performance. And to make suggestions to improve the pharmacy's services. The pharmacy team members feel comfortable to raise professional concerns if necessary.

Inspector's evidence

At the time of the inspection, the responsible pharmacist was the regular pharmacist. A qualified pharmacy assistant and a trainee pharmacy assistant supported her during the inspection. The pharmacy also employed a second pharmacist, four part-time pharmacy assistants and a trainee counter assistant who worked on Saturdays. The pharmacy manager organised the team rotas in advance to ensure enough support was available during the pharmacy’s busiest times. The team members were observed managing the workload well and had a manageable workflow. The team members felt they had enough staff to manage the workload efficiently, especially when all the team members were available to work. They explained if they needed extra support how the superintendent pharmacist often provided additional support if they were falling behind with their workload. 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 team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They mostly acknowledged people who were waiting to be served as soon as they arrived at the retail counter. They informed people of the waiting time for prescriptions to be dispensed and took time to speak with them if they had any queries. The pharmacist on duty had worked at the pharmacy for 18 years and knew many of the people who used the pharmacy by their first name. The team members were observed giving advice to several people about their health.

The trainee pharmacy assistant was working through a Buttercups dispensing course. And she was supported by the pharmacist and other team members. The assistant received some protected time to complete the modules in her course. The protected time allowed the assistant to work without any distractions. But she was not able to get the time regularly due to the pressures of the dispensing workload. The other team members completed training ad-hoc by reading various material they received in the post. And by discussing various topics with the pharmacists. There was no formal planned ongoing training. The pharmacy had an appraisal process in place for its team members. The appraisals took place every year. The appraisals were an opportunity for the team to discuss which aspects of their roles they enjoyed, where they wanted to improve and if they wanted to give any feedback to improve the services the pharmacy offered.

The team attended ad-hoc, informal meetings and discussed topics such as company news, targets 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 pharmacy's owner, to help improve the pharmacy’s services. The pharmacy did not have a whistleblowing policy. And so, the team members may not be able to raise concerns anonymously. The team were not set any targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and is well maintained. The premises are generally suitable for the services the pharmacy provides. It has a consultation booth where people can speak to the team members. But the booth is small and does not always properly protect people's privacy.

Inspector's evidence

The pharmacy appeared slightly dated, but it was clean and well maintained. Most areas of the pharmacy were kept tidy and well organised, but there were some boxes kept on the floor which could present a risk of a trip or a fall. The benches in the dispensary were cluttered with several medicines waiting to be put into stock and prescriptions awaiting a final check. But this improved throughout the inspection. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was an outdoor WC. This was not ideal, but it was kept clean and had a sink with hot and cold running water and other facilities for hand washing.

The pharmacy had a consultation booth rather than a separate room for the team to hold private conversations with people. At the time of the inspection the booth was not available for use as it was cluttered with stock and did not have adequate seating facilities. The booth was signposted but was not well soundproofed. It had a clear, glass window which could be seen into from the retail area. And so, people’s privacy was not well protected. The team members said they only used the room occasionally and they would make sure the retail area was empty before engaging in sensitive conversations with people. The temperature in the pharmacy 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 pharmacy manages its services safely and effectively. And it sources, stores and manages its medicines appropriately. The pharmacy provides medicines to people in multi-compartmental packs to help them take them correctly. And it suitably manages the risks associated with this service. The pharmacy keeps a record or people it delivers medicines to. But it doesn't ask people to sign for receipt. So, it may be difficult for the pharmacy to evidence the delivery and resolve 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. It stocked a small range of healthcare related leaflets in the retail area, which people could select and take away with them. There were several informative posters attached to the retail counter, including ones for flu and eye care support from NHS Ayrshire.

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 annotated prescriptions with ‘W’ to indicate the person was waiting in the pharmacy for their prescriptions to be dispensed, or with ‘CB’ if the person was calling back later. This helped the team prioritise their workload. 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. But the records did not include a signature of receipt. This was not in line with the pharmacy’s SOP on the delivery of medicines. This meant there wasn't an 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 pharmacy provided a service called Pharmacy First. The service allowed the pharmacy to supply medicines, normally only available with a prescription, to people for various conditions. For example, trimethoprim for urinary tract infections and Fucidin cream for impetigo. The pharmacist went thought a comprehensive conversation with people who wanted to use the service to establish their symptoms and make a diagnosis. The pharmacy kept records of each consultation and supply. The pharmacy provided the chronic medicines service (CMS) for people with a long-term condition such as high blood pressure or diabetes. It provided reviews of the way people used their medicines, provided care plans for people and dispensed serial prescriptions which were valid up to 56 weeks. The team annotated the prescriptions to avoid them being mixed up with other types of prescriptions. A SOP of

the service was in place.

The pharmacy supplied medicines in multi-compartmental compliance packs for around 40 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. The pharmacy managed the workload across four weeks. It kept master sheets which the team members used to check off prescriptions and confirm they were accurate. They also kept details of any changes to people's medicines. But did not keep records of who had authorised the change, for example, the person's GP. And so, an audit trail was not in place. 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. The pharmacy also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members annotated prescriptions and attached them 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 the pharmacy kept records of the conversations if it was significant. For example, if the person was not having regular blood tests. 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. A shelf edge sticker was attached to where valproate was stored in the dispensary to remind the team about the programme. 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. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check. And the team members used alert stickers to help identify medicines that were expiring within the next three months. They 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 any training on how to follow the directive. But the pharmacy had the correct type of scanners and software installed. The team was unsure of when they were to start following 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's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

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 to help dispense multi-compartmental 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 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. The electrical equipment looked to be in good working order and had been subjected to portable appliance testing in June 2019.

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.