General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** William Murray Pharmacy, 35 Galloway Street, DUMFRIES, Dumfriesshire, DG2 7TN

**Pharmacy reference:** 1042005

**Type of pharmacy:** Community

**Date of inspection:** 05/06/2019

## Pharmacy context

The pharmacy is on the edge of the town centre. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It offers a prescription collection service from local surgeries. And delivers to people's homes. It supplies medicines in multi-compartmental compliance packs to help people take their medicines. And it offers a range of services including a substance misuse service.

## 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 | 1.2 | Standard not met | The pharmacy team members are not following the systems in place to learn from their mistakes. And they are missing opportunities to learn and improve their service to patients. |
| | | 1.4 | Standard not met | The pharmacy team members are unclear of the process for dealing with complaints and have failed to respond appropriately to these |
| **2. Staff** | Standards not all met | 2.1 | Standard not met | The pharmacy does not have enough pharmacy team members to ensure that it keeps up to date with required routine tasks. |
| **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

The pharmacy has some written procedures which the team members generally follow to manage the risks associated with its services. It maintains the pharmacy records it must by law. But, some records are not frequently checked to make sure they match what is in stock. So, pharmacy team members may not know if there are any errors or losses. The pharmacy team members are not following the procedures to learn from their mistakes. They have discussions. But there are no written records and reviews are not being undertaken. They are unclear of the process for dealing with complaints and have failed to respond appropriately to these. This means that they may be missing opportunities to learn and improve their service to patients.

### Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs) which the pharmacy team members have read.
These provided the team with information to perform tasks supporting delivery of service. They covered areas such as the dispensing and assembly of stock (updated May 2019). This was following the changes with the process when implementing the Falsified Medicines Directive (FMD). The SOPs had a range of revision dates from May 2018 to May 2019 and the team members had signed once read.

The team could advise of their roles and what tasks they could do. The team advised that the workflow had changed in the dispensing process following the use of the scanners. They now had to obtain the stock first for all items on the prescriptions before they could generate labels. The team members were working together to establish a better work flow. There was a separate area for multi-compartmental compliance aid preparation.

The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They dispensed the waiters and call backs at one terminal to distinguish patients' prescriptions by degree of urgency and this helped plan workload. The team dispensed other prescriptions at the other side of the dispensary. The team marked deliveries on the prescription.

The pharmacist advised he kept a basket which he put any completed CD prescriptions in and this ensured that he entered these daily. He also had a basket for putting any prescriptions for discussion for near misses, but he had not used this lately. The pharmacy team had not been logging near misses lately, with no records for the last few months. They explained that they had been busy and the recording of these had lapsed. The team members advised that the process had changed to recording electronically and they couldn't manage to enter with the workload. They informed each other of near misses and advised they had discussed reverting to paper, so they could record more easily and then put on the computer later. The pharmacy used shelf edge alerts infrequently to highlight picking errors.

There was no information available to people on how to provide comments and about the complaints process. The pharmacy team were unclear of any process. There was no SOP in place. And no form or system for taking any details or information, should any person raise a concern. The pharmacist advised

that the pharmacy did not really get many complaints. He advised he used to have a book and he made any notes in it. But he had not done this for some time. The GPhC had received a concern and the pharmacy had not documented this at the time. It had been an error in quantity and the patient had made the pharmacy aware of this. They had dealt with it. But there were no records. The pharmacy advised there was a Community Pharmacy Scotland leaflet on complaints and they should look at getting this. And reviewing their process.

The pharmacy had current indemnity insurance with an expiry date of 30 April 2020.

The pharmacy had the correct Responsible pharmacist (RP) notice. And the pharmacist completed the Responsible pharmacist records as required. The pharmacy also completed the Community Pharmacy Scotland book and had a record of all team members for each day.

A sample of the CD registers looked at were complete, these were electronic. The pharmacy team undertook running balance checks but not as frequently as intended. The pharmacy team had not checked the register monthly as required by the SOPs, with some sections not been checked since March 2019. The team explained they randomly checked the sections and generally reconciled at each time of entry to try to ensure the quantities were correct. Physical stock of an item selected at random agreed with the recorded balance.

The pharmacy kept a record of CDs which people had returned for disposal and it had a process in place to ensure the team destroyed these promptly. And did not allow a build-up in the CD cabinet.The pharmacy maintained the records for private prescriptions and special records for unlicensed products as required.

The team had read General Data Protection Regulation (GDPR) information. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. The pharmacy stored confidential waste and shredded this as required.

The pharmacy had a safeguarding SOP, with relevant contact details available.

## Principle 2 - Staffing **Standards not all met**

### Summary findings

The pharmacy does not have enough pharmacy team members to ensure that it keeps up to date with required routine tasks. The pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete ad-hoc training, but don't have a regular training plan. And the pharmacy doesn't formally discuss team members performance or training needs. So, they may not keep their knowledge and skills up to date.
Pharmacy team members do not always establish and discuss specific causes of mistakes. This means they may miss chances to learn from errors and make the most effective changes to make pharmacy services safer.

