General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tarbolton Pharmacy, 14 Cunningham Street, TARBOLTON, Ayrshire, KA5 5QF

Pharmacy reference: 1041899

Type of pharmacy: Community

Date of inspection: 16/03/2022

Pharmacy context

This is a community pharmacy in the rural village of Tarbolton, Ayrshire. There is no other healthcare provision within 2 miles of the village. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including emergency hormonal contraception, and supplies for people receiving care through substance misuse services. People receive advice and medicines for minor ailments through the pharmacy first scheme. The pharmacy supplies medicines in multi-compartment compliance packs for some people to help them take the medicines at the right time. The inspection was completed during the COVID-19 pandemic.

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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy keeps the records it needs to by law. And members of the team know how to keep private information safe. They discuss mistakes they make to help identify learning and reduce the chances of similar mistakes happening again. But the pharmacy does not have records readily available to show the team's learnings from mistakes.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) which were last reviewed in January 2021. Members of the pharmacy team had signed to say they had read and accepted the SOPs. A dispenser had recently completed an accuracy checking training course. The pharmacy had documentation from the training course to provide some structure about the accuracy checking dispenser's (ACD) role with regards to completing the final accuracy check. But it did not form a clearly defined process with assigned roles or responsibilities across other members of the pharmacy team. So there is a risk team members may not always know when to refer items to be checked to the pharmacist.

In the event of a near miss incident, the pharmacist said he would discuss the error with members of the pharmacy team before recording the details on an electronic recording system. But error records could not be seen due to a technical error on the recording system. The pharmacist provided examples of learning which had been identified, such as segregating sertraline 50mg and 100mg away from one another to help prevent picking errors. Dispensing errors were also recorded on the recording system and could not be viewed. The pharmacist provided an example of a recent error which involved two patients with the same name. To help prevent a similar mistake the pharmacist highlighted the incident to members of the pharmacy team.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A dispenser was able to explain what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure. Any complaints would be recorded and followed up by the superintendent (SI). A current certificate of professional indemnity insurance was seen on display.

Records for the RP, private prescriptions and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were electronically maintained with running balances recorded and checked at least once a month. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. The policy had been read by members of the pharmacy team. When questioned, a dispenser was able to describe how confidential waste was segregated and destroyed using the on-site shredder. But there were no details on display about how the pharmacy handled people's personal data, so people may not always be fully informed. Safeguarding procedures were included in the SOPs and contained the contact details of the local safeguarding board. A dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload and they are appropriately trained for their roles. Members of the pharmacy team complete their own reading to help them keep their knowledge up to date. But the pharmacy does not provide opportunities for regular learning as it does not have a structured training programme. So, it may not identify or address team members' learning and development needs.

Inspector's evidence

The pharmacy team included a pharmacist, who was the SI, four dispensers, one of whom was trained to accuracy check, a medicine counter assistant (MCA) and a driver. All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist and three dispensers. The volume of work appeared to be well managed. Staffing levels were maintained by part-time team members and a staggered holiday system.

Members of the pharmacy team had historically completed online training packages. But these had not been completed in the last 12 months. So there may be missed opportunities for learning and development. Members of the team said they would also read pharmacy magazines to learn about any new over the counter medicines. A dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines she felt were inappropriate, and refer people to the pharmacist if needed.

The dispenser felt she received a good level of support from the pharmacist and members of the team worked well together. And she felt able to ask for further help if she needed it. Appraisals were conducted annually by the SI. A dispenser explained how the manager discussed her performance and areas for improvement. She felt able to speak about any of her own concerns. Team members held meetings to discuss their work, and any issues that had arisen, including when there were errors or complaints. Members of the team were aware of the whistleblowing policy and reported being able to comfortable raising any concerns to the SI.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and the pharmacy acts to help make the premises COVID secure. It has a consultation room available so people can have private conversations about their health.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. Customers were not able to view people's sensitive information due to the position of the dispensary. The temperature was controlled by the use of electric heaters. Lighting was sufficient. The staff had access to a kettle, microwave, separate staff fridge, and WC facilities.

Plastic screens had been installed at the medicines counter to help prevent the spread of infection, and only two people were permitted in the retail area at any one time. Members of the pharmacy team were wearing masks and were all completing twice-a-week lateral flow tests to check for any asymptomatic COVID infections. Hand sanitiser was available.

