General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 5-9 High Street, TAIN, Ross-Shire, IV19 1AB

Pharmacy reference: 1042861

Type of pharmacy: Community

Date of inspection: 22/09/2020

Pharmacy context

During the Covid-19 pandemic the pharmacy is mainly dispensing NHS prescriptions and delivering medicines to people at home. It supplies some medicines in multi-compartment compliance packs and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines use and supplies a range of over-the-counter medicines. It provides a seasonal flu vaccination service.

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 regularly updates its working instructions to keep its processes and procedures safe and effective. The pharmacy's team members sign the instructions to show they follow safe systems of work. They record and discuss their dispensing mistakes and then review the information to learn from them and manage risks. The pharmacy satisfactorily protects people's personal information and prevents sensitive information being seen by people who are not allowed to do so. Team members know the importance of their role in protecting vulnerable people. They also keep their legal records up to date.

Inspector's evidence

The company had been issuing regular safety updates since the start of the Covid-19 pandemic. The updates supported its team members in introducing new working practices. An area manager had been visiting the pharmacy every few weeks to support team members to implement the new practices to keep them safe. This included confirming they were wearing appropriate face masks as personal protective equipment (PPE). It also included carrying out individual risk assessments to identify team members that were disproportionately affected by the coronavirus. One team member had shielded at the start of the pandemic and had recently returned to work. Another had been supported to stay at home when someone else in their household had tested positive for the coronavirus. The pharmacist had contacted a dispenser who was employed on a zero-hours contract. They had provided backfill and supported the rest of the pharmacy team. A Perspex screen at the medicines counter created a barrier between team members and people visiting the pharmacy. Another Perspex screen in the consultation room protected the pharmacist and people receiving flu vaccinations. The pharmacy had restricted the number of people in the pharmacy to two at a time. Markers on the waiting-room floor showed people how to keep a two-metre distance from each other. Notices in the window provided public health information about virus transmission and how to protect against it. This included social distancing and the wearing of masks. Hand sanitizer was available at the entrance to the pharmacy and at various locations in the dispensary. Team members used it on a regular basis as well as washing their hands. The pharmacist and one other team member worked in the dispensary at the one time. The dispensary was small and not large enough for the team members to maintain social distancing. They minimised crossing over each other when working, for example, when they were removing stock from storage areas for dispensing.

The pharmacy had been inspected in July 2019, and an action plan had been issued to make improvements. The action plan had been updated and the necessary improvements were seen. The company kept its electronic working instructions up to date, and team members had read and signed them. This ensured their learning was up to date, and that services were safe and effective. The pharmacy had updated its business continuity plan and it was valid until March 2022. It included information to support team members in the event of service disruptions, for example it provided the IT helpdesk number for PMR problems. The pharmacy displayed the responsible pharmacist notice. It showed the name and registration number of the pharmacist in charge. The pharmacist in charge kept the responsible pharmacist record up to date. Team members signed dispensing labels to show they had completed a dispensing task. This helped the pharmacist support individual team members to improve their accuracy and manage dispensing risks. It also acted as an audit trail of who had been

involved in the dispensing process. Team members had been keeping records of their near miss errors throughout the pandemic. They had an awareness of the risks in the pharmacy and had separated products to manage selection errors, for example, the different formulations and strengths of co-codamol products. Team members had also attached ‘similar name’ stickers to shelves, for example to highlight sertraline and sumatriptan products. The pharmacist managed the incident reporting process, and they used the company's standardised report form to document the root cause and the improvement action taken. The company used a policy to define its complaints process. It trained its team members to follow the policy and to handle complaints in a sensitive and effective manner. Team members knew to refer dispensing incidents to the pharmacist for them to investigate and correct. Since the start of the pandemic people using the pharmacy had expressed their gratitude and appreciation of the pharmacy service. Letters and thank you cards were seen on display in the dispensary.

