General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newmachar Pharmacy, 17 Oldmeldrum Road, Newmachar, ABERDEEN, Aberdeenshire, AB21 0PJ

Pharmacy reference: 1090277

Type of pharmacy: Community

Date of inspection: 22/09/2020

Pharmacy context

This is a community pharmacy on the main road through the village of Newmachar. People of all ages use the pharmacy. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs and provides substance misuse services. This pharmacy was visited 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's team members follow written processes for the pharmacy's services to help provide them safely. The pharmacy has made some suitable changes to its procedures to help keep people safe when they are using its services during the pandemic. The pharmacy mostly keeps all the records that it needs to by law and keeps people's private information safe. Team members know how to find out who to contact if they have concerns about vulnerable people. They record some mistakes to learn from them, but don't review these regularly enough to identify common themes. So, they could be missing some learning opportunities.

Inspector's evidence

The pharmacy had put a few processes in place to try to keep people safe from infection during the COVID-19 pandemic. It had marked the floor to encourage people to socially distance and was restricting access to two people at a time. The premises were small and social distancing at the medicines' counter was difficult. And the pharmacy did not have a screen installed to add protection. It had hand sanitiser available for team members and people using pharmacy services. Team members washed their hands frequently and cleaned surfaces two or three times a day. The team had implemented a one-way system in the dispensary, involving rearranging its layout. But head office had asked for this to be reverted to normal. The dispensary was very small, making social distancing between team members impossible. They wore cloth face coverings. The pharmacy manager had identified team risks, including a team member who was vulnerable, and the increased risk potentially posed by a high number of locum and relief pharmacists working in the pharmacy. The team member at increased risk had good insight of this and maintained as much distance as she could from other people and washed her hands frequently. The pharmacy had a sign up in the dispensary reminding the team to do this.

The pharmacy had standard operating procedures (SOPs) which team members followed. They had been reviewed and updated since the previous inspection. Team members had read and signed them, and the pharmacy kept records of this. 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 pharmacist was very rarely absent. 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. It had 'useful' phone numbers on a notice on the dispensary wall for support, including other pharmacies and healthcare professionals.

Team members sometimes used near miss logs to record dispensing errors that were identified in the pharmacy, known as near-miss errors. This was an improvement from the previous inspection, but there was no evidence of records being made when the pharmacy manager was not working. In the action plan following the previous inspection the superintendent pharmacist (SI) stated that near miss logs were sent to head office each month. The pharmacy manager was not aware of this requirement and had not been doing this. There had been no request from head office. The pharmacy team also recorded errors reaching patients to learn from them and these were sent to head office. There had not been any recently. The pharmacy had not recorded many near misses over the past few months, so there wasn't enough data to review. But the pharmacist described incidents and strategies to avoid

repeat incidents. For example, packets that had been opened were being sealed with tape to avoid tablets falling out. As part of the drive to identify counterfeit medicines, manufacturers sealed packets, and they could not easily be securely closed after opening. Team members present during the inspection described incidents involving ramipril tablets/capsules, and the extra care they took when selecting these. The pharmacy had a complaints procedure and welcomed feedback. Team members could not think of any examples.

The pharmacy had an indemnity insurance certificate, expiring 30 September 20. The pharmacy displayed the responsible pharmacist notice and accurately kept the following records: responsible pharmacist log, although two locum pharmacists seldom completed this; 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 the records, so they were attributable. 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. The pharmacy had issued them with a staff handbook when they started working for the company, and it documented the company's confidentiality requirements. Team members segregated confidential waste and shredded it. No person identifiable information was visible to the public. Team members had not undertaken safeguarding training, except the pharmacist who had completed a child protection module. There was information about safeguarding within the patient group direction for the supply of emergency hormonal contraception. Team members knew where to look for phone numbers to raise concerns. The pharmacist was registered with the Protecting Vulnerable Groups (PVG) scheme which was managed by Disclosure Scotland.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough qualified and experienced staff to provide its services. The pharmacy does not set aside time for team members to continue their learning so they may find it difficult to keep their knowledge up to date. Team members know how to raise concerns if they have any.

Inspector's evidence

The pharmacy had the following staff: one part-time pharmacist manager (two days per week and alternate Saturdays), a regular pharmacist working alternate Saturdays only, one part-time dispenser (four days per week), one Saturday only medicines counter assistant and a part-time delivery driver. A variety of different relief and locum pharmacists covered the other three days each week. Sometimes this was challenging due to lack of continuity, and some pharmacists not familiar with processes in the pharmacy. Sometimes when the dispenser was absent, cover was arranged from other branches. Typically, there were one or two team members including the pharmacist working at most times. There was one at the time of inspection. Sometimes the pharmacist worked alone. Team members were able to manage the workload when there were two working. The Saturday team member was leaving over the next few weeks and a replacement had been recruited. But she was not trained. The pharmacist explained that the new team member would be registered on a course as soon as possible. The inspector signposted her to the GPhC website and new training requirements for pharmacy support staff from 01 October 20.

The pharmacy did not provide learning time during the working day for team members to undertake regular training and development. Team members present during the inspection explained that they tried to read promotional and other material that was delivered to the pharmacy. Since the previous inspection the focus had been on ensuring that all team members were trained to the required standard. Team members present at the last inspection no longer worked in the pharmacy. The pharmacist explained that they kept up with new products and were planning to ensure everyone was trained and competent to deliver the Pharmacy First service. The pharmacy had not pursued other training and development during the pandemic as the pharmacy had been too busy. Team members usually had annual development meetings with the pharmacy manager to identify their learning needs. Due to the pandemic she had not managed to do this yet this year. 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 pharmacy team discussed incidents when they occurred and how to reduce risks. Team members did not have structured meetings but discussed incidents as they worked. The company had a whistleblowing policy that team members were aware of. They knew who to address questions or concerns to but did not always get the outcome they hoped for. For example, a pharmacist had suggested installing a Perspex screen at the medicines' counter, but this had not been taken forward. The pharmacy did not have targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy's services. The pharmacy is usually suitable for people to have private conversations with team members. The pharmacy is secure when closed.

