General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lossiemouth Pharmacy, 34 Queen Street, LOSSIEMOUTH, Morayshire, IV31 6PJ

Pharmacy reference: 1042791

Type of pharmacy: Community

Date of inspection: 10/03/2020

Pharmacy context

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

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 Governance	Standards not all met	1.1	Standard not met	The standard operating procedures are out-of-date, no longer fit for purpose and therefore not read or followed by team members.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not identify team members' learning and development needs. And it does not provide them with time or resources to address their learning needs.
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 does not have up-to-date written processes to follow so there is a risk of mistakes as team members may not all follow the same procedures. They record mistakes to learn from them. And they review these and make changes to avoid the same mistakes happening again. The pharmacy asks people for feedback. And team members discuss this to make pharmacy services better. The pharmacy keeps all the records that it needs to by law, although some are incomplete. It keeps people's private information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which had been written in 2012 and reviewed 2014, over five years ago. Some team members had read and signed some of these. But the pharmacist acknowledged that as they were out of date and did not all represent processes in the pharmacy, it was not appropriate for team members to read these. 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 pharmacy did not display the government recommended show material regarding COVID-19. And team members had not discussed how they might manage people with symptoms presenting at the pharmacy. (The inspector provided basic guidance.)

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They recorded their own errors to help reinforce any learning. The pharmacist reviewed these monthly and tried to represent graphically using bar charts for type of error and pie charts for the time of day. She also sometimes individuals their own personal written feedback privately. She had not managed to complete this over the past few months as her time had been spent coaching and training a trainee team member. The pharmacy introduced strategies to minimise the same errors happening again e.g. separating amlodipine and amitriptyline. The pharmacist had recently ordered 'caution' labels to place on shelves in front of items involved in incidents here or elsewhere that she was aware of. Head office did not provide any shared information/learning, but the pharmacist was aware of some common incidents from industry media. The pharmacy had made an error with a multicompartment compliance pack recently and this had reached the patient. The pharmacist had undertaken a review and analysis of what to do and discussed this with all team members. She had asked them all to complete a learning event cycle. The team described the changes and improvements it had made to improve record keeping for multicompartment compliance packs to minimise the chance of this type of error happening again. But it had not updated the SOP, as it was not fit for purpose and did not reflect the process in the pharmacy.

The pharmacy had a complaints policy which was visible to the public. Team members welcomed feedback from people, and this was usually related to retail stock. The pharmacy ordered items for individuals e.g. incontinence pads. And took products into general stock following requests from the local community e.g. Calcough®. Team members use a white board to record items requested by people.

The pharmacy had an indemnity insurance certificate, expiring 28 September 20. The pharmacy

displayed the responsible pharmacist notice and accurately 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 pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost. Some team members did not record all the information required by law in the private prescription register. Some records were not facsimiles of prescriptions and some were incomplete, lacking dates, prescriber and addresses. Although not complying with legislation, this did not have an adverse effect people using pharmacy services.

Pharmacy team members were aware of the need for confidentiality. They all read information annually when renewing their employment contracts. They shredded confidential waste continually through the day. No person identifiable information was visible to the public. Team members had not read information or undertaken training on safeguarding. This had been highlighted in the previous inspection report. But the pharmacist had completed the NHS Education for Scotland (NES) child protection module. She was aware that local contact details were available on the Community Pharmacy Scotland (CPS) website. Team members had awareness of safeguarding issues to be aware of and how to manage them from previous employments. The delivery driver described an example from the previous day when she had concern for a person she delivered to. She told pharmacist who contacted the GP. The GP was going to alert the duty team and follow-up. The pharmacist was PVG registered.

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

Summary findings

The pharmacy has enough qualified or team members in training to provide safe services. But the trainees do not have time set aside to complete their courses. And the pharmacy team do not have time set aside to keep team members' knowledge and skills up-to-date. This could affect how well they care for people and the advice they give. Team members share information within the pharmacy to help keep the pharmacy safe. And they know how to raise concerns.

