General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Toll Pharmacy, 153 Ayr Road, PRESTWICK, Ayrshire, KA9 1TP

Pharmacy reference: 1041880

Type of pharmacy: Community

Date of inspection: 16/09/2019

Pharmacy context

This is a pharmacy on the main road on the outskirts of Prestwick. It dispenses a large volume of prescription items per month. Including for people on multi-compartmental compliance packs. It also supports people receiving supervised methadone doses. It provides the usual services found under the local health board Pharmacy First Scheme. These include the minor ailments service and flu and travel vaccinations. There is an online doctor and online pharmacy service and Independent prescriber clinics. It makes use of a SynMed robot for the dispensing of multi-compartmental compliance packs.

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	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

Members of the pharmacy team follow written procedures to help them work safely and effectively. They record things that go wrong so that they can learn from them. And they take action to help prevent similar mistakes from happening again. The pharmacy protects people's privacy and confidentiality. It keeps the records that are needed by law. But some of its records are missing information. So it is not always able to show whether things have been done in the correct way.

Inspector's evidence

The pharmacy was large sized with several distinct work spaces. There was the main dispensary which handled walk-in and repeat prescriptions. And there was a SynMed dispensing robot to dispense multi-compartmental compliance packs. There was also an area which dispensed multi-compartmental compliance packs by hand. The pharmacy used other areas as a delivery assembly and de-blistering area. The checking bench overlooked the front counter and allowed for effective supervision. The pharmacy had a set of standard operating procedures (SOPs) which were in date and were being reviewed. They had been properly authorised by the previous Responsible Pharmacist who had now left the company. But they had not been formally reviewed by a currently employed registrant. So it was unclear who was responsible for making sure that the SOPs were appropriate for the pharmacy. The pharmacy team members generally followed the SOPs. There was a whiteboard with a daily checklist of key activities which were ticked off as they were completed each day. This helped focus staff on key tasks and responsibilities, but no records were kept or reviewed of compliance.

The pharmacy recorded and reviewed near misses and took some actions to prevent recurrence. Examples included separating prednisolone and propranolol on the shelves. But they didn't record details of the action they took to prevent a similar error. And they did not always fully analyse data collected to identify opportunities for improvement. So there may be a risk that some action points could be overlooked. Pharmacy team members reviewed near miss data on a monthly basis.

The pharmacy informed people via a notice to speak to their pharmacist if they had a complaint about their services. People could complete and post a written feedback form in store. Feedback was generally very positive. The area of greatest weakness was the time taken to collect prescriptions. This was due to the large volume of items dispensed, stored and delivered. Pharmacy team members had suggested the use of an IT system, Pro-delivery Driver, to check what items were in store and which were out on delivery. This had been introduced after the feedback and reduced the amount of time needed to search for an item in store. And reduced the time taken to collect and deliver prescriptions. Customer feedback was not displayed to people in the store. Nor was there information on how the pharmacy used their feedback.

Professional indemnity insurance was in place. Controlled drug (CD) records were generally complete, and there had been regular balance checks. A check of actual versus theoretical stock showed agreement. Not all records of patient-returned controlled drugs (CDs) were complete. Not all had both pharmacist and witness signatures for destruction. The pharmacy kept the private prescription records electronically on CDRx system. But many entries did not have the complete address details of patients or prescribers. There were six paper "prescriptions" for the online prescribing service. The details of both the online doctor and the pharmacy independent prescriber were on all the prescriptions. But the

prescriptions bore no electronic or physical signatures of the individual prescriber. So it was not clear who had authorised the supply and the prescriptions were not legally valid. The pharmacy made emergency supplies under the Community Pharmacy Urgent Supply (CPUS) scheme and records were complete. The pharmacy recorded fridge temperatures daily. And these were within the required range of two to eight degrees Celsius. The Responsible pharmacist log was complete.

People standing at the counter could not see other people's details on prescriptions awaiting collection. Nor could they see computer screens. Pharmacy team members collected confidential waste and sent if off-site for destruction. And they knew to keep such waste separate from normal waste.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are suitable numbers of qualified staff to provide the services on offer. Pharmacy team members can provide a range of services. And they have access to some training for vocational qualifications. There is a process of appraisal to identify ongoing training needs. And there is some time in the working day to allow the pharmacy team members to further develop their skills. But there are no structured training plans to ensure a range of training materials are available. There is some evidence of learning from feedback and errors. But this is inconsistent. Pharmacy team members are comfortable providing feedback and the owner responds to this.

Inspector's evidence

On the day of inspection there were: two pharmacists (full time), two Accuracy Checking Technicians (ACTs), two NVQ2 dispensers, two trainee NVQ2 dispensers, one NVQ3 Pharmacy Technician and one trainee NVQ3 Pharmacy Technician. There were also a medicines counter assistant, and a pharmacy student. There were three delivery drivers who the pharmacy had trained on the NPA Delivery of Medicines course.

There were enough suitably qualified staff on the day of the inspection. Pharmacy team members reported having training to achieve their NVQ2 and 3 qualifications. But they struggled to give examples of ongoing training once they completed these qualifications. There was a bi-annual appraisal system in place. But there were no formal training plans. Pharmacy team members had time set aside during the working day to complete their course work. Further training arrangements were ad-hoc. Pharmacy team members were confident they could provide feedback to the Responsible Pharmacist (RP) and the Superintendent. And they were able to give examples of ideas for improvement that they had come up with. These included arranging the layout of stock to make the most used items easiest to access. And implementing the pro-delivery system. Pharmacy team members did not feel under undue pressure to meet targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and very clean and tidy. There is good provision of facilities to protect people's privacy and confidentiality. And there is sufficient space to provide the range and volume of services. The pharmacy website does not provide full details about its prescribing service, so people may not understand how the service is provided.

