General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 191 Rannoch Road, Letham, PERTH, Perthshire, PH1 2DP

Pharmacy reference: 1042837

Type of pharmacy: Community

Date of inspection: 19/08/2019

Pharmacy context

This is a community pharmacy beside other shops on a main road. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs.

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 follow processes for all services to ensure that they are safe. Team members record mistakes to learn from them. They use feedback from people to improve pharmacy services. The pharmacy keeps most of the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. 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. One dispenser described being less experienced with some processes such as the management of multi-compartmental compliance packs, so she was not currently involved routinely with this. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. An accuracy checking technician (ACT) checked collection service prescriptions and multi-compartmental compliance packs after the pharmacist had clinically checked these. The pharmacy had a robust process in place to ensure that the accuracy check could not be carried out before the pharmacist had clinically assessed prescriptions. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. It also displayed phone numbers on the wall for maintenance and useful contacts internally and externally.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They used an electronic tool, Datix which provided an analysis at the end of each month. Team members described sharing information about similar packaging. But they did not give examples of improvements made or learning from incidents. The pharmacist undertook root cause analysis following errors and one was observed from several months ago. This had resulted in a team discussion on how to manage dose changes for people on regular medication when the pharmacy had been notified of a pending change.

The pharmacy had a complaints procedure and welcomed feedback. The pharmacy had discontinued some items that were popular when the retail shelves had been changed a few months ago. Team members recognised that people still wanted to buy these, so kept a few items under the medicines counter. People knew that they had to ask for these as they were not on the shelves. People had asked about perfume testers, so the pharmacy had asked head office if these could be provided. They were only available during promotions.

The pharmacy had an indemnity insurance certificate, expiring 31 June 20. The pharmacy displayed the responsible pharmacist notice and 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. Team members signed any alterations to records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost. Some entries in the private prescription

register were incomplete, so did not comply with legislation.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to raise concerns locally and had access to contact details and processes. The pharmacy had a chaperone policy in place and displayed a notice telling people. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide services. The pharmacy compares staff numbers to how busy the pharmacy is and sometimes makes changes. This ensures appropriately skilled and qualified staff provide pharmacy services. Team members can share information and raise concerns to keep the pharmacy safe. They discuss incidents to learn from them. They have access to training material which they could make more use of.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, 1 full-time accuracy checking technician (ACT), 4 full-time and 2 part-time dispensers, and a part-time delivery driver contracted from a courier service. Typically, there were 4 team members and the pharmacist working. At the time of inspection there were three as a team member was on holiday. The pharmacy had not covered the holiday today as this was usually a less busy day. Team members were able to manage the workload. The pharmacy used rotas to manage staff levels depending on workload. Part-time team members had some scope to work flexibly providing contingency for absence. Each team member spent one day per week on the medicines counter. They described this as useful to prevent them losing the skills required when selling medicines and it helped them all to recognise people. A team member described some people trying to buy medicines intended for short use too often. She was able to share this information with the whole team and the pharmacist provided advice as appropriate.

The pharmacy provided protected learning time for all team members to read new SOPs or other mandatory material within the company. Team members had access to electronic learning modules on a range of topics but did not routinely use them. They had annual development meetings/appraisals with the pharmacy manager to identify their learning needs. They had development plans in place and objectives included working on areas where they were less confident. 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 and referred to the pharmacist when required.

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 or area manager. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. The team discussed a variety of topics ‘on the job’. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members explained that these were helpful, reminding them to offer services to people who would benefit.

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 hear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises that had benefited from a refit about a year ago. The layout was improved with the pharmacist checking bench overlooking the medicines counter and retail area. The back-shop area included limited storage space and staff facilities. The premises were clean, hygienic and well maintained. 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. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. 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 door was kept locked to prevent unauthorised access. The consultation room had a hatch which opened to the dispensary and was used for the supervision of self-administered medicines. The pharmacist unlocked the door using a buzzer in the dispensary to enable people to access the consultation room. 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 and advice to help them use their medicines. They provide extra written information to people with some high-risk medicines. And the pharmacist shares relevant information with people's doctors. This helps people get the best from their medicines.

Inspector's evidence

The pharmacy had one step and an automatic door at the entrance. Team members helped people with the step if necessary, but this was not often required. The pharmacy listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order, could provide large print labels and had low areas on the medicines counter. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines. Team members did not know how fridge items or controlled drugs were stored in vehicle.

