General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Parkhead Pharmacy, 18 Grant Street, BURGHEAD, Morayshire, IV30 5UE

Pharmacy reference: 1042777

Type of pharmacy: Community

Date of inspection: 18/06/2019

Pharmacy context

This is a part time community pharmacy in a village. People of all ages use the pharmacy. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartment compliance packs. The pharmacy superintendent works in the pharmacy as responsible pharmacist while it is functioning as a pharmacy.

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 processes for all services to ensure that they are safe. They record mistakes to learn from them and make changes to avoid the same mistake happening again. The pharmacy asks people for feedback. Team members discuss this to ensure that pharmacy services are maintained to a high standard. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place and followed for all activities/tasks. But they had not been reviewed for a few years. They had been signed off by the superintendent pharmacist and read and signed by relevant staff members. Staff roles and responsibilities were recorded on individual SOPs.

The team members described the potential high risk and challenges of this being a 'part-time' pharmacy. The pharmacist was not on the premises all the time the shop was open, so there were a few hours each day when a team member was alone on the premises. The pharmacy managed workload, dispensing prescriptions when the pharmacist was on the premises. Most prescriptions were collected from the GP practice so this could be planned. The GP practice was a satellite from another village, and open restricted hours.
There was an audit trail in place for dispensed medicines in the form of dispensed and checked by signatures on labels. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members used near miss logs. They recorded all mistakes, but the pharmacist explained their dispensing was accurate, so there were not many. They re-located items that had been involved in mistakes to reduce the risk of the same mistake happening again. The pharmacist described an incident and the learning – the wrong medication had been ordered, mistaken for the correct one and placed on the shelf. When he realised what had happened, the pharmacist discarded the wrong item to avoid it being dispensed in error. The same two drugs were involved in a GP prescribing error, this time the other way around. When the pharmacist saw the prescription, he realised it was probably wrong and contacted the GP. The GP had selected the wrong drug in error. This gave both the pharmacy team and GP an opportunity for shared learning and discussion.

Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The dispenser present at the time of inspection was aware that there were many routine pharmacy tasks that she could not undertake at certain times of day when there was no pharmacist signed in. She sometimes had to explain this to people, although the local community were all familiar with this arrangement and happy to come back later in the day see the pharmacist or go to the other branch in the village two miles away. The dispensers frequently phoned the pharmacist and he sometimes used FaceTime to have conversations with people. This meant that people got timely advice, either signposted to another healthcare professional or they knew what product to purchase when the pharmacist was available. The dispenser occasionally undertook activities such as dispensing if there was an urgent need when the pharmacist was not in the pharmacy. She never supplied medicines to patients, but when there was an urgent need this speeded up the

supply when the pharmacist came to the pharmacy.

There was a complaints procedure although there were no examples of complaints described. The pharmacy had asked the local community for feedback on social media. This was all positive and was observed during inspection. The pharmacy shared feedback with other team members, and it was discussed. This reassured the pharmacist that despite the unusual hours of pharmacy services being provided, the pharmacy was meeting the needs of the local community.

Indemnity insurance certificate was displayed, expiring June 2019. The following records were maintained in compliance with relevant legislation: Responsible Pharmacist notice displayed; Responsible pharmacist log; Private prescription records including records of emergency supplies and veterinary prescriptions; Unlicensed specials records; Controlled drugs registers, with running balances maintained and regularly audited; Controlled drug (CD) destruction register for patient returned medicines; The electronic patient medication record was backed up each night to ensure no data was lost.

Team members were aware of the need for confidentiality and had signed an SOP. They ensured that no person identifiable information was visible to the public. And they segregated confidential waste and shredded it. This was a small tightknit community where the pharmacy team members knew all the patients, so they described taking great care with personal information.

Team members were also aware of safeguarding. Guidance and local contact details and processes were available in the dispensary. The preregistration pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough qualified and experienced staff to safely provide services. But there are times when another pharmacist or team member would be beneficial. The pharmacy reviews staffing and plans to make appropriate changes. Team members have access to training material to ensure that they have the skills they need. They can share information and raise concerns to keep the pharmacy safe.

