General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Strachan Pharmacy Limited, 69 High Street, BANFF, Banffshire, AB45 1AN

Pharmacy reference: 1041916

Type of pharmacy: Community

Date of inspection: 09/03/2020

Pharmacy context

This is a community pharmacy beside other shops in a town centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers the NHS smoking cessation service, and seasonal flu vaccination. The owner works in the pharmacy at least one day each week.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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

The pharmacy team members follow written processes for all services to ensure that they provide them safely. They record mistakes to learn from them. And they review these and make changes to avoid the same mistakes happening again. The pharmacy keeps all records that it needs to and keeps people's private information safe. Team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent had signed them off recently. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. This had been successfully used during a recent power cut. Team members took people's dispensed medicines to them at the door. This minimised the risk of injuries from people accessing the premises when they were dark. The pharmacy had a range pf phone numbers accessible to be used for maintenance issues or during disruption to services. It displayed the COVID-19 show material following government and NHS guidance. Team members had placed this material on the entrance door and at the medicines' counter. They had discussed what to do in the event of a person with symptoms on the virus presenting in the pharmacy. They knew to send people home with advice to self-isolate and possible call NHS 24. They described situations when they might take a person to the consultation room. And they knew that the area could not be used until it had been suitably cleaned following NHS guidance.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. The pharmacist analysed the data and represented it graphically over the previous six months to discuss with team members. This showed that errors had decreased during the last month. Team members were reminded to carry out their own accuracy check before passing for the final accuracy check. They had placed shelf edge labels in front of items involved e.g. Tegretol. They had discussed taking care with products with similar names e.g. Daktarin and Daktacort products. The pharmacist had commended the team for accurate date checking – there had been no date expired items identified for a few months. The pharmacy kept a folder for recording errors reaching people. But there had not been any recently. This process was a great improvement from the last inspection. At that time the pharmacy did not record all incidents and did not review these so could not learn from them. The pharmacy had a complaints procedure with other SOPs, which team members were aware of and had signed. This was not available at the previous inspection.

The pharmacy had an indemnity insurance certificate, expiring 31 March 20. The pharmacy displayed the responsible pharmacist notice and accurately kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and

regularly audited; and a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read a confidentiality agreement. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members had also read the RPS guidance on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified or team members in training to provide its services safely. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is. And then makes changes if required. This ensures skilled and qualified team members always provide pharmacy services. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training during the working day. Team members can share information and make suggestions to improve ways of working and to keep the pharmacy safe. And they know how to raise concerns if they have any.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one part-time (three days per week) accuracy checking technician (ACT), one part-time (two days per week) pharmacy technician, four qualified part-time dispensers (four days, four days, three days and one day per week), one part-time trainee dispenser (four days per week) and a delivery driver four days per week. The trainee dispenser had been working in the pharmacy for two months. She had read and signed the SOPs and been registered on the Buttercups® joint dispensing/medicines counter assistant course. The owner pharmacist worked one or two days per week in the pharmacy and sometimes at other times to undertake management activities. There were usually two pharmacists working on Tuesdays which were busy days. And Thursday afternoons to do paperwork. One team member spent most of her time on the medicines counter. The pharmacy found this helpful as it limited interruptions to team members who were dispensing. And she was developing helpful relationships with people using the pharmacy. She was able to identify and give appropriate advice to people trying to repeatedly purchase medicines intended for short term use. The pharmacy displayed team members' certificates of qualification. Typically, there were at least three team members and one or two pharmacists working at most times. At the time of inspection there were two pharmacists and four team members. The team was able to manage the workload. The pharmacy reviewed staffing levels recently when it had undergone an extension and refit. At that time the pharmacy increased staffing, with two team members returning from maternity leave and recruitment resulting in a new qualified medicines counter/dispensing assistant and the trainee. Part-time team members had some scope to work flexibly providing contingency for absence. Although this was not really needed unless there was more than one person absent at a time. The pharmacy could manage easily with one team member off. Team members were often able to swap days with colleagues to accommodate personal requirements such as childcare. This was a great improvement from the previous inspection when the pharmacy was short staffed.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development using Numark® modules. They chose topics that they were interested in or had identified a gap in their knowledge. The pharmacy provided the trainee team member with additional time to complete coursework. Other team members helped coach the trainee in different activities such as the management of multicompartment compliance packs. And the pharmacist supervised all activities. The pharmacy also arranged specialist training as required for team members. It was hoping to provide the NHS needle exchange service and naloxone program to appropriate people. An expert from the local NHS substance misuse service was coming to the pharmacy to train all team members. A fraud awareness expert was also coming to the pharmacy to provide training to the team. Team members were observed going about their tasks in a systematic and professional manner.