### Inspector's evidence

There was one pharmacist, one accuracy checking technician (ACT), four dispensers and two medicines counter assistants who worked at the pharmacy.

The pharmacist worked full time and up until later last year, had received additional support two days a week with a regular locum. And more days if required. This had allowed some time to keep on top of tasks. But this was no longer in place as the locum had changed roles. And recruiting for pharmacists in the area appeared difficult. The superintendent pharmacist worked at the pharmacy, usually one day a week to assist and sometime did more.

The pharmacy no longer having regular double cover was having an impact on routine tasks being undertaken such as date checking, recording and reviewing near misses, undertaking running balance checks for controlled drugs and time spent being able to deal with situations such as concerns raised.

The accuracy checking technician worked 37 and a half hours weekly. She advised that due to the staffing structure she did not often get to use her ACT role.

One of the dispensers worked full time and the others worked between 17 and a quarter hours and 24 hours weekly. The two MCAs, both worked two days a week.

Most of the pharmacy team had worked at the pharmacy between seven and 30 years.

The pharmacy had a trainee technician from the health board who was working three days a week to gain experience in community pharmacy.

Certificates and qualifications were available for the team.

The pharmacy team members advised that here was little time for ongoing training to be undertaken in the pharmacy. But some of the team members had attended evening meetings on the Chronic medication service and smoking cessation and how to assist people managing medicines in their homes. This ensure they were up to date for these services. There was no formal appraisal system in place.

The team discussed issues as they arose during the day with suggestions of how to deal with issues.

They were discussing how to manage the workflow following the introduction of the scanners and implementation of the Falsified Medicines Directive (FMD). The team advised that the introduction of the process for FMD had changed the way they dispensed and was taking longer. They were trying to develop the best way to work. The team said that they thought that the staffing was being looked at due to the introduction of FMD.

There was a whistleblowing policy and telephone numbers were available, so the team members could easily and confidentially raise any concerns outside the pharmacy if needed.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy's premises are of a suitable size for the services it provides. And people can have private conversations with the team in the consultation room.

### Inspector's evidence

The pharmacy was clean and reasonably tidy. And fitted out to an acceptable standard. The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The benches, shelves and flooring were all clean and a cleaning rota was available to ensure this was maintained. Floor spaces were generally kept clear to reduce the risk of trip hazards. The room temperature was comfortable and well lit.

The pharmacy had a good sized, signposted, sound proofed consultation room which the team promoted for use. The pharmacy had separate facilities for the substance misuse service, with a separate room and entrance.

The team used cordless phones for private conversations. Members of the public could not access the dispensary. The counter was clearly observed from the dispensary and the staff were aware of customers in the premises.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy's services are accessible to people. And it displays information about health-related topics. It supplies medicines in multi-compartmental compliance packs to assist people to take their medicines at the right time. The pharmacy gets it medicines from reputable suppliers. It generally adheres to storage requirements during the dispensing process. It takes the right action if it receives any alerts that a medicine is no longer safe to use. And takes the correct action to return it to the supplier.

### Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was some customer seating. The pharmacy displayed its services in the window and within the pharmacy. The hours of opening were on the door. It displayed a variety of posters and had a range of leaflets on healthcare topics for self-selection.
The pharmacy had a defined professional area. And items for sale were mostly healthcare related. People could not reach Pharmacy only medicines and the pharmacy team members assisted them when these were required. The team signposted to other healthcare services and had a standard operating procedure (SOP) for self-care and signposting which they referred to if required.

The pharmacy had very few people who had received reviews on the Chronic Medication Service (CMS). The team members advised that this had not had good uptake, but the Health Board was renewing this again. The pharmacy champion for the area had been to the pharmacy and surgeries, advising of the refresh to the service. The team had attended training, with follow up training due in six months. They were nominating suitable people for serial prescriptions to the surgeries.

The pharmacy used Patient Group Directives (PGDs) for Impetigo and flucloxacillin, with limited use, and trimethoprim which had more uptake. The Minor Ailment Scheme was popular with about 500 people registered and around 12 supplies each day.
The pharmacy provided a needle exchange service with around 1500 supplies each month. The pharmacy referred people to the outreach worked for supplies of naloxone. The people using the needle exchange service had client codes and could collect for others. Some people returned items and they were encouraged to do so. The pharmacy provided them with sharps bins, needles, paraphernalia, including foils. The pharmacy also provided steroid kits.

