General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Freefield Pharmacy, Burgh Road, LERWICK, Orkney & Shetland, ZE1 0HJ

Pharmacy reference: 1042799

Type of pharmacy: Community

Date of inspection: 23/05/2019

Pharmacy context

The pharmacy is in Lerwick, the main town and port of the Shetland Islands. The pharmacy dispenses NHS prescriptions and provides extra services. It collects prescriptions from surgeries in Lerwick and Scalloway when needed. And provides a delivery service to support housebound and vulnerable people. A consultation room is available, and people can be seen in private.

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 complete training and work to professional standards. They provide safe services and look after people. And senior pharmacy members carry out checks to make sure the pharmacy is running safely. The pharmacy keeps some records of mistakes when they happen. But, this could be improved upon to make sure that services develop and improve. The pharmacy keeps the records it needs to by law. It understands its role in protecting vulnerable people. And it provides regular training to keep confidential information safe. People using the pharmacy can raise concerns. And staff know to follow the company's complaints handling procedure. This means that staff listen to people and put things right when they can.

Inspector's evidence

A pharmacist manager had been in post for around two and a half years and was providing cover at the time of the inspection. The pharmacist had displayed the responsible pharmacist notice. And people could identify who was in charge.

The pharmacy team signed to confirm they followed standard operating procedures. And the procedures defined the pharmacy processes and staff responsibilities.

The pharmacy team signed dispensing labels to show they had completed a dispensing task. And this included assembly and accuracy checking prescriptions. The pharmacist checked prescriptions. And gave feedback to dispensers when they failed to identify their own errors. The pharmacy used an electronic system to record near-misses. But, the system could not be easily accessed, and not all the near-misses could be seen.

The pharmacist had reviewed the near-misses at the end of March 2019. But, only four had been recorded. The pharmacist stated that the dispensing robot was accurate. And that near-misses mostly happened when the pharmacy team put stock away in the wrong shelf location. The pharmacist had identified a fault in the robot when the wrong light had illuminated and the pharmacy team had placed stock in the wrong channel.

The dispensing robot was not capable of dispensing split packs. And these were kept in a series of drawers. The pharmacy team knew to take care when dispensing split packs to ensure that people did not go without their medication.

The pharmacist managed the incident reporting process. And the pharmacy team knew when incidents had happened and what the cause had been. For example, they knew about a mix-up with Novorapid and Novomix insulin products. And had agreed to take more care when selecting the products and to keep them separated in the fridge. The pharmacist had informed the locum pharmacist. But could not retrieve the incident report at the time of the inspection.

A complaints procedure ensured that staff handled complaints in a consistent manner. The pharmacy promoted the complaints process and displayed contact information to support people who wished to submit a complaint.

The pharmacy maintained the legal pharmacy records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy team kept the controlled drug registers up to date. And checked and verified the balance of controlled drugs at the time of dispensing. The checking process did not take account of slow-moving stock and did not identify any discrepancies that were in the system. The pharmacy recorded controlled drugs that people returned for destruction. The staff destroyed the controlled drugs on a regular basis. And recorded their names once completed. A sample of private prescriptions were up to date and met legal requirements. A sample of specials records were up to date. And the pharmacy team recorded the name of the person who had received the medication.

The pharmacists used patient group directions to improve access to medicines and advice. A sample trimethoprim patient group direction was valid until January 2020.

The pharmacy team completed data protection training during induction. And the pharmacy displayed a notice at the medicines counter so that people knew that their personal information was safeguarded. The pharmacy shredded confidential information. And archived spent records for the standard retention period. The pharmacy stored prescriptions for collection in drawers which were out of view of the waiting area. And computer screens were not visible. The pharmacy team took calls in private using a portable phone when necessary. And used individual passwords to restrict access to patient medication records.

The protecting vulnerable group scheme helped to protect children and vulnerable adults. And the pharmacy had registered the pharmacist with the scheme. The pharmacy team had read the Safeguarding Children and Young People in Shetland resource. And they knew to raise concerns when they recognised the signs and symptoms of abuse and neglect. The pharmacy team knew to refer concerns to the pharmacist. For example, one of the dispensers followed an elderly lady when she refused to speak to her. The lady went to a telephone box and on further questioning admitted to not knowing her own name. The dispenser called the police for help and looked after the lady until they arrived.

The pharmacy did not sell co-codamol and monitored requests for Nytol products. And this ensured that vulnerable people did not become addicted.

Public liability and professional indemnity insurance were in place and were valid until 30 April 2020.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And ensures it has the right number of pharmacy team members throughout the week.
The pharmacy team members support each other in their day-to-day work. They can speak up when there are problems and suggest service improvements when needed. The pharmacist updates team members when there are service changes. But there is limited access to ongoing training. This may prevent pharmacy team members from improving in their roles. And they may not always be up to date with developments.

Inspector's evidence

The pharmacy work-load had decreased over the past year. And this was due to a sister branch relocating from the centre of town to an edge-of-town location in August 2018. The pharmacy team levels had remained the same with cover provided to the sister branch when needed.

The pharmacy kept staff qualifications on-site so that evidence of accreditation was available. The pharmacy team was well-established and experienced. And the following staff were in post: one full-time responsible pharmacist; one full-time dispenser; one full-time trainee dispenser; one part-time dispenser; one full-time trainee medicines counter assistant; one Saturday trainee medicines counter assistant and one delivery driver covering both branches.

