General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Parkhead Pharmacy, 26 Harbour Street, HOPEMAN, Morayshire, IV30 5RU

Pharmacy reference: 1042789

Type of pharmacy: Community

Date of inspection: 19/06/2019

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-compartmental compliance packs. It provides flu and travel vaccinations.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 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 the pharmacy maintains its services to a high standard. 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) in place and followed for all activities/tasks. They had been signed off by the pharmacy superintendent and read and signed by some but not all team members. Staff roles and responsibilities were recorded on individual SOPs. They had not been reviewed for a few years.

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. Team members were familiar with processes and what could not be done when there was no pharmacist present. They explained this to people as required.

The pharmacy managed workload carefully and this could be planned around the part-time opening hours of the satellite GP practice in the village. Prescriptions were dispensed and checked when the pharmacist was on the premises. 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 in place to address maintenance issues or disruption to services. The pharmacy did not undertake formal structured reviews of these, but team members described strategies to minimise repeat incidents. For example, labels were attached to shelves to highlight medicines that had changed pack size. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. They were very familiar with this, as it was a daily occurrence. They were fully aware of the difference between absence and no pharmacist signed in, as was usually the case.

The pharmacy had a complaints procedure and actively encouraged feedback through social media. 'What's important to you day' recently had been promoted on Facebook. A lot of responses were received, all positive. Several had commented on good communication, friendliness and effective liaising with the GP practice. The pharmacist planned to collate responses under different themes. He was going to have meetings with the pharmacy team to discuss what was important to people and do more of this.
The pharmacy ordered items that it did not normally stock in following requests. And specific brands of prescription medicines were kept for some people. The pharmacy displayed an indemnity insurance certificate, expiring June 2019.

The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log, but not all locum pharmacists where recording all required detail; 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, but not weekly as the SOP stated; controlled drug (CD) destruction register for patient returned medicines. The pharmacy backed up the electronic patient medication record each night to ensure data was not lost.

Staff members were aware of the need for confidentiality. They had read and signed a data protection policy. No person identifiable information was visible to the public. Confidential waste was segregated and shredded.

All team members had read safeguarding information. And local process and contact details were on the dispensary wall to raise concerns if necessary. A team member described a situation where the pharmacy team were concerned about a patient. The pharmacy contacted the GP practice and a social work review had been arranged. The various agencies worked together putting strategies in place to support the person. The pharmacy had a good relationship with the surgery, so they highlighted concerns and issues to each other. A few examples were described. Several were related to memory and medicines management.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough trained and skilled staff to provide pharmacy services during contracted hours. Pharmacy team members have access to training material to ensure that they have the skills they need. But this is not structured. 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

Staff working in the pharmacy: one part-time pharmacist (superintendent pharmacist), who worked full-time between two branches; one part-time dispenser working 24 hours over three days; two part-time medicine counter assistants, both registered on the dispensing course.

Typically, one team member worked with the pharmacist. But on Wednesdays and Fridays which were busier there were two team members. The GP practice functioned on Tuesdays, Wednesdays and Thursdays which impacted the pharmacy workload. The pharmacist was currently collecting data on dispensing volume for different days, especially Fridays and was reviewing staffing levels. The pharmacy was busier on Fridays, partly due to people paying for their newspapers which were sold from the premises. There were periods during the week when a team member was on the premises alone, when pharmacy services were not offered. Team members had scope to cover for absence, and one routinely worked one afternoon a fortnight in the other branch.

The pharmacy workload was affected by how busy the other branch was. This pharmacy ordered stock for the other branch, so a busy day there resulted in more stock to be handled. The pharmacy displayed its team members' certificates of qualification.

Staff members were observed to manage the workload, although as noted elsewhere some tasks sometimes fell behind e.g. date checking had not been done over the past few months, controlled drug running balances were not audited as per the SOP and there had not been opportunity to train the team on the requirements of the falsified medicines directive (FMD). There was also some risk associated with lone working.

The pharmacy did not provide regular protected learning time and there was no formal training or development in place. The pharmacist described on-the-job coaching and discussions with team members. And they were encouraged to read training material and information. All team members attended external events and courses occasionally. Recently they had attended a course provided by the Royal Pharmaceutical Society on the menopause. Sometimes team members undertook coursework in their own time at home. At the time of inspection, the preregistration pharmacist was on study leave. The pharmacy provided a half day per week protected learning for her. She shadowed the pharmacist as he moved between the two pharmacies. She had been given more responsibility throughout the year and now undertook most of the tasks that the pharmacist would usually do.

A team member worked alone on the premises for spells of three days per week. She had access to the dispensary (registered pharmacy) to check if prescriptions had been received and take phone-calls. Occasionally she dispensed medicines if the need was urgent, so that the pharmacist could check these

and supply them quickly on his return to the pharmacy. The local community knew the hours he worked and were often waiting for him. A team member described this as sometimes challenging. The owner and superintendent pharmacist recently reviewed the staff profile, considering increasing dispensing volume and the concerns of lone working. A locum pharmacist was due to work an additional two days per week starting in three months' time. This would address the lone working and provide additional pharmacy cover over the peak times in this pharmacy and the other part time branch. Team members described covering absence for each other.

