General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: William Taylor, 1 High Street, BUCKIE, Banffshire, AB56 1AL

Pharmacy reference: 1041918

Type of pharmacy: Community

Date of inspection: 03/09/2019

Pharmacy context

This is a community pharmacy on a high street. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs and provides substance misuse services.

Overall inspection outcome

Standards not all 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 not all met	1.1	Standard not met	The pharmacy does not have up-to-date standard operating procedures (SOPs) for all processes. And some team members have not read SOPs.
		1.2	Standard not met	The pharmacy team does not routinely record and review dispensing accuracy.
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 not all met

Summary findings

Some pharmacy team members follow process for some activities. Some written processes are out of date. And team members have not all read the written processes for tasks they do. So, they could make mistakes. They record a few but not all mistakes. And they do not review these. They are missing learning opportunities to make services safer. The pharmacy keeps all the records that it needs to by law. Team members may not all know about keeping people's information safe and looking after the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for all activities and tasks. They were old, undated and had no reference to who had written them or if they had ever been reviewed. The pharmacist believed these had been in place at the previous inspection almost five years ago. The controlled drug CD SOP referred to paper registers, but the pharmacy had been using electronic registers for some time, so this was not being followed. The pharmacy did not have evidence of team members reading them. A trainee accuracy checking technician (ACT) had written and established a few new SOPs as she was required to do as part of her course. A trainee medicines counter assistant who had worked in the pharmacy for eight weeks had not read any SOPs. An experienced trainee pharmacy technician had not read the SOPs in this pharmacy. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The trainee ACT described her accuracy checking process, and the planning that she and the pharmacist were doing for her new role. The pharmacy managed dispensing, a high-risk activity, well, with baskets used to separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members sometimes used near miss logs sometimes to record dispensing errors that were identified in the pharmacy. The trainee ACT did this for her course. They also recorded errors reaching patients to learn from them. But they didn't review incidents regularly or in a structured manner. They had made some changes to improve accuracy, such as not checking multi-compartmental compliance packs late in the day, improving marking on split boxes and moving all dispensing stock from the upper floor to the dispensary. Team members highlighted unusual doses as soon as they were 8identified e.g. when labelling.

The pharmacy had a complaints procedure and welcomed feedback. Medicines counter assistants described ordering specific items for people e.g. a new ibuprofen product. And they took items into stock that people often requested. They moved stock location to ensure products were accessible for people.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. The pharmacy displayed the responsible pharmacist notice and 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. But they had not all had training or read a SOP or policy. The trainee medicines counter assistant who had been in the pharmacy for eight weeks had not read or signed any documentation on information governance or safeguarding. Team members had not all read any documentation or SOP on safeguarding. Those who had undertaken accredited training recently had covered these topics in their course work. The pharmacist was not PVG registered. The pharmacy did not have local safeguarding process or contact details available. Team members segregated confidential waste for shredding. No person identifiable information was visible to the public.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained or training team members. Some of them read training material that is available. But they do not have time set aside for using it. And it is not structured. This means that their knowledge and skills may not be up-to-date and could affect how well they care for people. Team members can share information and raise concerns to keep the pharmacy safe. Some team members make suggestions to improve services.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one full-time pharmacy technician undertaking ACT training, one full-time trainee pharmacy technician, three full-time and three part-time medicines counter assistants and three Saturday only dispensers, one of whom was trained. She worked in another branch in the company during the week. One of the full-time medicines counter assistants worked mainly on an upper floor managing company administration and a photo-lab. Most medicines counter assistants were trained. One was half-way through a medicines counter course, and another was not yet registered on a course. One medicines counter assistant who had recently completed her course explained that she had undertaken most of it in her own time. The pharmacy displayed their certificates of qualification. Typically, there were two team members in the dispensary, and two or three on the medicines counter, and a pharmacist. Team members were able to manage the workload. The pharmacy had employed pharmacy students over the summer who had provided cover for holidays. Part-time team members had some scope to work flexibly providing contingency for absence.

The pharmacy provided some protected learning time. The trainee ACT described having time to undertake practice exams when the students were working. She was being supported 'on-the-job'. The pharmacy did not have structured training and development in place. Team members did not have development meetings to identify their training needs. But some team members described reading material on-the-job, such as 'Counter Excellence' modules as they were received. The pharmacist supervised trainee team members to an extent. The layout of the pharmacy meant that she could not see or hear the medicines counter, other than on a CCTV monitor. The pharmacy had CCTV covering the medicines counter with a monitor in the dispensary, so the pharmacist could see if there were people at the medicines counter. But she relied on team members asking for advice, which they did. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. Experienced medicines counter assistants helped the recently started trainee.

