General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Coylton Pharmacy, 13 Main Street, JOPPA, Ayrshire, KA6 6JW

Pharmacy reference: 1041839

Type of pharmacy: Community

Date of inspection: 23/10/2019

Pharmacy context

This is a community pharmacy in a residential area of Coylton, 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. It provides NHS services, such as the Minor Ailment Service (eMAS) and Chronic Medicines Service (CMS). The pharmacy provides a substance misuse service. It supplies medicines in multi-compartmental compliance packs to people living in their own homes. And it provides a home delivery service.

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 to people. And it has a set of written procedures for the team members to follow to help them deliver the services safely and effectively. The pharmacy keeps the records it must have by law. 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.

Inspector's evidence

The pharmacy had a small retail space which led to a small dispensary to the rear of the pharmacy. The pharmacy counter prevented access from the retail area to the dispensary. The area was open plan and the pharmacist on duty used the dispensary bench which 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) 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 Medication 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 were implemented in 2012 and each team member had read them. They had been reviewed in 2018 but the date of the review had not been recorded. The pharmacy assistant 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 an electronic recording system. And records dating back to June 2019 were seen. The details recorded included the time and date the error was made, the type of error, for example the wrong label or the wrong quantity, the action taken and the learning points. The reason for the error was not recorded. And so, the team may have missed out on some learning opportunities. The team members openly discussed the errors that happened. And they did this as soon as possible. This was to make sure they did not forget the details of the error and to make the team aware of the learning points straight away. The pharmacist also analysed the errors each month for any trends and patterns. And he discussed his findings with the team. The pharmacist explained that he had noticed several errors involving medicines that looked or sounded similar, known as LASA medicines. For example, amlodipine and amitriptyline. And the standard release and extended release forms of Tegretol. The team members thought about and discussed ways they could prevent the errors from happening again. They decided they would separate some LASA medicines away from each other, to help prevent selecting them in error. The pharmacy used the same electronic recording system to keep records of any dispensing incidents that had reached the patient. The most recent example involved the pharmacy supplying a person with candesartan 4mg instead of the 8mg version. The pharmacist investigated the cause of the error. And discussed the findings of the investigation with the team. The error was attributed to the two strengths being very similar in appearance and the wrong strength was selected. To prevent the error happening again, the team has stocked a different brand of candesartan, which has more distinguishable strengths.

The pharmacy had a formal complaints procedure in place. But it was not available for people to see. So, they may not be able to raise a complaint effectively. The pharmacy assistant 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 pharmacist explained they had some negative feedback from some people about the availability of some medicines that were out of stock. They tried to help people understand the reasons why some medicines were out of stock and what they could do to help them.

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 and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every month. 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. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team was aware of the need to keep people's personal information confidential. And they were seen offering the use of the consultation room to people who were discussing their health when other people were present in the retail area. They had all undertaken General Data Protection Regulation (GDPR) training. 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. The confidential waste was periodically destroyed via a third-party contractor. The pharmacy did not outline to people using the pharmacy how it stored and protected their information.

The pharmacist was PVG registered and had completed a course on safeguarding the welfare of vulnerable adults and children. The other team members had not completed any formal training. But they gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. The pharmacy assistant 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 training to keep their knowledge and skills up to date. And they are provided with regular appraisals to discuss their performance. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection, the responsible pharmacist was the regular pharmacist who had been working at the pharmacy for several years. A part-time trainee pharmacy assistant supported him. There was a pharmacy assistant, a counter assistant and a delivery driver employed, but were not present during the inspection. The pharmacist 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 pharmacy assistant was 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 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. The team members felt they had enough staff to manage the workload efficiently, especially when all the team members were available to work. They said 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. And 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 trainee pharmacy assistant was working through a Buttercups dispensing course. And she was supported by the pharmacist and other team members. The assistant received protected training time each Friday to work through her course. A counter assistant worked additional hours on Fridays to cover the pharmacy assistant. The protected time allowed her to work without any distractions. And she was able to easily speak to the pharmacist and other team members if she had any queries or questions. The pharmacy assistant explained that she had worked in another pharmacy several years ago but felt she did not have enough knowledge about new over-the-counter products and asked for additional support. The assistant had regular one-to-one discussions with the pharmacist to ask questions about various new medicines. The other team members were able 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 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 pharmacist explained that at his last appraisal, he had been set a goal to improve the pharmacy's complaints procedure. And hold a meeting with the team, to explain to them how they should be handling and managing any potential complaints.

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 was set various targets to achieve. These included the number of prescription items they dispensed and the number of services they provided. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. 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. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room which contained two seats. 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. It engages with people using the pharmacy to help them improve their health. 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-compartmental 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.

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. But the opening hours did not match. Which may cause some confusion for people. 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 information about cancer and the symptoms that people should report to their doctor. The team members described how several people had engaged with the 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 included a signature of receipt. So, there was 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 pharmacist was seen advising a person who wanted treatment for an ear complaint. The pharmacist supplied the person with olive oil ear drops and general advice. 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 for the service was

in place.

The pharmacy supplied medicines in multi-compartmental compliance packs for around 20 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. And they kept records of who had authorised the change, for example, the person's GP. 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. 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. 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 12 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 received some training on how to follow the directive and had the correct type of scanners. 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 two CD cabinets in place. And they were 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 and rollers 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 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. The electrical equipment looked to be in good working order and was due to be subjected to portable appliance testing in November 2020.

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.