General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Normac Pharmacy, Ardach Health Centre, Highfield Road, BUCKIE, Banffshire, AB56 1JE

Pharmacy reference: 1041919

Type of pharmacy: Community

Date of inspection: 17/10/2019

Pharmacy context

This is a community pharmacy in a health centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And it supplies a range of over-the-counter medicines. It offers smoking cessation.

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

Pharmacy team members follow written processes for all services to ensure that they are safe. They are starting to record mistakes to learn from them. The pharmacy keeps all the records that it needs to by law. And it keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy manager reviewed them every two years and signed them off. 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 accuracy checking technician (ACT) followed a robust process for checking prescriptions. She checked all prescription types after they had been clinically checked and signed by the pharmacist. She checked schedule two controlled drugs, and the pharmacist also checked these. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. And it had an action plan to develop and improve services.

Team members had not been using near miss logs recently to record dispensing errors that were identified in the pharmacy. The team had previously used near miss logs but some team members did not like them so this had stopped. Following an inspection recently in another pharmacy, the pharmacy superintendent had asked the team to reinstate these. The preregistration pharmacist was in the process of re-implementing an appropriate system. Team members explained that when they made a mistake it was fully discussed at the time. They described quantities being the most common error. They attributed this to interruptions when the pharmacy was busy, and they had to go to the front counter. They recorded errors reaching patients to learn from them. The pharmacy did not make many errors, and these were usually quantities or incorrect form. All team members discussed these and were reminded to read prescriptions carefully and doublecheck their work before passing for the final accuracy check.

The pharmacy had a complaints procedure and welcomed feedback. Examples were described of significant work undertaken to meet people's expectations related to when medicines were ready for collection.

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. The team recorded out of date schedule three controlled drugs in this register. 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 and signed a SOP. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read a SOP 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 and experienced team members to safely provide its 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. Pharmacy team members make decisions and use their professional judgement to help people. Team members can share information and raise concerns to keep the pharmacy safe. They discuss incidents and learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, and occasional double cover, one full-time accuracy checking technician (ACT), 4 part-time dispensers, one who was completing accredited training; and one part-time trainee not yet registered on a course. There were no medicine/front counter assistants. The pharmacy did not have a big over the counter business, but team members were observed to be constantly interrupted to attend to people at the front counter, mainly handing in prescriptions. The pharmacy displayed their certificates of qualification. Typically, there were three or four team members working at most times including ACT. The pharmacy had a pre-registration pharmacist. She was not included in staff numbers when planning as she was in a training role. At the time of inspection there were two dispensers, ACT and pre-registration pharmacist. Team members were able to manage the workload despite frequent interruptions to go to the counter. They rotated through different tasks to keep their skills up. Part-time team members had some scope to work flexibly providing contingency for absence.

The pharmacy provided protected learning time for all team members to undertake regular training and development. It provided team members undertaking accredited courses with additional time to complete coursework. Although this could be challenging as the pharmacy was constantly busy. The pharmacy did not have a structured training programme in place. But it had a box of training material including ‘counter excellence’ modules, pharmaceutical journals, the valproate pregnancy prevention programme and NHS initiatives such as ‘sick day’ rules and the NSAID care bundle. The pharmacy manager had created an information pack on the non-steroidal anti-inflammatory drug (NSAID) care bundle and all team members had read it. The pack included Scottish patient safety association bulletins, information from other areas advising when to issue steroid cards and a sheet the pharmacist had developed with examples of medicines, questions to ask and advice to give people. The pharmacist had asked the preregistration pharmacist to create an information on pack on medicines with anti-muscarinic side effects to enable the team to advise frail people when taking these. The pharmacist was observed to supervise all team members including the preregistration pharmacist during the inspection. The preregistration pharmacist had a half-day per week for her own learning and development. She stayed on site to enable her to speak to the pharmacist if necessary. She explained that this half-day was always very timely and allowed her to consolidate the learning of the previous week. Team members did not have regular or structured development meetings/appraisals to identify their learning needs. But the pharmacy manager provided continual feedback including praising the team and individuals for good work. Team members highlighted their training needs to her. An example was a team member identifying that she was not confident with all aspects of the management of multi-compartment compliance packs. So, she asked the pharmacist for additional coaching and training, which was arranged. The various individuals were observed going about their tasks in a systematic and professional manner. They shared information continually and asked each other questions. They asked

appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. The pharmacy made good use of staff skills e.g. the ACT checking all prescription types to free up the pharmacist for clinical checking and interventions. The pharmacist delegated a sensitive query regarding a person's new medicine to the pre-registration pharmacist. This was good for the pre-registration pharmacist's development, encouraged thorough investigation into the issue and did not put pressure on the pharmacist's time. The pre-registration pharmacist shared her findings with the pharmacist and delivered good quality advice to the person. The pharmacist explained that she trusted the pre-registration pharmacist's judgement. She was confident in her competence.