They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. And they could make suggestions and raise concerns to the manager or area manager. They provided examples of suggesting moving things round following the recent refit. And the superintendent pharmacist asked team members' opinion before making changes. The superintendent pharmacist had asked for the pharmacy manager's opinion when designing the refitted pharmacy. Team members shared information throughout the working day on a variety of topics related to their work such as stock shortages and changes in people's medication. They also used a whiteboard for communication. And the pharmacy had a variety of information on the dispensary wall for team members to refer to. This included the near miss reviews, a list of people whose medicines were delivered and a weekly checklist to ensure that all essential tasks were undertaken. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean, and suitable for the pharmacy's services. The pharmacy team members use a private room for some conversations with people. Other people cannot hear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were large premises incorporating a retail area, coffee shop, dispensary and back shop area including storage space and staff facilities. The pharmacy had completed a refit and extension within the past few months providing a larger 'fit-for-purpose' dispensary, two consultation rooms and staff facilities. Previously team members had to use facilities on an upper floor shared with non-pharmacy staff from the coffee shop and retail area. The consultation room previously was very small and unprofessional in appearance. The pharmacy had designed the dispensary to include a small 'quiet' area for the management and storage of multi-compartment compliance packs. Previously team members had used a room on an upper floor for this activity. Following the refit all pharmacy activities were undertaken in the one area which was creating a better and more streamlined working environment. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had two consultation rooms. One had a desk, chairs, sink and computer and was clean and tidy, and the door was kept locked to prevent unauthorised access. The other smaller room had a hatch through to the dispensary which could be used for team members to deliver substance misuse services. But they did not use it, preferring to go into the room with people. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy team provides safe services. Team members support people by providing them with information and suitable advice to help them use their medicines. And they provide extra written advice to people taking higher risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. And it could provide large print labels for people with impaired vision. All team members wore badges showing their name and role. The pharmacy provided a delivery service and most people signed to acknowledge receipt of their medicines. The pharmacy displayed information signposting people to guidance on coronavirus.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacist initialled prescriptions that she had carried out clinical assessment of. So the ACT could undertake the accuracy checks of these. A team member checked the dispensing dates on medicines on retrieval shelves weekly. The pharmacist assessed items that had been on shelves for more than two weeks, and if appropriate a team member contacted the GP practice to inform prescribers of compliance concerns. She marked the bag labels to provide an audit trail of this.

The pharmacy usually assembled owings later the same day or the following day. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these prior to people coming to the pharmacy. Team members recorded due dates and collection dates. They monitored these and contacted patients or prescribers if medicines had not been collected after two weeks. The pharmacy attached labels to CMS dispensed medicines' bags to highlight these.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. The pharmacy team had reviewed and improved this process since the previous inspection. Team members assembled packs at least a week before the first one was due to be supplied, in a dedicated quiet area of the dispensary. They stored completed trays in this area in individual named boxes. Team members included tablet descriptions on labels and provided patient information leaflets with the first pack of each prescription. And they kept comprehensive records including dose regimes, changes, hospital discharges and other interventions. A team member updated and re-printed the dose regime following a change. Team members kept records of when they ordered and received prescriptions. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these in entirety on receipt. And the pharmacy notified prescribers if people did not collect their medicine. Any trained team member entered information onto the 'methameasure' pump device when methadone prescriptions were received. And the pharmacist double checked that the information was correct.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group. The pharmacist had counselled them appropriately and checked that they were on a pregnancy-prevention programme. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle. Team members gave verbal and written information to people supplied with these medicines over-the-counter, or on prescriptions. They also discussed 'sick day rules' with people on certain medicines, so that people could manage their medicines when they were unwell. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, and emergency hormonal contraception, and chlamydia treatment. It also followed private PGDs for flu vaccination. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence and under supervision. 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 was planning to start the NHS needle exchange service soon. It was arranging hepatitis B vaccination for team members and had contacted occupational health to arrange this. The pharmacy had arranged for the NHS lead pharmacist for substance misuse services to come to the pharmacy to train team members.

The pharmacy obtained medicines from licensed wholesalers such as Phoenix. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy had the equipment on the premises. But team members had not had any training yet. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items required for palliative care use in a labelled box. And it stored items requiring cold storage in a fridge and team members monitored minimum and maximum temperatures. They took appropriate action if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. The team member who usually worked on the medicines' counter was a qualified dispenser so provided relevant advice to people when collecting prescription medicines or buying over-the-counter medicines. She described how she managed repeat requests for medicines intended for short-term use. And this was appropriate.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. The pharmacy looks after tis equipment to ensure it works.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board. The pharmacy kept gloves for use by team members filling multi-compartment compliance packs and had antimicrobial wipes and sharps bins. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy had a 'methameasure' pump available for methadone use and this was cleaned, and test volumes poured daily. And it had a finger print reader in the consultation room linked to this device for identification. The pharmacy had clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets. It kept this in a separate labelled box with methotrexate tablets.
The pharmacy stored paper records in the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and never left them unattended unless they were locked.

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.