Inspector's evidence

These were very small premises incorporating a retail area, dispensary and staff toilet. The dispensary was very small and much tidier and more organised than it was at the last inspection. People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room. But it did not have a door. Following the last inspection, a curtain was hung, but the curtain pole had fallen off the wall. So, the room could still not be used due to lack of privacy. And the room was used for storage due to limited space in the pharmacy. The pharmacist explained that she was able to have private conversations with people in the retail area as the pharmacy was quiet. She stopped the consultation if anyone else came into the pharmacy. Temperature and lighting were comfortable. Team members were cleaning surfaces throughout the day including touch points. But there were few corporate strategies in place to protect them from infection. E.g. the pharmacy did not have protective screens up at the medicines' counter, unlike many other pharmacies and retail premises. There were sinks in the dispensary and toilet. These had hot and cold running water, soap, and clean hand towels. The pharmacy had storage space in an attic reached by a Ramsay Ladder which was not accessed during the inspection.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to easily access its services. It provides safe services. Team members support people by providing them with information and advice to help them use their medicines safely. And they provide extra written advice to people taking higher-risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. 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 level entrance and team members helped with the door if required. The pharmacy signposted people to other services such as travel and flu vaccinations. There had been little demand over recent months for travel vaccination, but the seasonal flu vaccination programme had just started. This pharmacy was not providing it and team members did not know what the arrangements were for local people. The pharmacist intended to contact the local surgery so she could inform people. At the time of inspection pharmacy team members were suggesting people called the surgery for details.

Pharmacy team members followed a logical and methodical workflow for dispensing. Most of the dispensing workload now came direct from the GP surgery with few 'walk-in' prescriptions. Most GP consultations were by phone with people to minimise footfall to the GP practice and GPs emailed prescriptions to the pharmacy. And then a pharmacy team member collected prescriptions later in the day. The pharmacy used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. The pharmacist usually labelled to carry out a clinical assessment, and the labelling ordered stock automatically. Locum pharmacists often didn't do this so sometimes there was a backlog of 'owings' towards the end of the week. The pharmacy usually assembled owings later the same day or the following day using a documented owings system for walk-in prescriptions. It did not document owings for collection service prescriptions. Team members had usually completed these by the time people came to collect their medicines. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacist explained that sometimes she had to dispense and self-check. This included dispensing methadone instalments which she attached warning labels to. She tried to have a mental break to create two distinct activities to reduce any risk of error. Some people received medicines from medicines care review (MCR) serial prescriptions. The pharmacy dispensed these a few days in advance and stored the dispensed medicines in a different area from other dispensed medicines. This enabled the pharmacy team to monitor compliance. If people did not collect their medicines as expected the pharmacy contacted the practice pharmacist. Team members noted people's names on a calendar to ensure medicines were ready on the expected date. The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. Team members assembled these the week before the first supply. The pharmacist undertook the prescription ordering, labelling and record keeping. She had tablet descriptions for most items on backing sheets. The dispenser placed medicines into packs and left packaging to facilitate the final accuracy check. The pharmacist sealed completed packs after checking. The pharmacy stored completed packs in cupboards in the dispensary. This was an improvement from the previous inspection when they had been stored in high cupboards in the retail area. This had posed a health and safety risk and potentially compromised people's privacy. The pharmacy provided patient information leaflets with the first pack of each prescription. It kept a

folder for each person containing their medicines' regime template and needs assessment form. But there was no list of medicine changes or interventions. A pharmacist supervised methadone consumption in the retail area as the consultation room was not in use. People did not mind this arrangement and the pharmacist described being discreet.

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. The pharmacist had counselled them appropriately and checked that they were on a pregnancy-prevention programme. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle. 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 team members had received training to enable them to provide this information. The pharmacist used labels attached to dispensed medicines' bags to highlight any storage requirements such as fridge, or to identify people that she wanted to speak to when they collected their medicines. 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. Team members had not yet had training to deliver the Pharmacy First service. So, they were delivering it in the same way they had for the previous minor ailments service. 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. She had undertaken the training and planned to cascade it to other team members.

The pharmacist described how she had delivered services throughout the pandemic while adhering to guidance and maintaining social distance. Where possible she had encouraged people to phone the pharmacy for consultations for services such as treatment of urinary tract infections (UTI) and the supply of emergency hormonal contraception (EHC). When appropriate and required, a team member dispensed the medicines ready to be collected to limit the time people were in the pharmacy. The pharmacy had recently started providing the smoking cessation service again and this was delivered by a pharmacist.

The pharmacy obtained medicines from licensed wholesalers such as Alliance, Ethigen and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy had the equipment on the premises. But team members had not had any training yet. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It used space well to segregate stock, dispensed items and obsolete items. It stored items requiring cold storage in a fridge and team members monitored minimum and maximum temperatures most days. 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 to deliver its services. The team 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 had a carbon monoxide monitor maintained by the health board to use with people accessing the smoking cessation service. But the pharmacy team was not using this during the pandemic for infection control. And it had crown stamped measures including separate marked ones used for methadone. It also had clean tablet and capsule counters including a separate marked one for cytotoxic tablets. The pharmacy stored paper records in the dispensary inaccessible to the public. And it stored prescription medication waiting to be collected in a way that prevented personal information being seen by other people. 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.