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: 21/06/2021

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. The pharmacy was inspected during the COVID-19 pandemic.

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

The pharmacy suitably identifies and manages the risks with its services, including reducing the infection risk during the pandemic. The pharmacy team members follow written processes for the pharmacy's services to help ensure they provide them safely. They record and review their mistakes to learn from them and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to by law and keep people's private information safe. Team members contact relevant services when they have concerns about vulnerable people.

Inspector's evidence

The pharmacy had put some strategies in place to keep people safe from infection during the COVID-19 pandemic. It did not have screens up at the medicines' counter, but team members had used tape to create a barrier keeping people a safe distance from the counter. It did not look very professional. And the pharmacy had tape on the floor to encourage people to socially distance. It allowed two people on the premises at any time. Most people coming to the pharmacy wore face coverings and team members all wore masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points several times during the day. A team member cleaned the consultation room immediately after use although it was not used often. Team members carried out lateral flow COVID tests twice weekly and had not had any positive results.

The pharmacy had standard operating procedures (SOPs) which were followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent or pharmacy manager reviewed them periodically and signed them off. Some, but not all had been reviewed since the last inspection. And some dates of review had not been updated which could be misleading. Staff roles and responsibilities were recorded on individual SOPs. 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 had a business continuity plan to address maintenance issues or disruption to services.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. And they recorded errors that had been identified after people received their medicines. They reviewed all near misses and errors each month to learn from them and they introduced strategies to minimise the chances of the same error happening again. This process had greatly improved since the previous inspection. Changes made following incident reviews included separating similar items and attaching warning labels to shelves.

The pharmacy had an indemnity insurance certificate, expiring 30 September 2021. The pharmacy displayed the responsible pharmacist notice and had an accurate responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited. It had a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. All records were accurate and up to date. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and they segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. They described several examples of intervention and working with local GPs to support vulnerable people manage their medicines and helping them to access other services. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. They are trained and competent for their roles and the services they provide. The pharmacy gives them time for training and development during the working day. Team members can make decisions within their competence to provide safe services to people. They know how to make suggestions and raise concerns if they have any to keep people safe.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager and two regular locum pharmacists covering days' off, two full-time and two part-time dispensers and a part-time delivery driver. The pharmacy displayed some certificates of qualification and one team member was about to sit her final assessment before qualifying. Typically, there were two or three team members and a pharmacist working at most times. At the time of inspection there were two and the pharmacist. One part-time team member was not currently working which was challenging at times. The pharmacist explained that the team was managing most of the time and requested help from head office occasionally. The delivery driver was currently on annual leave and recently a new driver had been employed to cover absence across the company. The new driver had not yet been registered on an appropriate training course and the inspector reminded the pharmacist of the requirement for this.

The pharmacy now provided learning time during the working day for all team members to undertake monthly training and development. And it provided team members undertaking accredited courses with additional time to complete coursework. Recently team members had completed face-to-face training on how to deliver the NHS smoking cessation service. 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. The pharmacist felt that the counter advice and sales was suffering during the current absence as team members did not always have time to spend with people. They demonstrated an 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. They could make suggestions and raise concerns to the manager. Team members described how they helped locum pharmacists to ensure that they followed the pharmacy's usual processes. An example of this was showing a locum pharmacist how to use the paperwork associated with multi-compartment compliance packs. The pharmacy team discussed incidents and how to reduce risks and continually discussed issues and concerns about medicines and people. Team members used a whiteboard to share information and remind them of tasks to be completed. This included tasks such as making changes to multi-compartment compliance packs to ensure they were done on time. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for the services it provides. It has suitable facilities for people to have conversations with team members in private. The pharmacy is secure when closed