Inspector's evidence

The pharmacy staff profile was the same as it had been at the previous inspection: one pharmacist worked set hours each day when the premises was functioning as a pharmacy (superintendent pharmacist); one preregistration pharmacist shadowing the pharmacist work patterns, who was on study leave at the time of inspection; one regular locum pharmacist – she provided cover while the superintendent pharmacist was on secondment one and a half days per week; two part-time dispensers who worked 'back-to-back', so there was always one working. They worked together alternate Friday afternoons, and a medicines counter assistant from the other branch worked the other Friday afternoons. The dispensers had scope to work additional hours to cover absence.

Certificates of qualification were displayed. The superintendent pharmacist and one dispenser were present during the inspection.
Staff members were observed to manage the workload. The superintendent pharmacist and owner had just undertaken a review of staffing levels, recognising that dispensing volume had increased and there was a possibility of this further increasing over coming months as nearby military bases were increasing personnel levels. They had arranged for an additional two days locum pharmacist cover. This would provide a pharmacist in each branch all day on the two busiest days, Tuesday and Friday. The locum pharmacist had agreed to start this new work pattern in November. The superintendent pharmacist explained that this was in time for the winter months which were busier.

The pharmacy did not have structured training and development in place, but due to the nature of the pharmacy and the small number of team members, there was much sharing of information and coaching on-the-job. The team members had worked in pharmacy for several years so were experienced in managing the unusual and part-time nature of this pharmacy. All team members attended external local training courses and recent topics had included menopause, Scholl foot products and the new computer system.

The team members went about their tasks in a systematic and professional manner. The pharmacist and dispenser knew people well, addressed them by name and had a friendly and professional manner when speaking to them. The dispenser asked appropriate questions when selling products over-the-counter and demonstrated awareness of items with potential for abuse and frequent purchases. She understood the importance of reporting mistakes and was comfortable owning up to any mistakes she made. She described sharing information and learning between the two branches. And the team members in both branches knew each other well.

The team member present during inspection described how she would raise concerns if she had them and felt able to offer feedback and opinion to the pharmacy superintendent. She gave appropriate

responses to scenarios posed. She often phoned the pharmacist for advice when he was in the other branch. The pharmacist welcomed this and sometimes used technologies such as FaceTime to speak to customers/patients.

The pharmacy did not set targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean, and suitable for its services. The pharmacy team members use a private room for some conversations with people. People cannot overhear private conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises incorporating a dispensary and retail area. The dispensary was the only part of the premises registered as a pharmacy. Pharmacy (P) medicines were stored in it. Dispensed medicines waiting to be collected were stored in the non-registered area of the premises. Team members stored them in a way that prevented patient information being seen by any other patients or customers. People were not able to see activities being undertaken in the dispensary.

The premises were observed to be clean, hygienic and well maintained. The pharmacy had sinks in the dispensary, consultation room and toilet. These had hot and cold running water, soap, and clean hand towels.

The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. The door was kept locked to prevent unauthorised access. The pharmacy was alarmed, had CCTV, and had panic alarms. 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 high-risk medicines. The pharmacy gets medicines from a reliable source and stores them properly.

Inspector's evidence

There was good physical access to the premises and consultation room. Pharmacy team members helped people as required. The pharmacy displayed a list of its services, community information and had leaflets on a range of topics available. It had a hearing loop in working order. The pharmacist was often required to triage symptoms and signposted people to a variety of other services depending on their needs e.g. GP, minor injuries clinic and charities such as Clan Cancer. All team members wore badges showing their name and role.

The pharmacy team members followed a logical and structured process when dispensing. As the GP practice was not open all day, or every day, workload was managed appropriately. A dispenser assembled prescribed medicines when the pharmacist was on the premises. The pharmacist checked all items, which were then re-checked and placed in bags by the dispenser. She placed dispensed medicines on shelves in the non-registered part of the premises unless the pharmacist wanted to speak to the patient.

Dispensers highlighted any changes or new medications to the pharmacist using an intervention form. They placed a bag label (with patient name and address) onto the form, then recorded the information for sharing. The pharmacist took necessary action, or counselled patients depending on this information. After the medicines had been supplied, the pharmacist filed these forms for future reference. Dispensing audit trails were in place in terms of initials on dispensing labels of personnel who had dispensed and checked medicines. Owings were usually assembled later the following day.