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. They could make suggestions and raise concerns to the manager or area manager. The team had occasional team meetings when there were issues to discuss that could not be managed 'on-the-job' e.g. implementing the NSAID care bundle, and frailty awareness. Team members used a communication book to share information on various topics e.g. when material had been ordered or received for initiatives such as sick day rules. The superintendent pharmacist occasionally shared information across the organisation e.g. re-implementation of near miss logs following a recent inspection elsewhere. 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 overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were reasonably sized premises within a health centre. There was no retail area but a small over-the-counter medicine offering at a desk where people handed prescriptions in. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff area and shared toilet. These had hot and cold running water, soap, and clean hand towels. The dispensary had adequate dispensing space which was well organised. Team members undertook most dispensing and checking on an 'island' dispensing bench. This enabled a compact and effective workflow.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, and computer which was clean and tidy, and the door closed providing privacy. The door was kept locked to prevent unauthorised access. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access from the health centre. It listed its services and had leaflets available on a variety of topics. And it had a low counter enabling wheelchair users to easily hand in prescriptions. The pharmacy signposted people to other services within the health centre such as GPs and nurses. Team members frequently used the consultation room with people with impaired hearing. They provided large print labels to people with impaired vision. The pharmacy had access to a translation service through the surgery.

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. The pharmacy received prescriptions twice daily. One team member labelled, placing all labels and prescriptions in an appropriately coloured basket. The pharmacist then clinically checked, looking at every patient record and initialled prescriptions to enable the ACT to carry out the final accuracy check. The pharmacist added any relevant notes or information to be shared with people when they collected their medicines. She made it clear if a team member could do this or if she required to do it herself. Then a dispenser assembled the medicines and placed on a dedicated shelf for the ACT to check. This process was very smooth, logical and calm. The team strived to complete all dispensing by late morning before the afternoon 'bundle' of prescriptions was received. And they strived to clear the afternoon ones by the end of the day. This enabled team members to start with clear benches each morning and worked well. They usually achieved this, but it was dependent on the level of interruptions at the front counter. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines.

The pharmacy usually assembled owings later the same day or the following day. They always provided 5ml oral syringes with liquid medicines to help people measure doses accurately. They labelled prescriptions for controlled drugs with stickers to ensure these medicines were not supplied beyond the prescriptions' 28-day validity. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when people requested them. The pharmacist checked the computer monthly to monitor compliance. She had no concerns, but shared information regarding compliance with GPs. The pharmacy stored prescriptions alphabetically and team members inspected these monthly to ensure the paperwork was up-to-date and highlight any issues. They kept records of date of supply and the next expected supply date. The pharmacist clinically checked CMS prescriptions at the start, then again if there were any changes. The pharmacy was actively registering people for this service. The pharmacist identified pharmaceutical care issues when discussing people's medicines with them. These included over-use of some medicines.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. Team members did not always attach backing sheets firmly, so they could become

detached meaning that the contents of the pack would not be known. They included tablet descriptions on backing sheets. And they supplied patient information leaflets (PILs) with the first pack of each prescription. They kept a folder of PILs. The pharmacy kept comprehensive records of changes and other relevant clinical information. GPs phoned or emailed, and pharmacy team members recorded the information on a bespoke template which they retained with the patient records. This enabled them to record who was involved with the change and when they had completed it. The detail included date, prescriber, tick box for changing backing sheet, checking repeat slip, updating master template, supplying new PIL and a note to discuss with the person. The pharmacy stored completed packs in individual named baskets at the rear of the dispensary. People signed for their pack at the time of supply. The pharmacy used a weekly communication sheet to note relevant information such as people in hospital and people who needed additional supplies to cover holidays. Team members also used a communications diary to share information.

The pharmacy supplied a variety of other medicines by instalment. They followed a robust process. When prescriptions were received a team member gathered stock and placed it in a named basket in the rear area. Then the week before supply a team member assembled the medicines which were stored in sealed and labelled bags in baskets at the front of the dispensary. The pharmacy supplied clozapine to a few people. A hospital in another town dispensed the instalments. The hospital team emailed the pharmacy with blood test results before the pharmacy supplied the medication. The pharmacy kept records and the process worked well. This meant people did not have to travel long distances to receive their medicine.

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 and the pharmacist had counselled them appropriately. 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 team members had received training to enable them to provide this information. 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 and under the pharmacist’s 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 pharmacist delivered the smoking cessation service.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. 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 pharmacy actioned MHRA recalls and 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 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 in the consultation room where it was used with people accessing its smoking cessation service. Team members kept BS marked 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 each evening and test volumes poured each morning. The pharmacy team kept clean tablet and capsule counters in the dispensary. As methotrexate tablets were supplied in blister packaging there was no longer a separate counter kept for these.

The pharmacy stored paper records in a filing cabinet in the consultation room which was kept locked, and 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 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.