The pharmacy had limited uptake for blood pressure readings and glucose tests. The pharmacist and ACT provided the smoking cessation service with two people. The ACT had attended training recently. The Community Pharmacy Unscheduled care service was well used, and the pharmacy advised they used it for synchronisation of medicines which was beneficial for patients to have their medicine aligned together. The pharmacy supplied around 165 people with multi-compartmental compliance packs to help them take their medicines. The pharmacy supplied most people with trays weekly. And about half of them delivered. The team members advised that recently people were receiving assessments before the pharmacy provided compliance packs, as these were not suitable for all people. The team had had training on the assessments and often people only required, and wanted their medication synchronised, to assist them in taking it. The pharmacy kept backing sheets with discharge notes and any notes in patients' folders. The pharmacy provided Patient information leaflets (PILs) with

each cycle.

The pharmacy provided a substance misuse service to several people who received methadone or buprenorphine. There was a mixture of collections, with some daily and others two or three times a week, or weekly. The pharmacy made up sugar free prescriptions each morning and placed these in the controlled drugs cabinet in an organised manner, with items on separate shelves. The pharmacy used the Methameasure system for the normal methadone. The pharmacy had a separate rear entrance which the people used. This went in to a small room and had a hatch to the rear of the dispensary. The members kept the hatch shut when it was not in use. The people had an agreement and did not attend for the service after 5pm. The team members checked the identity of the people collecting their doses and completed the back of the prescriptions, ready for the next day. The pharmacy kept electronic register entries in the controlled drugs (CDs) register. The pharmacy had dedicated shelves in this area and kept medication for the people using this service which provided easy access when they were receiving their medication.

There was a clear audit trail of the dispensing process. The team completed the “dispensed by” and “checked by” boxes which showed who had performed these roles. And a sample of completed prescriptions looked, at found compliance with this process.

The team used a stamp on the prescription to show that the pharmacist had completed a clinical checked. This allowed the accuracy checking technician to do their accuracy check. Although the ACT generally did not use this role and spent most of the time dispensing.

There were some alerts stickers used to apply to prescriptions to raise awareness at the point of supply. These included warfarin, methotrexate and lithium which ensured patients received additional counselling.

The team used CD and fridge stickers on bags and prescriptions to alert the person handing the medication over to add these items. The CD stickers recorded the last date for supply, to make sure it was within the 28-day legal limit. This prevented supplies when the prescription was no longer valid.

When the product or quantity prescribed could not be provided in full patients received an owing slip. And one was kept with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers if items were unobtainable at the current time for an alternative.

The pharmacy team members were aware of the Valproate Pregnancy Prevention Plan. And provided the required information to patients as required.

The pharmacy kept a delivery sheet as an audit trail for the delivery of medicines from the pharmacy to patients. This included a signature of receipt of the delivery. The driver used a separate delivery sheet for controlled drugs.

The pharmacy generally stored medicines within the original manufacturers packaging and at an appropriate temperature. But the container used for methadone in the Methameasure only had methadone on it. The pharmacy filled up the container from smaller original bottles. The team advised they kept a note of the batch and expiry date in the register. The container did not have any required details such as manufacture, batch number or expiry date. The pharmacy also had some amber bottles which were inadequately labelled, with the name of the medication only e.g. furosemide, tegretol 200mg and mefenamic acid. The pharmacist disposed of these. And the labelling of the stock bottle for methadone was being addressed.

The pharmacy had a refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range.

The pharmacy had a date checking rota and process explained in its standard operating procedures (SOPs). But the team had not undertaken any date checking for a year. The last date on the matrix used was a year ago (June 2018). The pharmacist advised they had recently had a stock take and the auditors found very little out of date on the shelves. The team advised that they had good stock turnover so expected stock to be in date. But they were aware to be vigilant in the checking process to checks date as they knew they had not been undertaking routine date checking. They explained that this was a task which had gone uncompleted due to lack of time.

The pharmacy obtained medicines from reputable sources.

The team were scanning medicines as required by the Falsified Medicines Directive (FMD). They explained that this had caused a change in their dispensing process and it had slowed the workflow. They showed how they could override the processes if they received an error message. They had not finalised SOPs as they were adapting to the process and trying to establish how best to do things.

The team used appropriate medicinal waste bins for patient returned medication. These were uplifted regularly. The pharmacy had appropriate denaturing kits for the destruction of CDs.

The pharmacy had a process to receive drug safety alerts and recalls. The team actioned these and kept records of the action taken. The pharmacy kept alerts in a folder as a reference.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people's privacy.

### Inspector's evidence

The pharmacy had access to a range of up to date reference sources, including the British National Formulary (BNF). The team members used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs).

The pharmacy had measuring equipment available of a suitable standard, including clean, crown-stamped measures. It used the Methameasure system for measuring methadone. And the team cleaned this and calibrated it as required. It had a separate range of measures for measuring methadone for calibration and some supplies if required. It also had a range of equipment for counting loose tablets and capsules.

The team had access to disposable gloves and alcohol hand washing gel.

The equipment such as the carbon monoxide monitor was checked as required.

The pharmacy stored medication waiting collection on shelves. People could not see any confidential details from the retail area. The team filed these in boxes in a retrieval system out of view, keeping details private.

The computer screens were out of view of the public.

## 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. |