Inspector's evidence

The pharmacy had the following team members: one full-time pharmacist manager, a part-time delivery driver, and two full-time and two part-time dispensers. One was recently qualified and the other had been in the pharmacy around five months and was undertaking the Buttercups® joint medicines counter/dispensing assistant training. The pharmacy had reviewed staff levels when two full-time team members had left several months previously. It had employed four part-time team members to provide some flexibility during absence. They worked several consecutive days then had several days' off. The pharmacist explained that this was challenging as inevitably individuals 'de-skilled' during days' off. So, when there had been further resignations, she had recruited for set days. The pharmacy displayed some certificates of qualification. Team members were able to manage the workload. But it was sometimes challenging as the pharmacy provided a lot of prescription medicines from serial prescriptions. The pharmacy's staffing model was based on prescription numbers (which was typical) but this model did not always recognise the work involved in serial dispensing. The pharmacy typically had a pharmacist and either two or three team members. It usually had two on Mondays and Tuesdays. The team undertook routine tasks and other planned work towards the end of the week to relieve pressure on Mondays and Tuesdays.

The pharmacy did not provide learning time during the working day for trainee team members to complete coursework. And it did not provide time for team members to undertake regular ongoing training and development. Team members did not have development meetings or development plans in place. This was despite this being planned and documented on the action plan following the last inspection and un-met standards. But the pharmacist supervised trainees and provided continual coaching and help on the job. A trainee team member explained that it was easy to ask for help and the pharmacist and other colleagues always provided full explanations and demonstrations. Currently only the pharmacist and an experienced dispenser were trained and competent to deliver the smoking cessation service. The dispenser had received training within the past year. But the pharmacist had arranged for the NHS specialist to visit the pharmacy and train all team members. Team members were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

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. The team did not have formal meetings but discussed various topics during the working day. The pharmacist shared knowledge of incidents from elsewhere with team members. And she took appropriate action e.g. separating prednisolone and propranolol preparations and attaching

caution labels to shelf edges. But there was no evidence of sharing across the company which would have given opportunity for increased learning. The pharmacy did not have a formal mechanism for raising concerns, but team members gave appropriate responses to scenarios posed.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and suitable for the pharmacy services. The pharmacy is secure when closed. It has a room available for private conversations with people. But it is not in use as it is used for storage.

Inspector's evidence

These were small premises on a corner site with two access doors. One was generally not in use and was blocked with refuse bins at time of inspection. The medicines' counter was close to this entrance. So, people entering the pharmacy did not immediately see the medicines' counter and were naturally led to another till point. The premises were on two levels with the medicines counter and consultation room on the lower level. There was access at either end of the dispensary to both these counters. This meant that team members in the dispensary had to be vigilant to people at either counter. A monitor screen was in place to facilitate this. The premises included the dispensary, retail area, staff facilities and very limited storage space. The pharmacist explained that the pharmacy was planning alterations to this layout. She believed this would lead to improvements, including providing clarity around the medicines counter and providing an enclosed area for the management of multicompartment compliance packs. The premises were clean but untidy and cluttered in some areas. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs and sink. But it was untidy and cluttered, meaning that it was unlikely to be able to be used. The door closed providing privacy. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy team provides safe services. But team members do not have written processes to follow as noted elsewhere. Team members support people by providing them with information and suitable advice to help them use their medicines. And they provide extra written information to people to. The pharmacy obtained medicines from reliable sources and stores them properly. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a very low step and an automatic door. It displayed signage highlighting the step as a possible trip hazard. It listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as travel vaccination. It could provide large print labels for people with impaired vision. And other strategies were used such as lipreading, writing notes, using Google translate, writing days onto tablet packaging and repackaging medicines into bottles to help people with various limitations. The pharmacy provided a delivery service.