The pharmacy technicians understood the importance of discussing and learning from 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. They could make suggestions e.g. what stock to keep and how to review people receiving multi-compartmental compliance packs and those on the medicines' management service. The pharmacy used a whiteboard to share information, and to remind team members of tasks to be undertaken. The company did not have any routine or structured sharing in place. But the pharmacies that were close shared information such as people requesting medicines for short-term use too often. A team member who worked in two branches shared information frequently e.g. a person who was receiving the same medicine from both branches. This had resulted in team members clarifying with either the GP or other pharmacy when a prescription is received for a

person who does not normally use this pharmacy. Team members described feeling able to raise concerns although they had not had to do this.

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 confidential conversations with people. People outside the room are not able to hear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises that had benefited from a refit around a year ago. The premises incorporated a retail area, dispensary and large upper floor area including storage space and staff facilities. The company used this area for storage for all six pharmacies, but not medicines. 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 which was in a separate room from the retail area. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. Team members manage serial prescriptions to ensure people have the correct amount of medicines. They give people information to help them use their medicines safely. And they usually provide written information including extra information with some high-risk medicines. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

The pharmacy was accessed through an automatic door and had one step. It listed its services and had leaflets available on a variety of topics. It could provide large print labels for people with impaired vision. The pharmacy provided a delivery service and people signed to acknowledge receipt of controlled drugs only. Medicine counter assistants provided this service following a rota. They used a company vehicle and took items requiring cold storage first. They estimated that these medicines would typically be out of the fridge for around ten minutes.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to separate people's medicines and prescriptions. And they used designated benches for labelling, dispensing and checking. One team member labelled, marking prescriptions if there were any new items, then another team member dispensed when possible. The pharmacist undertook clinical assessment before labelling, using the patient medication record (PMR) to facilitate this. She marked prescriptions to confirm this. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The trainee ACT initialled labels of items she had checked in addition to the pharmacist's initials. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these on request. The pharmacy was actively registering people for this service. The pharmacist sometimes identified pharmaceutical care issues including overuse of 'reliever' inhalers, and people not wanting preventative medicines such as stations. She sometimes saw changes in prescribing following these conversations and attributed some of them to her interventions. The surgery pharmacists were becoming more involved with the clinical aspects of this service, reducing opportunities for the pharmacy to intervene. The pharmacist prescribed using the universal claim form (UCF) to synchronise people's medicines when they started CMS prescriptions. This enabled her to monitor and discuss compliance with people. She contacted the GP when she had concerns. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Team members followed a robust process and kept records of changes. They gathered stock then a colleague checked it and kept a record of this. The pharmacist checked the completed packs. Team members hand-wrote tablet descriptions onto packaging while assembling. This ensured they were always accurate regardless of brand of tablet used. Completed packs were stored tidily on shelves in the dispensary and marked for delivery or collection. The pharmacy currently only supplied patient information leaflets (PILs) with new medicines, but the team was reviewing this. Team members printed additional PILs from EMC (electronic medicines compendium) when required. The pharmacy supplied a variety of other medicines by instalment. A team member assembled these on Saturdays for the following week. Then placed them on a designated shelf with the day of collection marked. The pharmacy also supplied medicines administration (MAR) charts to people on the medicines' management service. Team members were reviewing this as there

had been confusion recently with dates on prescriptions. If the dates on the MAR chart were not correct carers could not administer medicines to people.

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. There were no people prescribed valproate in the risk group, but the pharmacist explained that she was vigilant and would provide the appropriate advice and counselling. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy had recently received NHS Education for Scotland (NES) safety culture discussion cards. Team members were aware of these but had not used them yet. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception and supply of chloramphenicol ophthalmic products. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. 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 confident in the competence of team members working on the medicines counter. She was not able to directly supervise the counter due to the layout but knew team members asked for advice appropriately. The team was supporting the new team member and she was referring to the pharmacist frequently.

All team members except the 'new-join' were involved in the smoking cessation service. They had attended a refresher course a few months previously. People were prescribed Champix or nicotine replacement therapy and the pharmacist had input into all consultations.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy had equipment, but team members had not been trained. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in two fridges with minimum and maximum temperatures monitored and action taken 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 new team member asked for help.

The pharmacy actioned MHRA recalls and alerts on receipt but didn't keep records. It kept evidence of returning affected items to suppliers. 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 this 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 a carbon monoxide monitor maintained by the health board in the consultation room where it was used with people accessing the smoking cessation service. Team members kept ISO and crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and consultation room inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. 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.