General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Stewart Pharmacy, 55 High Street, STEWARTON, Ayrshire, KA3 5BP

Pharmacy reference: 1041893

Type of pharmacy: Community

Date of inspection: 29/11/2019

Pharmacy context

This is a community pharmacy in a residential area of Stewarton, 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 seasonal flu vaccinations. 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 for 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 record some of the mistakes they make when dispensing. And they openly discuss their mistakes. So, they can learn from each other. 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 spacious retail space which led to a spacious 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. An SOP was available for the dispensing of medicines in multi-compartment compliance packs. An index was not available. So, it was difficult to find a specific SOP. The SOPs were variations of NPA or Alphega templates. Most of the SOPs had a recorded review date of 2016, but they had not been reviewed since. And so, they may not have accurately reflected the pharmacy's current practices. Each team member had read each SOP that was relevant to their role. A 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 into a paper near miss log. And records dating back to August 2018 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 the opportunity to make specific changes to their practice to prevent a similar error from happening again. 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. But the pharmacy's near miss log had been completed in September 2019 and the pharmacy had not ordered a new log. And so, the team had not recorded any near misses since. Prior to September 2019 the pharmacy completed a formal analysis of the near misses to help identify any trends or patterns. Any significant findings were discussed with the team. For example, the team had recently identified several picking errors involving co-careldopa and co-beneldopa. The reason for the errors was identified as because the two medicines had similar sounding names. The team members discussed ways they could prevent a similar error from happening again. And they decided to separate the two medicines from each other to reduce the risk of them being mixed up in error. The pharmacy kept records of any dispensing errors that had reached the patient. The most recent example involved the pharmacy supplying a person with the incorrect quantity of doxycycline capsules. The pharmacist investigated the cause of the error. And discussed the findings of the investigation with the team. The pharmacist explained that the error was because the prescription was handwritten and the quantity of

the doxycycline that needed to be dispensed was misread. To prevent a similar error happening again, the pharmacy has implemented a policy for all handwritten prescriptions to be accuracy checked by two dispensers before the dispensing process was begun.

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 generally complied with legal requirements but on several days the time the responsible pharmacist duties had ended were not recorded. This is not in line with requirements. The importance of keeping complete records was discussed with the pharmacist. The pharmacy kept complete 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 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 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 who were discussing their health when other people were present in the retail area. Some team members stated they had all undertaken General Data Protection Regulation (GDPR) training. But there was no evidence available to confirm this. 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 shredder. The pharmacy did not outline to people using the pharmacy how it stored and protected their information.

The regular pharmacist and the other team members had not completed any formal training on safeguarding the welfare of vulnerable adults and children. But they gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. A 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 affixed to a wall 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. The pharmacy team members complete some training to keep their knowledge and skills up to date. And they can tailor their training to their own personal needs. They feel comfortable to give feedback and raise professional concerns when necessary.

Inspector's evidence

On the day of the inspection the pharmacist on duty was the regular pharmacist and the pharmacy's manager. Three pharmacy assistants and a trainee pharmacy assistant supported him. The pharmacy also employed an accuracy checking technician, two other pharmacy assistants and a counter assistant. A regular locum pharmacist or the pharmacy's superintendent pharmacist covered the regular pharmacist when he was not working. 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 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 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 superintendent pharmacist to ask for additional support if they felt they were falling behind with their workload. And occasionally the superintendent pharmacist would work alongside the pharmacist to support the team. 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 was supported by the pharmacist and other team members. The assistant received protected training time each week to work through the course. The protected time allowed the assistant to work without any distractions. And he was able to easily speak to the pharmacist and other team members if he had any queries or questions. A pharmacy assistant who had been working at the pharmacy for ten years explained although the pharmacy did not have a formal training process for its team members, they were encouraged to read various training material that the pharmacy received through the post when the pharmacy was quiet. And consider tailoring their training to their own needs. For example, the assistant felt she wanted to improve her knowledge on mental health issues and how she could help people who were suffering from mental health conditions such as depression. To help her achieve her goal, she attended an evening training event on mental health and addiction. The team held 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 superintendent pharmacist, 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 pharmacy did not set any targets for the team to achieve.

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 toilet which had a sink with hot and cold running water and other facilities for hand washing. The pharmacy had a sound-proofed consultation room which contained two seats, so people could sit down to speak privately with the team members. The room was smart and professional in appearance and was signposted by a sign on the door. The pharmacy also had an 'advice' room, which was used for the team to supervise people collecting methadone instalments. 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. And the pharmacy manages and delivers its service safely. The team members identify people taking high-risk medicines. And they take appropriate steps to support these people in making sure they take their medicines safely. The pharmacy team members provide medicines to some people in multi-compartment compliance packs to help them take them correctly. And they suitably manage the risks associated with the service. They source medicines from licenced suppliers. And they store and manage 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 door was power assisted, but the function was not working during the inspection. This had been reported to the superintendent pharmacist. The pharmacy advertised its services and opening hours in the main window. It stocked a wide range of healthcare related leaflets in the retail area, which people could select and take away with them. There were leaflets about smoking cessation, child neglect and overcoming addiction. The pharmacy could supply people with large print dispensing labels if needed.

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. And the baskets were of different colours to indicate prescriptions that were waiting, for delivery or for people who were calling back. They highlighted the dates on prescriptions for CDs. 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 dispensed high-risk medicines for people such as warfarin. The team members used alert stickers attached to people's medication bags to remind the person handing out the medicine 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 the supply was made. 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 did not have access to literature about the programme that they could provide to people to help them take their medicines safely. The importance of this was discussed with the team. 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.

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 cardboard boxes. The documents included master sheets which documented people's current medication regimes. The team members used these 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 of how to take them. 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.

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 pharmacist had access to a medicines' shortage flowchart. He explained he used the flowchart to assess what the pharmacy could do if there was a medicine that the pharmacy could not supply to a person due to a shortage.

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-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.

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.