The pharmacy used a holiday planner to manage annual leave. And allowed only one member of staff to take leave at the one time unless there were exceptional circumstances. The pharmacy arranged cover when pharmacy team members were on leave. And a relief pharmacist provided regular cover across the three Shetland branches. A medicines counter assistant was working extra hours at the time of the inspection to cover for some-one who was on sick-leave. And the pharmacist had called on a retired medicines counter assistant who was also providing cover. A full-time medicines counter assistant was on maternity leave and a member of staff had been moved from the sister branch.

The pharmacist was providing support to a trainee dispenser who had enrolled on the NVQ pharmacy services level 2 course around three years ago. The dispenser had not contacted the training provider and could not confirm if the course was still valid.

The pharmacy owner did not use targets to develop services. And staff did not feel pressure to offer services.
The pharmacy did not use an annual performance review to develop staff. And the pharmacist updated the pharmacy team whenever there were changes. For example, when pregabalin and gabapentin were re-classified as Schedule 3 controlled drugs. And ensured that the pharmacy team asked people to sign for their prescriptions. The pharmacy had recently provided the pharmacy team with access to e-learning modules. But, there was no evidence of the pharmacy team having completed any of the modules.

The pharmacy team members raised concerns and provided suggestions for improvement. For example, they identified the need to increase the turn-around-time of care home prescriptions to provide more time for dispensing and checking. And this had been implemented. The pharmacist discussed queries with patients. And gave advice when handing out prescriptions.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean. And provide a safe, secure and professional environment for patients to receive healthcare.

Inspector's evidence

The pharmacy maintained and cleaned the premises on a regular basis. And a large well-kept waiting area presented a professional image to the public. The pharmacy provided seating in the waiting area. And the consultation room was organised and professional in appearance.

The pharmacy had sited the dispensing robot in the centre of the dispensary. And the dispensing benches were arranged so that the pharmacy team could easily load and retrieve products. The pharmacist supervised the medicines counter from the checking bench. And could make interventions when needed.

The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to the local area. It displays its opening times in the window. But does not always provide easy access to patient information leaflets. This may mean that people do not know what services and extra support is available to them. The pharmacy carries out dispensing in a safe and effective way. And makes arrangements to ensure that people do not run out of their medicines. The pharmacy sources, stores and manages its medicines and updates the pharmacy team about high-risk medicines. This means that team members know when to provide people with extra information.

Inspector's evidence

The pharmacy had developed and implemented a business continuity plan. And this provided the pharmacy team with a set of instructions in the event of staffing shortages.

The business continuity plan did not cover transport disruptions. And the pharmacy team monitored the weather to identify potential problems. The pharmacy kept stock levels high to manage the risk of the boat being cancelled. And liaised with other pharmacies and shared medicines when necessary. The GPs prescribed alternatives when needed.

People with mobility difficulties could access the pharmacy on a level surface. And an automatic door provided extra support.
The pharmacy provided a limited range of patient information leaflets for self-selection. With most being kept in the consultation room.

The pharmacy had experienced a reduction in its dispensing workload. And this was due to a sister branch re-locating from the centre of town to an edge-of-town location. The pharmacy team used dispensing baskets. And kept prescriptions and medicines contained throughout the dispensing process. The dispensing robot attached dispensing labels to medicines at the time of dispensing. And the pharmacy team carried out checks before passing to the pharmacist for a final accuracy check. The pharmacy team attached labels to prescription bags to communicate key messages to each other. For example, to highlight people suitable for the chronic medication service. The pharmacy dispensed a significant number of serial prescriptions. But, the standard operating procedure did not adequately inform the pharmacy team when dispensing should be carried out. And did not state what checks were needed to ensure that people were taking their medicines as intended. But, the pharmacist confirmed that he had advised the GP when people were not suitable for serial prescription dispensing.

The pharmacy dispensed prescriptions to a 20 bedded care home. And provided original packs and medication administration records to ensure that people were supported. The pharmacy provided a delivery service to housebound and vulnerable people. And made sure that people signed for controlled drug prescriptions to confirm receipt.

The pharmacy kept controlled drugs in a well-organised cabinet to avoid selection errors. And kept expired stock in bags that were labelled. The pharmacist held the keys to the controlled drug cabinets to restrict access. And placed the keys in a key safe at the end of the day.

The pharmacy team carried out regular stock management activities. And emptied the robot each month to check the expiry dates. The pharmacy team attached yellow stickers to highlight short-dated stock and crossed part-packs. The pharmacy team recorded the fridge temperatures. And demonstrated that the temperature had remained between two and eight degrees. The pharmacy team accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected.

The pharmacy team acted on drug alerts and recalls. And recorded the outcome, and the date they checked for affected stock. For example, they had checked stocks of co-amoxiclav in May 2019 with none found. The pharmacist had briefed the pharmacy team about the use of Valproate in people who may become pregnant. And they knew about the pregnancy protection scheme and where to find safety leaflets and cards. The pharmacist had carried out an audit and had not identified any patients that were in the at risk group.
The pharmacy had trained staff to follow the falsified medicines directive. And although the pharmacy had updated its software, it was not yet capable of implementing the new directive.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. A range of up to date reference sources are available to the pharmacy team. And, measuring equipment of a suitable standard is available.

Inspector's evidence

The pharmacy had been using a dispensing robot for five years. And a service contract ensured that a service was carried out twice a year. The service engineer covered the North of Scotland and was available for on-site visits at short notice. And the pharmacist and the dispenser had been trained to carry out emergency repairs.

The pharmacy had access to a range of up to date reference sources, including the British National Formulary (BNF). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures.

Cleaning materials were available for hard surface and equipment cleaning. And hand washing solution was available. The pharmacy sink was clean and suitable for dispensing purposes. The consultation room was clean and tidy. And the pharmacy protected people's privacy and dignity.

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.