General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sutherlands Pharmacy, 43 Victoria Street, KIRKWALL, Orkney, KW15 1DN

Pharmacy reference: 1093183

Type of pharmacy: Community

Date of inspection: 21/07/2022

Pharmacy context

This is a community pharmacy in Kirkwall. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs).

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

Pharmacy team members follow good working practices. And they appropriately manage dispensing risks to keep services safe. The pharmacy documents some mistakes team members make, and they learn from them to improve the safety of services. The pharmacy keeps the records it needs to by law, and it suitably protects people's confidential information.

Inspector's evidence

The pharmacy had introduced processes to manage the risks and help prevent the spread of coronavirus. The pharmacy provided hand sanitizer at the entrance for people to use. And pharmacy team members had access to supplies throughout the dispensary. A plastic screen at the medicines counter acted as a protective barrier between team members and members of the public. And the pharmacy team wore face masks throughout the day. This helped to protect colleagues from infections. The pharmacy used documented working instructions (SOPs) to define the pharmacy's processes and procedures. And team members had recorded their signatures to show they had read and understood them. A new trainee pharmacist had recently started at the pharmacy. And they were reading the procedures as part of the pharmacy's induction process. Sampling showed the superintendent pharmacist had last reviewed and authorised the procedures in January 2020. This included 'responsible pharmacist', 'controlled drug' and 'ACT checking' SOPs. The pharmacy had authorised two 'accuracy checking technicians' (ACTs) to conduct final accuracy checks. They knew to confirm that a pharmacist had approved each prescription. And to look for the pharmacist's signature which they annotated on each prescription. The pharmacist was conducting a review to assess the safety and effectiveness of electronic annotations. But the pharmacy continued to use manual annotations until the review was complete. Pharmacy team members signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist and the ACTs were able to identify dispensers to help them learn from their dispensing mistakes and so the pharmacy had an audit trail for dispensing.

The pharmacist and the ACTs recorded some near miss errors. But the records did not reflect the levels perceived by the team members. The pharmacist reviewed the records to identify areas for improvement. Previous reviews had identified risks associated with parallel import (PI) medications. The PI packaging did not include barcode information. And team members had to attach barcode labels for an automated dispensing machine to dispense. Team members knew to take greater care when attaching the barcode labels to manage the risk of labelling errors. The pharmacy team also identified that the 'arm' of the automated dispensing machine sometimes accidently moved the shelving. And this had led to selection errors. Although the company had not introduced a complaints policy for team members to refer to. They knew how to manage complaints. And they knew to record dispensing incidents on the company's report template which they shared with the superintendent pharmacist.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurances in place which were valid until 30 April 2023. The pharmacist displayed a 'responsible pharmacist' (RP) notice, and it was visible from the waiting area. The RP record showed the time the pharmacist took charge of the pharmacy. But it did not always show the time they finished at the end of the day. The company had introduced an electronic controlled drug register in 2021. Team

members kept the registers up to date. And they checked and verified the stock balances once a month. People returned controlled drugs they no longer needed for safe disposal. And an electronic destructions register showed the pharmacist had confirmed that destructions had taken place. Team members filed prescriptions so they could be easily retrieved if needed. And records of supplies against private prescriptions and supplies of 'specials' were up to date. The company had defined 'data protection procedures' to help keep information safe and secure. Team members knew to keep confidential information well-away from the medicine counter. And they used a shredder to dispose of confidential waste. Team members knew how to manage safeguarding concerns. And they knew to speak to the pharmacist whenever they had cause for concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And they complete some relevant training to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's workload had increased significantly over the course of the pandemic. The superintendent had kept the staffing levels under review. But they had not found it necessary to increase the number of team members that worked at the pharmacy. The pharmacy team was well established. And it included one full-time pharmacist, one full-time pharmacy technician, one part-time pharmacy technician, one full-time dispenser, one part-time dispenser, one full-time medicines counter assistant, one part-time medicines counter assistant, one trainee pharmacist and one part-time delivery driver. Team members could call on support from another two branches when they had staff shortages. And the superintendent pharmacist and a regular locum pharmacist provided cover when needed. The pharmacy replaced team members when they left. And it had recently appointed a new medicines counter assistant. Team members discussed their annual leave requirements to ensure there was sufficient cover. And only one dispenser was authorised to be off at the one time. The pharmacist supported team members in training. And currently they were supporting a dispenser who was undertaking the 'accuracy checker' course. The dispenser had completed the underpinning knowledge module. And they were in the process of checking prescriptions under the supervision of the pharmacist. They were required to demonstrate accuracy in checking and were in the process of checking 1000 items. The pharmacist provided ongoing support to help team members develop in their roles. And they informed team members whenever there were changes or when new services were introduced. For example, they had printed off the NHS Pharmacy First formulary and instructed team members to read it following changes. The pharmacy had recently introduced the 'medicines care review' service (MCR) in the past year. And the pharmacist had trained team members to manage serial prescription dispensing. The process had evolved over the past year as team members had identified improvements to make the service more effective. A new trainee pharmacist had recently taken up post. And the pharmacist and the trainee were awaiting receipt of the training materials from NHS Education for Scotland (NES). Team members were supporting the trainee pharmacist during their induction. And they ensured they had read and signed the relevant pharmacy SOPs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises adequately support the safe delivery of services. And the pharmacy suitably manages the space for the storage of its medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