A consultation room was available with access restricted by use of a lock. The space was generally clutter free with a desk, seating and adequate lighting. The entrance to the consultation room was clearly signposted for people.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. It has sufficient procedures in place the ensure services are managed in a way which are safe. And it gets its medicines from recognised sources. But the pharmacy lacks robust procedures to help prevent the clinical checks and expiry dates of prescriptions being overlooked. And it does not always identify people who are taking high-risk medicines to ensure they are routinely counselled. These procedures would help to provide additional oversight and ensure people are always taking their medicines safely.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was also wheelchair access to the consultation room. A service panel gave information about the services offered. The pharmacy opening hours were displayed. A range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. This had been adapted in response to current COVID guidance. The delivery driver would leave the person's bag of medicines at the door, knock, and stand back to allow social distancing. The driver would wait for the recipient to pick up the bag. If there was no answer the medicines would be returned to the pharmacy. A record was kept for the delivery of CD medication, but there was no record kept for the delivery for other medication. So the pharmacy did not have a reliable audit trail of deliveries made in the event of a query or a concern.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. The team used dispensing baskets to separate individual people's prescriptions to avoid items being mixed up. The pharmacist was seen to review all prescriptions which entered the pharmacy, and he said he performed a clinical check which enabled the ACD to perform the final accuracy check. But there was no audit trail to show when this had been completed.

If a prescription indicated it was to be dispensed in instalments at a set interval, members of the team used a form to record the date of supply. Members of the pharmacy team said they would check the date to ensure the time interval was appropriate in order to make the supply. If they felt the time interval was to short or long since the previous supply, they would seek authorisation from the person's GP surgery before making the supply.

Dispensed medicines awaiting collection were kept on a shelf using an alphabetical retrieval system. Prescription forms were not retained with the prescriptions, so members of the team may not always have important information to hand when supplying medicines to people. The pharmacy did not highlight dispensed medicines which contained schedule 3 or 4 CDs, and as the prescription was not retained there may be a risk medicines may be supplied when the prescription was not valid. The pharmacist said he routinely checked the collection shelves for any medicines which had not been collected, particularly for any which contained CDs. The pharmacist was seen to counsel people collecting medicines. He said he counselled people particularly if it was a new high-risk medicine (such as warfarin, lithium and methotrexate) or a change in dose. But there was no process to routinely highlight high-risk medicines. So staff may not be aware to provide counselling when handing out the

medication. The pharmacist was aware of the risks associated with the use of valproate during pregnancy. But he was not aware of any current people who met the risk criteria. Educational material was available to hand out when the medicines were supplied.

Some medicines were dispensed in multi-compartment compliance packs. Before a person was started on a compliance pack the pharmacist would discuss their suitability for the medicines to be assembled in a compliance pack. A record sheet was kept for each person, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information were sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance packs were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

The pharmacy dispensed medicines for a number of people who lived in care homes. A re-order sheet was provided to the pharmacy and it contained details about the medicines required, medicine changes and any handover notes for the pharmacy. When prescriptions were received from the GP surgery, they would be compared to the re-order sheet to confirm all medicines had been received back. Any queries were written onto a query sheet and chased up with the GP surgery. Any outstanding queries were provided to the care home. Medicines were dispensed in their original packaging, and a medication administration record (MAR) was provided.

An unscheduled care scheme enabled people to access medicines from the pharmacy if they been prescribed them before and at the pharmacist's discretion. The pharmacist said he had a copy of the signed patient group direction (PGD) in order to make the supply. He provided an example from earlier that week which involved a person who had lost their eye drops and the person did not have any medication left. The pharmacist was able to replace the medication so the person could continue taking their medication.

The pharmacy first scheme was provided by the pharmacy. Members of the pharmacy team showed an understanding of the service and a copy of the formulary of medicines which could be supplied was available. If the request was for a prescription only medicine permitted by the scheme, they would refer the patient to the pharmacist for a consultation under the relevant PGD. A recent example provided by the pharmacist involved a person who was requesting treatment for thrush, but the symptoms indicated a referral to the GP surgery would be more appropriate. The pharmacist said he had spoken to the surgery to arrange an appointment.

People who were stable on chronic disease medication had serial prescriptions written under the Medicines Care Review (MCR) service. People contacted the pharmacy when they were due their medication and the pharmacist counselled them about their compliance. The pharmacist had recently intervened for someone who was late in collecting their medication. It transpired they had stopped taking their medication. The pharmacist referred them to the GP surgery to ensure they were re-commenced on a suitable starting dose.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Stock was date checked on a 3-month basis. A date checking matrix was signed by team members as a record of what had been checked. Short-dated stock was highlighted using a sticker and liquid medication had the date of opening written on. Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out-of-date stock. CD denaturing kits were available for use. There was a clean medicines fridge with a thermometer. The minimum and maximum temperature was within range. But records had not been

kept since August 2021 due to a change in the pharmacy's computer system. So the pharmacy may not be able to demonstrate medicines are being suitably monitored. Any returned medication was disposed of in designated bins. Drug alerts were received by email from the MHRA. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The team had access to the internet for general information. This included access to the BNF and BNFc resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed members of the team to move to a private area if the phone call warranted privacy.

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.