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. They sometimes shared information with the pharmacist verbally or using notes, such as new items or changes in medication. But they did not routinely look at the medication history and the computer system did not flag up new items. So, this information was limited. Team members explained that they relied on their memories. Some of them knew people using the pharmacy well, so were sometimes aware of their medication. New team members had less knowledge of people's medication. This meant that the pharmacist's clinical assessment and check was limited. The pharmacy had dedicated dispensing areas and checking bench. Team members stacked baskets of dispensed medicines at one end of the checking bench. And they highlighted items for people waiting so that the pharmacist could prioritise these. 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. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when people requested. And kept records of supply. It did not have a process in place to monitor compliance or check when medicines were due. If the pharmacist noticed any compliance issues at the time of supply, she discussed these with people and reinforced the importance of taking medication regularly as prescribed. Sometimes she contacted prescribers.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. Currently team members undertook this in the dispensary where they were sometimes interrupted to attend to the medicines counter or undertake other tasks. The pharmacist explained that hopefully this would be improved when alterations were made to the premises to provide a dedicated area for this activity. The team ordered prescriptions early in the week, ordered and gathered stock when prescriptions were received, and assembled them the following week. The pharmacy did not attach backing sheets firmly to packs, so there was a risk of these being detached or

removed. Then people would not know what tablets were in the packs. Team members included the start date and the day of supply on backing sheets. They also included basic tablet descriptions on backing sheets. But these were mostly not detailed enough to identify tablets. And they initialled sheets to provide an audit trail of who had pharmaceutically assessed, dispensed and accuracy checked the items. The pharmacy kept progress trackers to ensure all packs were assembled in a timely manner. And it kept records of who had collected packs – people signed and dated a template. And it kept records of changes, interventions and hospital discharges. As noted elsewhere, the pharmacy team had reviewed record-keeping following an incident and recently this had been changed and improved. The pharmacy stored completed packs banded together on labelled shelves in the dispensary. It had separate areas for packs supplied by delivery and collection. The pharmacy supplied patient information leaflets (PILs) with the first pack of each prescription. The pharmacy supplied four packs at a time to some people although the prescriptions stated, 'dispense weekly'. It did this to accommodate requests from people's relatives or carers. But prescribers had not given authority for this. The pharmacy had worked with some people and prescribers to monitor and improve compliance. The delivery driver uplifted the previous pack when delivering the current one. The pharmacist reviewed any medicines still in the pack and discussed these with patients and prescribers. She had devised techniques along with people to improve their compliance e.g. setting reminders on their phones. And she had noted that a person often remembered to take medication at sometimes of day but not others. So, working with the GP, formulations had been changed from short-acting to long-acting to be taken at times that people could remember.

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. The pharmacy did not supply valproate to anyone in the at-risk group. But the pharmacist explained that she was very vigilant when saw prescriptions for valproate . She always checked the person's age and sex. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle yes. Team members gave verbal and written information to people supplied with these medicines over-the-counter, or on prescriptions. They also discussed 'sick day rules' with people on certain medicines, so that people could manage their medicines when they were unwell. The pharmacy had the cards at the medicines counter, so they were easy to supply to relevant people. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, and emergency hormonal contraception. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. 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 and one dispenser delivered the smoking cessation service although it was not busy. They described successes if you months previously. And as noted above all team members were going to receive training to widen the service. The pharmacist and part-time team members measured people's blood pressure infrequently on request. The pharmacy did not have an SOP in place and the team members relied on their previous training as nurses.

The pharmacy obtained medicines from licensed wholesalers such as AAH and Ethigen. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy had the equipment on the premises and had been trying to comply. But it only had one computer on the premises, so using this for FMD scanning prevented the labelling and dispensing process. Also, team members could not scan the medication if the labeller was in use for a prolonged period e.g. generating the labels for multicompartment compliance packs. This caused too much of a delay for people waiting

for their medicines and slowed the whole dispensing process down. The team hoped to get an additional computer when the alterations took place. And then team members would be able to resume scanning medicines. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge and team members monitored minimum and maximum temperatures. They took appropriate action if there was any deviation from accepted limits. Team members 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 stored patient returned waste medicines in an open receptacle in the staff toilet area. The NHS contractor regularly uplifted these receptacles.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety 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.

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 equipment required to deliver pharmacy services in the consultation room. This included a carbon monoxide monitor maintained by the health board, and a blood pressure meter. The pharmacy did not use this often. It was not known if it had been replaced or calibrated recently. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone.

The pharmacy stored paper records in the dispensary inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. 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.