

# Registered pharmacy inspection report

**Pharmacy Name:** Bishopmill Pharmacy, 20 North Street, Bishopmill, ELGIN, Morayshire, IV30 4EF

**Pharmacy reference:** 1042782

**Type of pharmacy:** Community

**Date of inspection:** 23/07/2024

## Pharmacy context

This is a community pharmacy in Elgin, Morayshire. Its main activity is dispensing NHS prescriptions. And it supplies medicines in multi-compartment compliance packs to some people who need help remembering to take their medicines at the right times. The pharmacy offers a medicines delivery service and provides a private travel vaccination clinic. The pharmacy team advises on minor ailments and medicines' use.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards not all met	2.2	Standard not met	The pharmacy employs some team members that are not actively undergoing training appropriate for their role in accordance with GPhC training requirements.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy identifies and manages the risks with its services. It keeps the records it needs to, and keeps people's private information safe. The team is adequately equipped to manage any safeguarding concerns. Team members record and review details of mistakes they make while dispensing and learn from these to reduce the risk of further mistakes.

### Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to define the pharmacy's working practices. The SOPs covered tasks such as record keeping, the responsible pharmacist (RP) regulations and stock control. The SOP's had a review date of July 2024. The pharmacy did not keep a record when team members had read the SOPs. But team members were seen following some procedures such as checking people's addresses when handing out prescriptions. All team members described their roles within the pharmacy and the processes they were involved in. And they accurately explained which activities could not be undertaken in the absence of the responsible pharmacist.

Team members kept electronic records about dispensing mistakes that were identified in the pharmacy, known as near misses. And they recorded errors that had been identified after people received their medicines. Team members were encouraged to learn from their mistakes, and they reviewed all near misses and errors as a team to learn from them. A whiteboard in the dispensary was used to highlight important issues related to people who received prescriptions from the pharmacy. This ensured all the team members were aware and could respond appropriately to any queries. The pharmacy trained its team members to manage complaints. And they knew to refer to the superintendent pharmacist (SI), who was usually present in the pharmacy, if people wished to complain.

The pharmacy had current professional indemnity insurance. It displayed a responsible pharmacist notice which could be seen from the retail area. This did not accurately reflect the details of the current RP at the start of the inspection and was promptly updated. The pharmacy maintained an accurate responsible pharmacist record. And it had accurate private prescription records including records about emergency supplies and veterinary prescriptions. It kept complete records for unlicensed medicines. The pharmacy kept digital controlled drug (CD) records with running balances. Stock balances were observed to be checked against the balances in the CD register on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy. The pharmacy backed up electronic patient medication records (PMR) to avoid data being lost.

Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste for secure shredding. No person-identifiable information was visible to the public. The pharmacy had a documented procedure to help its team members raise any concerns they may have about the safeguarding of vulnerable adults and children. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. A team member explained the process they would follow if they had concerns and would raise concerns to the RP. For example, the delivery driver provided examples of how they had raised concerns with the RP after seeing people at home who they identified as requiring further help. The pharmacist knew how to raise a concern locally and had access to contact details and processes.

## Principle 2 - Staffing Standards not all met

### Summary findings

Some team members are not actively undergoing training appropriate for their role in accordance with GPhC training requirements. And so, they carry out tasks for which they are not appropriately qualified. And the pharmacy could do more to support team member's learning and development. Pharmacy team members manage their workload well and support each other as they work. And they provide feedback on the pharmacy's services and implement change to help improve service delivery.

### Inspector's evidence

The pharmacy usually operated with two pharmacists working on the premises. On the day of the inspection the RP was one of the pharmacy's regular pharmacists. They were supported by a locum pharmacist who often worked in the pharmacy. There were seven team members present during the inspection which included two qualified dispensers, two trainee dispensers and a trainee medicines counter assistant. There were two part-time team members who worked in the pharmacy in between their formal education courses. One was enrolled on a pharmacy training course but had not accessed it for many months. And another was involved with receiving dispensary medicine orders and were also seen to hand out prescriptions during the inspection. They had been working at the pharmacy for many months but had not been enrolled onto approved qualification training. So some team members carried out activities without being enrolled on an appropriate accredited training course.

Team members who were enrolled on training courses were not provided with protected training time during their usual working hours. They completed learning in their own time. But they were unable to clearly demonstrate a learning plan for progressing with their qualification course. The trainee medicine counter assistant had recently attended face-to-face training alongside the SI for providing an ear-wax removal service. And they discussed their plan for completing supervised procedures before fully implementing the service.

Team members were seen to be managing the workload. Throughout the inspection, team members were observed working efficiently. They supported each other in completing various tasks. And they demonstrated a good rapport with many people who visited the pharmacy and were seen appropriately helping them manage their healthcare needs. Team members could cover each other's absences by working additional hours if required.

The pharmacy did not have a formal appraisal process, but team members felt able to make suggestions and raise concerns to the SI when required. Team members were encouraged to discuss ways to improve the way the pharmacy operated. When the pharmacy received a recent refit, team members described how they had been asked for their feedback on how the dispensary should be laid out. This had helped them reduce the risk of mistakes made during the dispensing process. And helped improve communication within the team by working in a more open dispensary environment. Pharmacy team members understood the importance of reporting mistakes and were comfortable openly discussing their own mistakes with the rest of the team to improve learning.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy premises are modern, clean and well-maintained. And are appropriate for the services it provides. It has two suitable, sound-proofed rooms where people can have private conversations with the pharmacy's team members.