The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter. All team members were comfortable owning up to their own mistakes and understood the importance of learning from these. There was constant sharing of information and discussion within this pharmacy and with the other branch two miles away. Team members phoned each other several times a day to share information. They also used a communication diary to leave messages for each other on various topics e.g. stock ordered or phone messages from other healthcare professionals. 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 are 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 the dispensary. Medication waiting to be collected was stored in the nonregistered area in a way that prevented patient information being seen by other people. This enabled medicines to be supplied when there was no pharmacist on the premises as a remote collection. People were not able to see activities being undertaken in the dispensary. The premises were clean, hygienic and well maintained. There were 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 premises had a large stock/storage room on the first floor. The pharmacy was alarmed, had CCTV, and 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 some people with high risk medicines. The pharmacy gets medicines from reliable sources 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 often triaged people's symptoms and signposted them to a variety of other services. These included GP, minor injuries clinic and charities. All team members wore badges showing their name and role.

The pharmacy team members followed a logical and structured process when dispensing. They managed their workload to reflect the opening hours of the GP practice. A dispenser assembled prescribed medicines when the pharmacist was on the premises. The pharmacist checked all items, which were then rechecked and placed in bags by the dispenser. They used baskets to separate patients' medicines. The dispenser used pharmacist information forms (PIFs) to inform the pharmacist of any clinical information such as new items. She placed a bag label onto the template and hand wrought the relevant information. Team members attached labels to bags of medicines to highlight any special instructions or storage. 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 the following day.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Patient information leaflets (PILs) were supplied, but not always monthly. The dispenser ensured that tablet descriptions were on packaging and the spine of the pack was labelled with the patient's name, date of supply and instalment number. The pharmacy stored these packs in a logical manner in the dispensary, except for the current week's pack which was stored with other medicines for collection in the nonregistered area of the pharmacy. This enabled packs to be supplied when the pharmacist was not present. People signed and dated a template on collection to provide an audit trail and ensure that one pack per week was supplied. A team member contacted the GP practice pharmacist if packs were not collected as expected. There was one person whose compliance could be erratic, and the pharmacy monitored this. Some people received a variety of other medicines by instalment. The pharmacy team dispensed these in their entirety and sealed each instalment into a labelled bag with the date of supply and instalment number.

The pharmacy supplied a lot of medicines from chronic medication service (CMS) prescriptions. The 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 prescription ended and invited them in for a review. He described some benefit and provided examples of interventions. The pharmacy was continuing to register people and the pharmacist used this opportunity to review medicines and discussed them with people.

The pharmacist undertook clinical checks and provided people receiving high risk medicines including valproate, methotrexate, lithium, and warfarin with appropriate advice and counselling. He also supplied written information and record books if required. The valproate pregnancy prevention programme was in place. The pharmacist had searched the patient medication record but there were no relevant patients prescribed valproate. The pharmacist was very involved in the development and implementation of the NHS non-steroidal anti-inflammatory drug (NSAID) care bundle. He had trained team members and implemented this. They gave written and verbal information was 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 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 chloramphenicol ophthalmic products. The pharmacist offered a complete travel service. Team members were trained and competent to complete paperwork to inform the pharmacist of travel plans. As the pharmacist was an independent prescriber he prescribed vaccines and other medication rather than using PGDs. He used the NHS PGDs for occupational health flu vaccination, so accessed the anaphylaxis training provided as part of this.

The pharmacist and pre-registration pharmacist delivered the smoking cessation service. One team member had expressed an interest in doing this, and another was interested in first aid. These were being explored with a view to improving access to these services. Team members were empowered to deliver the minor ailments service (eMAS) within their competence. But they were aware of warning signs e.g. repeat requests for antacids and referred these to the pharmacist. They managed self-limiting straightforward conditions such as hay-fever over a period of a few months.

The pharmacy was often the only medical provision accessible in the village, so the pharmacist responded to injuries and common clinical conditions. He was an independent prescriber, so had basic training in these as part of that qualification. He described only doing what he was competent at. For example, his knowledge of chest sounds was limited so he did not have a stethoscope and referred people to doctors for chest symptoms. 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 signposted to other services, having seen the patient. He sometimes advised coming back to the pharmacy later was there or going to the other pharmacy where he was working, 2 miles away.
The pharmacy was often the only medical facility available in the village, and the pharmacist administered first aid and try our symptoms, signposting to other services as appropriate. He dealt with several injuries and illnesses.

The pharmacy obtained medicines from licensed suppliers such as AAH. The pharmacy was not yet compliant with the requirements of the Falsified Medicines Directive (FMD). It had equipment, but the team had not been trained yet. The pharmacy kept a record of date checking but it had not been updated for a few months. Items inspected were found to be in date. The pharmacy stored medicines in original packaging on shelves/in drawers/cupboards. It kept tablets to treat diabetes on a separate marked shelf to reduce the risk of these being supplied in error. And it kept items requiring cold storage 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 (registered pharmacy). Team members did not supply these when the pharmacist was not on the premises. But they supplied general sales medicines which were stored in the loan registered area. They

followed the sale of medicines protocol. MHRA recalls and alerts were actioned on receipt and records kept. 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. It 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. It also had equipment to enable the pharmacist to respond to common clinical conditions. This included a pulse oximeter, blood pressure meter, digital thermometer and otoscope. And equipment and sundries required for vaccination. It had a carbon monoxide monitor maintained by the health board. It kept this equipment in the consultation room where it was used with people accessing pharmacy services. The pharmacy also had Crown stamped measures (including a separate marked one for methadone even though there was no-one currently supplied with methadone) and tablet counters in the dispensary. Paper records were stored in the consultation room and dispensary. 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.