Inspector's evidence

These were small premises on a corner site on a hill with two access doors on different levels. One was not in use and was blocked with refuse bins at time of inspection. During the pandemic the pharmacy had blocked access to the lower level to minimise people in the pharmacy. Previously the medicines counter had been on the lower level, but the pharmacy had relocated medicines close to the dispensary. The premises included the dispensary, retail area, staff facilities and very limited storage space. At the previous inspection a year ago, the pharmacist explained that the pharmacy was planning alterations to this layout which she believed would provide better facilities for the services provided. But this work had not been able to proceed during the pandemic. 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. The door closed providing privacy. The pharmacist was only using it occasionally during the pandemic. Often the pharmacy was quiet so she could have private conversations with people in the retail area. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to use its services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with suitable information and advice to help them use their medicines. And they provide extra information to people taking higher risk medicines. The pharmacy obtains medicines from reliable sources and stores them correctly. Pharmacy team members know 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. 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 and different sized baskets to differentiate between different prescription types and separate people's medicines and prescriptions. 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 day. The pharmacy sometimes supplied items, especially dressings and bandages, to the GP practice that were ordered on stock order forms (GP10A). These were wholesale transactions and it did not have a wholesale dealer's licence.

A lot of people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. These had greatly increased during the pandemic. Because these prescriptions were in use for six or 12 months, the items dispensed were not recorded and counted monthly. This made dispensing volume appear low some months. The pharmacy was currently dispensing these when people requested them. But the pharmacist explained that she and team members were discussing how these prescriptions were managed and exploring different options. Currently the pharmacy was not pro-actively monitoring compliance. This would involve devising a new process and reconciling medicines when people started serial prescriptions. When people requested their medicines, team members checked the date of the previous supply and highlighted any compliance concerns to the pharmacist. They had recently started supplying the exact quantity prescribed rather than a complete patient pack in some instances to try and synchronise items. The pharmacist carried out pharmaceutical care needs' assessments within three months of registration, as required by the service specification. The pharmacy had printed templates with the standard questions to facilitate this.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. They labelled packs with date of supply and tablet descriptions and supplied patient information leaflets with the first pack of each prescription. They kept robust records of medicines being ordered, labelled, dispensed and checked. This helped ensure that all medicines were prepared well in advance of the supply day. And team members kept records of changes to medication including who had requested the change and when it

was to be made. They ordered prescriptions two weeks in advance and labelled them on receipt. This gave plenty time to address any issues such as omissions or changes. They highlighted any issues to the pharmacist and contacted the GP practice if necessary. They also wrote the changes onto a whiteboard to ensure all team members were aware when they were assembling the packs. The pharmacy supplied a variety of medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. Except for medicines that were supplied daily as there wasn't space to store these. A team member dispensed these each day. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. They were stored in individually named baskets on labelled shelves. A pharmacist discreetly supervised some people taking their medicines on the premises. This was done in the retail area when there were no other people in the pharmacy.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, isotretinoin, 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. It had undertaken a search for people in the 'at-risk' group. The pharmacy did not supply valproate to anyone in this group. And it had the pregnancy prevention programme in place for isotretinoin. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care, emergency hormonal contraception (EHC), the Pharmacy First service, including two new conditions, and smoking cessation. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. 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. They captured personal and consultation details on a template to ensure all relevant information was shared with the pharmacist, and this reminded team members to record consultations on the computer as required by the service specification. During the pandemic the pharmacist had delivered some services remotely by phone. This had ensured service delivery while minimising footfall on the premises. Services delivered in this way included smoking cessation, urinary tract infection (UTI) treatment and supply of emergency hormonal contraception (EHC). The pharmacist carried out the consultation remotely and if appropriate, the team prepared medication ready for collection when the person came to the pharmacy. All team members had recently been trained to deliver the smoking cessation service although there were not many people accessing this service currently.

The pharmacy obtained medicines from licensed wholesalers such as Ethigen and AAH. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. And team members used space well to segregate stock, dispensed items and obsolete items. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if there was any deviation from accepted limits. Team members regularly 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 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 resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used. But it only had one computer which caused some challenges when providing some services such as Pharmacy First or unscheduled care if another team member was using the computer for labelling medicines. The pharmacist explained that another computer had been ordered.

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 carbon monoxide monitor maintained by the health board and a blood pressure meter. The team was not using this equipment during the pandemic to reduce the chance of spreading infection. Team members kept crown-stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary inaccessible to the public. And in a filing cabinet in the consultation room but people were never alone in this room. 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 did not leave 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.