The pharmacy maintained the records it needed to by law, and public liability and professional indemnity insurances were in place and up to date. Team members recorded private prescriptions and those records met legal requirements. Specials records were kept up to date with details of each person who had received a supply. Team members kept the controlled drug (CD) registers up to date. They checked the balance of controlled drugs (CDs) once a week and kept records of each check in the CD registers. Team members recorded controlled drugs that people returned for destruction. The pharmacist and another team member recorded their name and signature against each destruction they carried out. The company trained its team members to protect confidential information. It displayed information about its data protection arrangements at the medicines counter. This provided people with the assurance that their information was safe and secure. Team members kept prescriptions for collection well-away from the waiting area so that people’s names and addresses could not be read by others. They disposed of confidential information in a designated container which was uplifted for off-site shredding. The pharmacist had registered with the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The company trained its team members to identify vulnerable adults and children. They knew when to refer concerns to the pharmacist to protect people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are qualified for their roles and the services they provide. The pharmacy supports its trainees in developing their skills. It also provides them with some protected learning time in the workplace to complete training courses. The pharmacy updates the team members about changes to pharmacy services when they arise. And it provides structured training so that team members continue to develop in their roles after they qualify. Team members support each other in their day-to-day work. They are enthusiastic and knowledgeable in their roles, and they suggest improvements to make services more effective.

Inspector's evidence

The pharmacy's workload had increased at the start of the Covid-19 pandemic. It had since returned to its previous level. The pharmacy team had remained the same since the last inspection, and team members were long-serving and experienced in their roles. The following team members were in post; one full-time pharmacist, one part-time pharmacy technician, one part-time dispenser, two part-time trainee dispensers and one part-time delivery driver. The two trainee dispensers had been making some progress with their courses. The company had arranged for extensions to complete the training courses with the training provider. This was due to the impact of the coronavirus and the extra burden placed on the pharmacy team. The pharmacist supported the trainees with their coursework. They also provided protected learning time in the workplace when it was quiet.

The pharmacist carried out individual performance reviews once a year. This ensured team members were competent to provide the services they offered. They also felt empowered to raise concerns and to provide suggestions for improvement. The company provided ongoing structured training for all team members to continue to develop in their roles. They had kept up-to-date with training throughout the pandemic. And they had learned and adapted to the new arrangements that were needed to manage the risk of coronavirus transmission. They had also learned about the new flu vaccination service before it had been implemented.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and hygienic and has suitable infection control arrangements in place. It has appropriate consultation facilities to meet the needs of the services it provides so that people can speak in private.

Inspector's evidence

The pharmacy displays service information in the window and keeps people up to date with changes. It provides public health information and safety information to help protect people from the coronavirus. The consultation room was in use at the time of the inspection to administer flu vaccinations. A Perspex screen with a cut-out section had been installed. This protected the pharmacist and person receiving the vaccination. The pharmacist administered a flu vaccination at the time of the inspection. They thoroughly wiped-down the Perspex screen, and the table and chair using sanitizer after the person left the room to manage the risk of cross-infection. The pharmacist described the pharmacy's new consultation arrangements to people when they wanted to speak in private. People had agreed to speak to the pharmacist on the phone from their homes or their cars when they needed to speak about confidential matters. This ensured their privacy and dignity was respected and protected.

The pharmacist supervised the medicines counter from the checking bench. This meant they could make interventions when necessary. The pharmacy had effective lighting, and the ambient temperature provided a suitable environment from which to provide its services. A cleaning rota had been introduced to ensure that work surfaces and public areas were cleaned on a regular basis, for example, the door handles that were in constant use. The pharmacy's team members were unable to maintain a two-metre distance from each other throughout the day. They had organised the dispensary to help them maintain as safe a distance as possible. There were usually only two team members in the pharmacy at the one time. They worked at separate benches opposite each other, and the medicines counter assistant worked at the front counter. Multi-compartment compliance packs were assembled on the dispenser's bench. They were taken to a secure rear room for safe storage once the pharmacist had checked them. This managed the risk of congestion in the dispensary. There was restricted access to the rear room which was kept locked. The team members used a keypad passcode to unlock the door and gain access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy stores and manages its medicines appropriately. Its team members act appropriately on receipt of safety notices and remove faulty medicines from use. They know the importance of making additional checks with people about their high-risk medicines. And when to speak with them about their medicines to help keep them safe. The pharmacy has satisfactory working instructions for team members to follow which helps them to deliver services in a safe and effective way.

