General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Graeme Pharmacy, 124 High Street, BIGGAR, Lanarkshire, ML12 6DH

Pharmacy reference: 1090498

Type of pharmacy: Community

Date of inspection: 14/03/2024

Pharmacy context

This is a pharmacy in the town of Biggar in the Scottish Borders. Its main activities are dispensing NHS prescriptions and providing NHS services including the Pharmacy First Plus and Pharmacy First service. It provides some people with their medication in multi-compartment compliance packs to help them take their medicines correctly.

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

Overall, the pharmacy manages the risks with its services appropriately. Team members record errors they make during the dispensing process to help prevent the same error occurring again. They keep necessary records required by law and they keep people's private information secure. They have appropriate training to help them respond correctly to support vulnerable people. The pharmacy has written procedures to help team members provide services safely and effectively. But these do not cover all of the services it provides. And so it may be difficult sometimes to make sure team members are working in a consistent way.

Inspector's evidence

The pharmacy's newly instated superintendent pharmacist (SI) was in the process of reviewing the pharmacy's standard operating procedures (SOPs). There were SOPs for controlled drug (CD) management, responsible pharmacist (RP) and dispensing SOPs. The SI had signed SOPs to confirm he had completed a review of them within the last year. Team members had signed the SOPs in December 2023 to say they had re-read and understood the SOPs. There were no SOPs for the NHS Pharmacy First Plus service or for the management and dispensing of multi-compartment compliance packs. The SI confirmed he would introduce these SOPs as part of the ongoing review.

The pharmacy recorded errors identified during the dispensing process known as near misses. These were recorded by the pharmacist and highlighted to the person who made the error. Records seen captured the details of what the error entailed, such as a wrong strength given, but did not include any actions taken or learnings from the error. This meant opportunities to learn from the error may have been missed. The SI undertook a review of the data produced every six months to identify any common trends in errors made. And they had informal discussions with team members as to the common errors made. Changes had been made to reduce the risk of a further error, for example, prednisolone and propranolol had been separated in the dispensary. And the team displayed a warning sign where medicines beginning with "A" such as amlodipine and amitriptyline were kept, alerting dispensers to "stop and think" when dispensing these medicines. The pharmacy recorded details of errors that were identified after a person had received their medicine, known as dispensing incidents. These were recorded on an online platform and the team completed a root cause analysis as part of the learning. The pharmacy aimed to resolve any complaints or concerns informally. If team members were unable to resolve a complaint the SI pharmacist was available in the pharmacy to manage them. The pharmacy reported that they had good relationships with people who accessed the pharmacy's services and were given cards expressing people's gratitude for their help and assistance.

The pharmacy had current professional indemnity insurance. Team members understood the tasks they were responsible for and were observed working within the scope of their roles. They had some knowledge of which tasks could and could not take place in the absence of the RP. For example, they knew that prescriptions could not be handed out and pharmacy only (P) medicines could not be sold, but they they thought it was acceptable to dispense prescriptions. This was discussed during the inspection. The RP notice was prominently displayed in the retail area and reflected the correct details of the RP on duty. The RP record was compliant. The pharmacy had recently changed to recording the receipt and supplies of its CDs electronically. The entries checked were in order. Team members checked physical stock levels of CDs matched the running balance in the CD register on a weekly basis.

The pharmacy recorded details of CD medicines returned by people who no longer needed them. And these were destroyed in a timely manner and the destruction was witnessed. The pharmacy kept certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. It kept complete records for its supply of private prescriptions and kept associated paper prescriptions.

The pharmacy had a privacy notice and an NHS data processing notice displayed in the retail area which informed people of how their data was used. Team members had read SOPs relating to information governance (IG) and general data protection regulations (GDPR). And those currently in training received additional training as part of their qualification courses. The pharmacy separated confidential information and shredded it. Team members had received training about safeguarding vulnerable adults and children. And they confirmed they would refer any concerns to the pharmacist. The pharmacist explained they would liaise with a person's GP or with a known relative if needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large team, who have suitable skills to provide its services. Team members who are working towards a qualification for their roles, receive suitable support and supervision. Team members support each other to further develop their skills and knowledge and to manage the workload. They ask appropriate questions when helping people with their healthcare needs. And they feel comfortable to raise concerns if required.

Inspector's evidence

The pharmacy team included the SI, a second pharmacist who was the RP, four dispensers, two of whom were trainees and three medicines counter assistants. Additional staff, not working, included another trainee dispenser and two medicines counter assistants, one of whom was a trainee. Team members had completed, or were in the process of completing, accredited qualification training for their roles. And this was overseen by the regular full-time pharmacist. Trainees received protected learning time to help them complete their qualification training in a timely manner. Other team members developed their skills and knowledge by learning from the pharmacists and by reading pharmacy magazines. And they explained their most recent training involved learning about the updated legislation for supplying valproate in original packs. The SI was an independent prescriber (IP) and had been trained to use an otoscope. The regular pharmacist had signed patient group directions (PGDs) declaring their competency to give advice and treatment under the NHS Pharmacy First service. Some of the PGDs available had not been signed by the SI but he confirmed he had signed other copies previously. The SI explained he had assessed his own competency to deliver the NHS Pharmacy First Plus service and would refer any people he did not feel competent to treat to the GP. This included very young children. The SI ensured they followed governance and clinical pathways provided by the local Health Board.