Inspector's evidence

The pharmacy was large sized with several dispensary areas with good bench and shelf space. The premises were very clean and tidy. The pharmacy team members kept benches clear of clutter and shelves were well organised. The premises were well lit and temperatures were comfortable. Controlled drug security was good. The pharmacy had an alarm system. There were three consultation rooms. One was now used as an office and one was set aside for a clinic run by a podiatrist. The pharmacy used the third as a consultation room for treatments. And to allow people to speak to staff confidentially. The room was equipped with handwashing facilities, a table and chairs. It also contained carbon monoxide monitors for smoking cessation. And blood pressure meters and ear thermometers. There was a toilet for people using the pharmacy and this was used for to collect samples for analysis for infections.

The pharmacy also had a website which offered online prescribing by an independent pharmacist prescriber and a doctor. People could be prescribed medicines following an online consultation delivered through the website. But the website did not clearly state the name and address of the prescribing service, or the names and registration number of the prescribers. It also did not make clear whether the prescriber was a doctor or a non-medical independent prescriber and did not give any information about how to check the prescriber’s registration status. The website had an MHRA logo appropriately displayed. A GPhC logo was also displayed, but this had been done without consent and clicking the logo did not re-direct to the register entry for the pharmacy. Following the inspection, the pharmacy stopped offering the online prescribing service and details of it were removed from the website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a wide range of services to meet the needs of local people. And members of the pharmacy team work to professional standards to provide the services effectively. They identify when high-risk medicines are being supplied. So that they can check they are suitable and advise people about how to take them. But they do not always have all of the leaflets and warning stickers that should be supplied with some high-risk medicines. So, people may not get all of the information they need to make sure they use the medicines safely.

Inspector's evidence

Entry to the premises was through a door with a slight ramp from street level. There was a call bell to request help if needed. And the counters were low in height for those in wheelchairs. The pharmacy promoted the services it offered by leaflets in-store and posters in the window. It offered a range of services which included travel clinics and travel vaccinations. It also offered flu vaccinations and a podiatry service. It also provided some of the more recent and advanced services under pharmacy first scheme. Such as testing for streptococcal throat infections. It had an independent pharmacist prescriber, and also made use of private and health board patient group directions (PGDs). There was a website which offered access to online prescribers. And there was a delivery service. With another pharmacy chain now charging for deliveries the pharmacy had seen a substantial increase in requests for this service. And they had purchased a third van to ensure they could achieve deliveries safely and effectively. It offered needle exchange and harm reduction services, as well as supervised methadone. And it provided multi-compartmental compliance packs for a large number of people.
Safe working practices included the use of baskets to keep items all together. And audit trails of "dispensed by" and "checked by" signatures. The pharmacy had a range of stickers to alert the pharmacist to issues, including "controlled drug" and "Fridge Line". These stickers prompted counter staff to refer people to the pharmacist when they collected their prescriptions.

The system for dispensing multi-compartmental compliance packs had its own specific standard operating procedure (SOP). The pharmacy made up multi-compartmental compliance packs manually for some of them. And used a SynMed robot for others. There was a well-defined process for the SynMed robot. This dictated how the pharmacy team members operated the robot. This included which containers to use for specific tablets, and the de-blistering process to fill the containers. It also showed how to use barcodes to ensure the right tablets were always used for the right people at exactly the right time. Pharmacy team members recorded all requests for changes on a note on the people's record, as the call came in. The ACTs were aware of which items they could and could not accuracy check. Clinical checks only took place on new items or where an item had changed in some way e.g. dose, form etc. Such changes were recorded on the patient record. And the medicine could not be dispensed until a pharmacist had conducted, and signed for, a clinical check. In this way there was a record of which items had been clinically checked and which had not. However, the lack of a clinical check for repeat medication meant that some opportunities for clinical intervention could potentially be missed. There was a Methameasure machine which the pharmacy calibrated each morning.

The pharmacy offered a delivery service. And it kept records of people's signatures, obtained on receipt of delivery of controlled drug and POM items. The system used was Pro-delivery which recorded deliveries on line in real-time. And captured people's signatures which the pharmacist could view from

the pharmacy. This showed when the driver made a delivery to a person. And whether they put this delivery through the letter box. Such deliveries had verbal consent but there was no documented risk assessment confirming the absence of children and pets.

There was a system in place for date checking and no out of date stock was found during the inspection. Drug recalls and alerts were regularly received and acted upon. But some of the recalls only had details such as "Actioned" but not details of the actual actions taken. And some records had no details at all.

The pharmacy had not identified people currently on valproate nor assessed them for risk of pregnancy. This was particularly concerning given a particular local population who were at risk. There were not enough materials available to provide guidance to any female person presenting with valproate. Other than those found in the original medicine pack, pharmacy team members could not find such support material on the day of inspection. Subsequent to the inspection the SI confirmed that the educational material had been located and was now available to supply if needed. She had also visited the care home and confirmed all the carers and relevant patients were aware of the Pregnancy Prevention Programme, and had previously been trained by the pharmacy managers.

The pharmacy had installed the hardware needed to support the Falsified Medicines Directive (FMD). But this was not fully in use yet. So, the pharmacy had not implemented all the features of FMD. This was due to many of the scanned items showing "False" results. The pharmacy expected to resolve these issues within the next 3 months.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has sufficient equipment for the services it offers and such equipment is well maintained to provide accurate measurement. The calibration status of all its equipment is not easily identified.

Inspector's evidence

The pharmacy had a range of glass measuring equipment which was ISO or Crown stamped. The pharmacy had access to the British National Formularies for both adults and children and had online access to a range of further support tools. It used the Methameasure system which was calibrated daily. Other items such as blood pressure meters and ear thermometers were replaced regularly but had not replacement date recorded.

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.