The pharmacy supplied a lot of medicines from chronic medication service (CMS) serial prescriptions. A preregistration pharmacist had undertaken a project on the service including synchronising all patients' medication. People managed this themselves, so the pharmacy did not record dates of supply or dates due. The pharmacist contacted people before their prescriptions ended and invited them in for a review. He described some benefit and provided examples of interventions. The GP practice pharmacist was also involved with reviews and interventions following the change to the GMS contract. The pharmacy was continuing to register people and the pharmacist described the opportunity this provided to review medicines and discuss these with people. The pharmacy stored dispensed medicines on retrieval shelves in the nonregistered part of the premises. Team members checked these shelves regularly and reminded patients if they had not collected their medicines. They did not have to do this often as people usually collected their medicines in a timely fashion.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. The team had reviewed and improved this process over the past few months. The pharmacist checked the medicines for accuracy before they were placed into the compliance packs. He checked again after they had been put into the packs. The dispenser labelled completed trays with

instalment number, date of supply and patient details. And tablet descriptions were on labels. The pharmacy supplied patient information leaflets (PILs). It kept robust and thorough records of changes.

The pharmacist poured methadone instalments as people presented at the pharmacy.

The pharmacist undertook clinical checks and people receiving high risk medicines including valproate, methotrexate, lithium, and warfarin were given appropriate advice and counselling. He had searched patient records to confirm that there were no relevant people taking valproate. The valproate pregnancy prevention programme was in place. Written information and record books were provided if required. The non-steroidal anti-inflammatory drug (NSAID) care bundle had been implemented and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. 'Sick day rules' were also discussed with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy had a 'safety door' with a variety of data and information. This included data related to the NSAID care bundle. It showed when discussions to improve engagement and outcomes had taken place. And there was a list of medicines to stop during 'sick days'. Team members used this routinely to give appropriate advice to people when advising on symptoms.

The pharmacy followed service specifications for NHS services and had patient group directions (PGDs) in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, and chloramphenicol ophthalmic products. The pharmacy treated a lot of people under the Pharmacy First PGD. The GP practice frequently referred people to the pharmacy.

The pharmacist was on a working group encouraging hospital discharges to be sent straight to pharmacy at the same time as the GP practice. The hospital pharmacist obtained patient consent to do this and the benefits were described. This meant that any changes or errors could be addressed early.

The pharmacy provided travel vaccination and advice. The pharmacist was an independent prescriber so did not use PGDs. People made appointments which enabled the pharmacy to manage the workload. They usually had an initial consultation with the pharmacist by phone. He ordered vaccines before the first appointment. Pharmacy team members referred all requests for the minor ailments service to the pharmacist. The pharmacist sometimes spoke to patients using Facetime if they came to the premises for advice when he was not there. This meant he could offer advice and signpost to other services, having seen the patient. He sometimes advised coming back to the pharmacy later when he was there or going to the other pharmacy where he was working, two miles away.
The pharmacy was often the only medical facility available in the village, and the pharmacist administered first aid and triaged symptoms, signposting to other services as appropriate. Team members gave several examples of injuries and illness dealt with.

The pharmacist brought all medicines and medical devices from the other branch in the organisation – it had accounts with suppliers and was open longer hours. The pharmacy did not yet comply with the requirements of the Falsified Medicines Directive (FMD). It had the equipment (stand-alone scanner), but the team had not yet been trained – this was planned with the other branch over coming weeks. The pharmacy team undertook date checking, and items inspected were found to be in date. The pharmacy stored medicines in original packaging on shelves/in drawers and cupboards. It stored medicines for diabetes on a separate marked shelf to minimise the risk of these being supplied in error. Items requiring cold storage were stored in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits.

The pharmacy protected pharmacy (P) medicines from self-selection. It stored these in the dispensary which was the only registered part of the premises. All team members followed the sale of medicines

protocol when supplying medicines over-the-counter. General sales medicines were stored in the nonregistered area, so they could be supplied when the pharmacist was not on the premises. Pharmacy team members gave appropriate advice when selling these.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. Patients were contacted following patient level recalls. Items received damaged or faulty were returned 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. And it had Internet access allowing online resources to be used.

The pharmacy had equipment to enable the pharmacist to respond to common clinical conditions. This included a pulse oximeter, blood pressure meter, digital thermometer and carbon monoxide monitor. It also had Crown stamped measures and clean tablet and capsule counters including a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in cupboards in the consultation room and in the dispensary, inaccessible to the public. Team members never left computers unattended and used passwords.

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.