Inspector's evidence

The pharmacy had step-free access and it provided unrestricted access for people with mobility difficulties. It displayed information in the window about the services it provided and included information about the seasonal flu vaccination service. The pharmacy promoted public health information. This helped to protect people from the coronavirus. The pharmacist used patient group directions (PGDs) to improve access to medicines and advice. They were familiar with the PGDs they used on a regular basis and kept hard copies in the pharmacy. A sample was checked and the trimethoprim PGD expired in October 2020. The pharmacist had recently started providing flu vaccinations in the pharmacy. They gathered the relevant information at the time people made an appointment when they could. This minimised the length of time people were in the pharmacy. The pharmacy had maintained a delivery service throughout the pandemic. The driver knew to keep a safe two metres distance away from people. And they placed items at the person's door until they were taken inside. They kept an electronic audit trail of the deliveries they made. The pharmacy had introduced a ‘text’ service. Team members sent a text to people to let them know their medication was ready for collection. This reduced the number of visits to the pharmacy. Team members knew about 'high-risk' medicines. They knew to check prescription bags for messages or extra information and to act accordingly. For example, to add fridge items, and to call on the pharmacist to counsel people to take their medicines correctly. Stickers were also attached to identify vulnerable people eligible for the flu vaccination service. Team members had completed e-learning about the valproate pregnancy protection programme. They knew where to find the safety leaflets and cards and when to issue them to people. The pharmacy's team members used dispensing baskets. They used these to keep prescriptions and medicines safely contained throughout the dispensing process.

Multi-compartment compliance pack dispensing was provided for around 30 people. The level of dispensing had stayed the same since the last inspection. Team members had read and signed the working instructions for dispensing packs. This helped them to assemble and dispense the packs safely and effectively. Team members dispensed packs on a four-weekly cycle. They used supplementary records to keep track of when packs were due. These were kept in four folders that corresponded to each week of the cycle. Team members updated the records following prescription changes. They kept a robust audit trail of changes should it be needed. Team members provided descriptions of medicines on the labels. This supported the person or their carer to identify the medicines inside. They supplied patient information with the packs. This helped people to take their medicines safely.

The pharmacy purchased medicines and medical devices from recognised suppliers. Team members carried out regular stock management activities and highlighted short-dated stock and split packs during regular checks. They attached coloured stickers to packs to show products with a short-expiry

date. Team members checked the fridge temperature every day. Records showed that the temperatures had remained in the safe range of between 2 and 8 degrees Celsius. Medicines had been kept according to the manufacturer's storage instructions. The pharmacy kept the fridges organised. They used one fridge for stock items and the other for assembled medication awaiting collection or delivery. Team members acted on drug alerts and recalls. They recorded the date they checked for affected stock and what the outcome had been. For example, they had checked for zopiclone tablets in September 2020 with no affected stock found. Team members knew about the Falsified Medicines Directive (FMD). But the company had not implemented the system. Team members accepted returned medicines for disposal. They placed the bags beside the container used for medicines waste and processed it for destruction 72 hours later.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. It keeps it clean and well-maintained. And it takes sensible precautions to help people use its facilities safely.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used crown-stamped measuring equipment, and the measure for methadone was highlighted, so it was used exclusively for this purpose. The pharmacy kept cleaning materials for hard surface and equipment cleaning. Members of the team kept the pharmacy sink clean and suitable for dispensing purposes. They kept computer screens out of sight of people in the waiting area and used a portable phone to keep personal conversations private. Team members wore face masks throughout the day, and they washed and sanitised their hands on a regular basis.

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.