Team members were observed working well together to manage the workload. They supported each other and asked each other questions to help resolve queries. Annual leave was planned in advance so that contingency plans could be arranged. This included part-time team members increasing their hours to support periods of absence. And the pharmacists covered each other’s holidays with support from locums when required. Team members felt comfortable to raise concerns with management if required. Team members asked appropriate questions when selling medicines over the counter. They knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. They referred such requests to the pharmacist who had supportive conversations with people. The pharmacy did not set its team members targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services it provides. It has appropriate facilities where people can have private conversations with team members.

Inspector's evidence

The pharmacy premises portrayed a professional appearance. It had a large retail area to the front. The dispensary was situated to the rear of the pharmacy and was spacious, with stock arranged neatly on shelves in alphabetical order. There were other rooms used for storage and for team member's breaks. The pharmacy had a medicines counter which was tidy and acted as a barrier to help prevent unauthorised access to the dispensary. The medicines counter provided privacy for dispensing activities to take place without distraction. There was an organised workflow in the dispensary and there were different benches for the completion of different tasks. The pharmacist's checking benches were positioned to allow effective supervision of the dispensary and the ability to intervene in conversations at the medicines counter if necessary. The dispensary had a sink which provided hot and cold water and was used for professional use. The pharmacy was cleaned regularly by a cleaner. Toilet facilities were clean and had separate handwashing facilities. The temperature was comfortable, and lighting was bright throughout. There were empty medicine containers in front of a rear fire exit and ensuring this was kept clear was discussed.

The pharmacy had a soundproofed consultation room which allowed people to have private conversations and access services. It had a desk, chairs and a computer. A second consultation room was not in use.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages the delivery of its services safely and effectively. And it makes them easily accessible to people. Team members complete checks on medicines to ensure they remain fit for supply. And they respond appropriately when they receive alerts about the safety of medicines.

Inspector's evidence

The pharmacy had level access from the street to help those using wheelchairs or with prams. It advertised the range of services it provided in the retail area. And it had healthcare leaflets for people to read. Both pharmacists provided the NHS Pharmacy First service and accessed the most up to date PGDs for the service online. As an IP, the SI provided the NHS Pharmacy First Plus service and kept records of each consultation on the pharmacy's computer system. The record of the consultation, known as a SBAR, were shared with the person's GP so their records were updated.

Team members put people's medicines into paper bags after they had dispensed them and attached the prescription to the bag. The bags were left unsealed and passed to the pharmacist for checking. Team members explained this helped keep the items and prescriptions together to prevent them becoming mixed up and meant baskets did not take up space in the dispensary. Some baskets were used for certain medicines, including medicines that were dispensed weekly. Team members signed dispensing labels to confirm who had dispensed and who had checked prescriptions so there was an audit trail of those involved in each stage of the process. Stickers were used to highlight the inclusion of items such as CDs. Team members were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicine safely. The pharmacy kept records on the PMR of discussions they had with patients about valproate. Team members were observed completing suitable checks when handing out medicines to people to ensure they had been issued to the correct person. They informed people when the full quantity of their prescription could not be provided. For any medicines that were out of stock, team members provided alternatives where possible in agreement with the GP or referred people back to the GP if there wasn't a suitable alternative.

The pharmacy dispensed medicines as part of a substance misuse service. Team members prepared the medicines one week in advance, so they were ready for people to collect. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. The regular pharmacist organised the service and ordered prescriptions in advance which allowed time to resolve any queries. And they prepared the packs ahead of time when going on annual leave. Each person had a medication record sheet which detailed the medicines taken and dosage times. Team members did not provide descriptions of the medicines on the packs which would help people identify them. They provided people with patient information leaflets (PILs) when they first dispensed the compliance packs. And following that they only supplied PILs for newly prescribed medication.

The pharmacy sourced its medicines from licensed wholesalers and stored medicines in the original manufacturer's containers. Pharmacy only (P) medicines were stored behind the medicines counter which helped ensure the sales of these were supervised by the pharmacist. Team members had a process for checking the expiry date of medicines. They completed monthly checks of the expiry dates

of all medicines in the dispensary and kept a record of when medicines were due to expire. And at the end of the month medicines going out of date in the next month were removed from stock. A random selection of several medicines found all to be within their expiry date. The pharmacy had three fridges to store medicines that required cold storage. Team members recorded the temperatures daily and the records showed the fridge was operating between the required two and eight degrees Celsius. Team members received notifications about drug safety alerts and medicine recalls via email from various sources including the Health Board, wholesalers and GP surgeries. These were printed, signed to say they had been actioned and filed for reference. If the alert was for a medicine the pharmacy did not supply, the recalls were filed electronically in an email folder. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members mostly use the equipment and facilities in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to online resources including the British National Formulary (BNF) and British National Formulary for children (BNFc), Health Board clinical guidelines and Stockley's interaction checker. The SI had an otoscope and thermometer used in the NHS Pharmacy First Plus service. The pharmacy had crown stamped glass measuring cylinders which were marked to identify which were for water and which were for liquid medicines. And it had triangles used to count tablets and an electronic pill counter machine, which team members were observed cleaning between use.

The pharmacy had a cordless telephone so that conversations could be kept private. And it mostly stored medicines awaiting collection within the dispensary so that people at the medicines counter could not see people's private information. Confidential information was secured on computers using passwords. Screens were positioned in the dispensary and prevented unauthorised people from seeing confidential information.

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.