Team members processed prescriptions at two PMRs that faced directly onto the waiting area. Following a risk assessment team members reported the need for barriers in front of the PMRs. This had helped to manage distractions and the risk of disclosure of confidential information. Chutes from the automated dispensing machine were located above a long dispensing bench opposite the PMRs. The pharmacy had a series of drawers under the bench for storage, and this helped the team members to keep the bench tidy and free from clutter. This included dedicated drawers for multi-compartment compliance packs. The pharmacy used dispensing baskets to keep prescription items well-contained. This managed the risk of items becoming mixed up. The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary. A sound-proofed consultation room was available. And it provided a confidential environment for private conversations. A sink in the dispensary was available for hand washing and the preparation of medicines. And team members cleaned and sanitised the pharmacy on a regular basis. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate upstairs area was used for comfort breaks. This allowed team members to remove their face masks without being at risk of infections.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services to help people receive appropriate care. It gets its medicines from reputable sources. And it keeps some records to show it manages its medicines properly. But it only has some of the necessary controls in place to provide assurance it keeps its medicines safe and secure.

Inspector's evidence

The pharmacy advertised its services and opening hours in the window. It had two entrances that were step-free and had automatic doors. And its rear entrance faced onto a car park. This provided unrestricted access for people with mobility difficulties. The pharmacy used an automated dispensing machine. And team members kept stock neat and tidy on a series of shelves. They kept the controlled drug cabinets well organised. And they had sufficient space to keep items safely segregated. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members carried out an expiry date check once a month for items they kept on the shelves, although they did not document this. Sampling showed that items were well within their expiry date. Team members checked expiry dates when they received items into stock. And items with an expiry date of less than six-months were not placed inside the automated dispensing machine. The machine automatically applied a six-month expiry date to each item. And once a month team members instructed the robot to eject items after six months. They checked the stock and either reloaded it or disposed of it if it had reached its expiry date. The pharmacy had two fridges to keep medicines at the manufacturers recommended temperature. Team members used one of the fridges for assembled items and the other for general stock. Both fridges were tidy and well organised. At the time of the inspection the temperature was within the accepted range of 2 and 8 degrees Celsius. But team members could not provide evidence that they had checked the temperature every day. They had recorded the last temperature check on 12 July 2022. And had not kept any records in May and June 2022. This contravened the pharmacy's SOP. Team members knew about valproate medication risks and the Pregnancy Prevention Programme. And they knew to always provide original packs which contained patient information leaflets and warning information cards.

The pharmacist provided access to 'prescription only medicines' via 'patient group directions' (PGDs). And they kept 'hard copies' of the PGDs in a folder that were easy to access. Sampling showed the PGD for trimethoprim was valid until 2022, but it did not state the month it expired. The pharmacy supplied medicines in multi-compartment compliance packs to support people. And the pharmacy had defined the assembly and dispensing process in a documented procedure for team members to refer to. The pharmacy also used supplementary records which contained a list of the person's current medication and dose times which they kept up to date. Team members checked new prescriptions against the records for accuracy before they started dispensing packs. And they produced a sheet that listed the medications in each pack. The sheet contained all the relevant information and met labelling regulations. It also provided descriptions of each medication and what time of day to take them. But team members placed the sheets inside of the packs instead of making sure they were securely attached to them. And there was a risk they would become separated and lost and people would not have the instructions they needed to refer to. The pharmacy had recently started providing the 'medicines care review' service (MCR). And team members dispensed serial prescriptions from two

surgeries. They kept the serial prescriptions filed in a separate folder. And each week they retrieved and dispensed the prescriptions that were due. Team members dispensed instalments of medication in advance of it being needed. And they obtained accuracy checks at the time of dispensing and again at the time of supply. The pharmacy provided a prescription delivery service to people that lived on the other islands within the Orkney archipelago. Team members placed the items in totes that they secured with numbered seals. And the delivery driver took them to the pier for onward delivery by an approved courier. The courier delivered the totes to GP practices and people collected their prescriptions from the practices. The pharmacy kept an audit trail of the prescription deliveries. And people knew to contact the pharmacy to discuss their medication. Team members accepted unwanted medicines from people for disposal. And the pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacist received emailed notification of drug alerts and recalls. They moved the emails into a folder when they had read and actioned them. But they could not show the action they had taken, such as removing items from stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people’s private information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for methadone. They had highlighted the measures in red, so they were used exclusively for this purpose. The pharmacy used an automatic dispensing machine for original pack dispensing. And a six-monthly service mitigated the risk of breakdowns. Team members contacted the engineer when they had issues. And they carried out works on-site at the pharmacy. For example, they visited the pharmacy in April 2022 to carry out a repair. The pharmacy had contingency arrangements in place in the event the machine broke down. And they referred to a monitor to identify the shelf location to manually select the stock they needed. This had only happened on a few occasions since the robot had been installed. The pharmacy stored prescriptions for collection out of view of the waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. A portable phone allowed team members to carry out conversations in private if needed. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks.

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.