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. Usually one team member labelled and another dispensed on a separate bench. The pharmacist and ACT had separate but defined checking benches. Dispensers supplied warning labels to the pharmacist which included interactions and new medication to help her undertake clinical checks. She signed the top left-hand corner of prescriptions that she clinically checked. The ACT could then carry out the accuracy check. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacist was observed to dispense while a dispenser was busy, and she asked the dispenser to check – both signed labels. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. A team member explained that the pharmacy stored dispensed medicines on retrieval shelves for four weeks, then sent a letter to people reminding them to collect their medication. If the person had not collected their medication after a further two weeks, a team member removed this and changed the electronic endorsement on prescriptions to ensure payment was correct. A team member contacted the GP practice to share this information if the pharmacist felt it was relevant. Team members followed a calendar so that they knew which ones to remove. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these a few days before expected supply. Team members then stored these on the retrieval shelves and contacted people if their medicines had been on the shelves for four weeks. This meant there was a possibility that patients could be without medication. The pharmacist explained that she discussed compliance with people, and some acknowledged that they did not always take their medicines and others had additional supplies at home. When people received their first CMS serial prescription, the pharmacy attempted to ensure that they did not have excess medicines at home. The pharmacist contacted the GP practice when poor compliance was suspected or confirmed. The pharmacy was actively registering people for this service, although some people were receiving prescriptions from the GP before the pharmacy had registered them. The pharmacist occasionally identified pharmaceutical care issues when discussing people's medicines with them as part of the registration process. These often included not attending the GP practice for regular check-ups or monitoring. The pharmacist advised people appropriately. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Four dispensers were involved with this process, each having their own group of patients.

This meant that there were competent individuals to take over this process during absence. They kept robust records including a tracker to monitor and confirm progress of prescriptions. And they recorded updates about changes to compliance packs that they received from GPs. When these were received a team member updated the dose regime template to ensure it was always accurate. But, sometimes the strength of tablet was overwritten on the sheet rather than making a new entry, meaning that was not clear if this was change or an error at the time of writing. The pharmacy put tablet descriptions on packaging and supplied patient information leaflets each month. Team members stored completed packs in individually named boxes per person on designated shelves in a back-shop area. A team member poured methadone instalments when people presented at the pharmacy using a 'Methameasure' pump. The pharmacist checked instalments and then either supervised self-administration or made the supply to the person to takeaway. Team members packed each instalment for taking away into a separate bottle. They included the intended date of consumption as well as the date of labelling. A pharmacist supervised consumption at the hatch in the consultation room. She asked people their address before making the supply. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these in entirety when prescriptions were received. Instalments was placed into sealed and labelled bags and the pharmacy kept these in labelled baskets on designated shelves.

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. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled them appropriately. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. 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 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. Team members provided examples of symptoms that they could treat and symptoms that they referred to the pharmacist. They explained that they always confirmed that the pharmacist agreed with their recommendations.

The pharmacy was part of the local NHS palliative care network. The pharmacist explained that they were not required to supply palliative items often but ensured that they always had stock available. A prescription was received, and medicines supplied during the inspection. Several team members were trained and competent to deliver the smoking cessation service. It was popular, possibly due to a local NHS incentive. The pharmacist provided the service to people who took Champix (the local NHS first line treatment), and other team members saw people on nicotine replacement therapy. They described a few recent successes.

The pharmacy obtained medicines from licensed wholesalers such as NDC, Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). Team members explained that they were due for a new PMR system in October and it would be implemented then. The area manager had recently told them they would have training just before that. The pharmacist explained that team members had read the SOP but would reread it as the system was implemented. They were all aware of the security aspects of FMD compliant packaging. The pharmacy stored medicines in

original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken 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 MHRA recalls and 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. The pharmacy 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.

The pharmacy kept a carbon monoxide monitor maintained by the health board in the consultation room where it was used with people accessing the smoking cessation service. Team members kept Crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy had a 'Methameasure' pump available for methadone use and this was cleaned at the end of each day. The pharmacist calibrated it each morning when she set it up, and at 1pm. She explained that it was usually accurate but sometimes temperature fluctuations in the pharmacy had a slight effect. She was observed doing this during the inspection. Team members stored clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in locked cupboards in the consultation room inaccessible to the public. 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.