### Inspector's evidence

These were average-sized premises incorporating a small retail area, dispensary with large dispensing robot and back shop area including storage space and staff facilities. The premises were clean, hygienic and well maintained. The pharmacy had clearly defined areas for dispensing, with a separate distinct area for dispensing multi-compartment compliance packs. This provided suitable space for the assembly of medicines. And the pharmacists used a separate bench to complete their final checks of prescriptions. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. The pharmacy's overall appearance was professional.

People in the retail area were not able to see activities being undertaken in the dispensary. The pharmacy had two good-sized consultation rooms, each with a desk, chairs, sink and computer. They were clean and tidy, and the door closed which provided privacy. It provided a suitable environment for the administration of vaccinations and other services. Team members supervised access to the rooms, and the doors had locks to prevent unauthorised access. The pharmacy also had a separate area for specialist services such as substance misuse supervision. Temperature and lighting were comfortable throughout the premises.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides a range of services that support local people's health needs, and it suitably manages its services to help people receive appropriate care. The pharmacy correctly sources its medicines, and it completes checks of them to make sure they are suitable to supply. The pharmacy team provides appropriate advice to people about their medicines.

### Inspector's evidence

The pharmacy had good physical access by means of a level entrance and team members had clear view of the entrance to help those who required assistance. It advertised some of its services and its opening hours in the main window. And it provided a delivery service. A team member prepared the day's deliveries in advance of the delivery driver collecting them and kept electronic records of these. This was useful if people called the pharmacy asking about their expected delivery. People signed to acknowledge the receipt of CDs. The delivery driver left a card through the letterbox if people were not at home when they delivered, which asked them to contact the pharmacy.

Pharmacy team members followed a logical and methodical workflow for dispensing with a dispensing robot used. The robot had three workstations and outlet chutes. Team members used baskets to separate people's medicines and prescriptions. And they attached coloured labels to bags containing people's dispensed medicines to act as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line or a CD that needed handing out at the same time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines.

The pharmacy supplied many people with their medicines using Medicines Care Review (MCR) serial prescriptions. The pharmacy dispensed these a week before people were due to collect them. Team members only prepared medicines taken regularly in advance. They attached collection slips to each prescription to act as a prompt for team members to check if people needed medicines that were used only as needed. These collection slips were filed at the end of each day and one team member used them to check that people's records were up to date and that the next collection date was accurate. This meant they could then identify any potential issues with people not taking their medication as they should. The pharmacy notified the GP practice for a further prescription when all episodes of the prescription were collected. And they added notes of any care issues identified. This helped make sure people's medicines were reviewed by their GP appropriately. Team members checked regularly for any prescriptions that had not been requested. They then communicated with the GP practice to ensure the prescription remained appropriate.

The pharmacy supplied medicines in multi-compartment compliance packs for people who needed extra support with their medicines. Pharmacy team members managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept master backing sheets for each person. These master sheets documented the person's current medicines and administration time. They also kept a record of previous changes to medication, creating an audit trail of the changes. Team members used the dispensing robot to collect the medication used for the packs. These medicines were checked for accuracy by the pharmacist before a team member assembled them in the packs. The pharmacist then carried out a second separate accuracy check. Packs were labelled so people had written

instructions about how to take their medicines. These labels included descriptions of what the medicines looked like, so they could be identified in the pack. And team members provided people with patient information leaflets about their medicines each month. Shelving to store the packs was kept neat and tidy.

Team members had knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. And they always dispensed valproate in the original pack. The pharmacy supplied patient information leaflets and patient cards with every supply. The pharmacy had patient group directions (PGDs) for smoking cessation, emergency hormonal contraception and the Pharmacy First service, which included treatment of urinary tract infections and hayfever. The SI provided a private travel clinic using private PGDs. They maintained electronic and paper records of consultations and any vaccines administered or medication supplied.

The pharmacy displayed Pharmacy (P) medicines behind plastic screens within the retail area. Notices on the screens advised people to seek staff assistance when they required a medicine from these areas. And people were observed doing this. The team stored higher-risk P medicines liable to abuse close to the medicines counter so they could be closely monitored. Team members followed the sale of medicines protocol when selling medicines under the pharmacist's supervision and referred to the pharmacist when appropriate.

The pharmacy obtained medicines from recognised suppliers. It stored the majority of its medicines in the dispensing robot. Medicines that were not suitable for use in the dispensing robot were stored in their original packaging on shelves in the dispensary. The pharmacy stored items requiring cold storage in two fridges. Both fridges were seen to be operating within the accepted range of 2 to 8 degrees Celsius. Team members knew what appropriate action to take if these went above or below accepted limits, but they did not always record the checks they made for both fridges every day. The dispensing robot carried out automated checks on the expiry dates of the medicines it held. Team members explained they regularly checked expiry dates of medicines in the dispensary. But they did not record these checks. A random selection of medicines inspected were found to be in date. The pharmacy had disposal bins for expired and patient-returned stock. It actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records about what it had done. 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 appropriate equipment and facilities to provide its services. It keeps these clean, tidy and well-maintained. The pharmacy uses its equipment in a way that protects people's confidential information.

### Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had access to the internet and a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines. The pharmacy's computer system was password protected. And information displayed on computer monitors was suitably protected from unauthorised view.

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 blood pressure meter and blood testing equipment. There were no records of calibrations or checks of the equipment. And there were older test machines with expired testing strips that were no longer being used in the second consultation room. But test strips and consumables that were in use were seen to be in date. Team members kept clean crown-stamped measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. Team members had access to service support for the dispensing robot, and it was serviced regularly. The pharmacy used an automated pump for measuring doses of substance misuse medicines daily. Team members cleaned it and poured test volumes at the start of each day. The pharmacy team kept clean tablet and capsule counters in the dispensary. The pharmacy stored paper records in the dispensary inaccessible to 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.