General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tarves Pharmacy, 8 Duthie Road, Tarves, ELLON, Aberdeenshire, AB41 7JX

Pharmacy reference: 1106239

Type of pharmacy: Community

Date of inspection: 16/10/2019

Pharmacy context

This is a community pharmacy in a growing village. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And it supplies a range of over-the-counter medicines.

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. They record mistakes to learn from them. They review these and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records it needs to by law and keeps people's information safe. Team members help to protect vulnerable people. The pharmacy uses people's feedback to improve its services.

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 or another senior pharmacist in the company 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. Team members were clear of their own and others' roles e.g. a trainee dispenser was not trained to work on the medicines' counter. 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.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. The pharmacist had reminded them to always record errors, even when she was on holiday. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. The team rearranged medicines storage shelves to create more space; attached labels to shelves to highlight items involved in errors and in similar packaging; circled strengths on higher strength products; and re-visited the SOP and actual process for supply of medicines following a 'handing out' incident. Team members also discussed the information governance aspect of this incident. When the pharmacist was dispensing and checking her own work, she asked a medicines counter assistant to check it. She was soon registering on a dispensing course.

The pharmacy had a complaints procedure and welcomed feedback. It used this feedback to help determine what was stocked in the retail area. It stocked a large range of skin products which was popular with the local community. Team members ordered items not usually stocked when people requested them.

The pharmacy had an indemnity insurance certificate, expiring 30 April 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. The pharmacy had an effective and orderly filing system which was used across the company. This made it easy for team members or others to quickly access records and other information.

Pharmacy team members were aware of the need for confidentiality. Several team members had attended a general data protection regulations (GDPR) evening event. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members knew how to raise safeguarding concerns locally. They had access to contact details and processes in a signposting SOP. The pharmacist had undertaken the NES child protection training module. And she was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained or training team members to safely provide its services. Team members have access to training material to ensure they have the knowledge they need. And the pharmacy gives them time during the working day to use this. Team members can share information and make suggestions to improve services.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager; one full-time trainee dispenser who had worked in the pharmacy for two years; one part-time trainee dispenser who had worked in the pharmacy for several years; one full-time medicines counter assistant who had undertaken a dispensary stock control module; one new Saturday only team member and a part-time delivery driver. Team members had not prioritised completing training over the past two years due to extended periods of leave. And the pharmacy changing ownership, being refitted and settling into new ways of working. They were now making this a priority. The pharmacy displayed certificates for qualifications undertaken. At the time of inspection there were two team members and the pharmacist working. They were able to manage the workload.

The pharmacy provided learning time during the working day for team members to undertake accredited course work. And the pharmacist supervised trainees. The pharmacy kept records of training episodes e.g. periodic attendance at external events, and undertaking topical quizzes devised by the pharmacist. These were not recent, and the team had discussed different ways that regular training could fit into the working week. Team members were considering the introduction of 'training Tuesdays' to try and establish a regular time. They had annual appraisals with the pharmacy manager to identify their learning needs. Their objectives included completing their accredited courses. And the pharmacist's objectives included developing services and meeting chronic medication service (CMS) and minor ailments service (eMAS) targets. 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. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The pharmacist gave good advice and counselled people appropriately. People came back to the pharmacy to tell her the outcome of her interventions. This was observed. A person brought a prescription to treat a condition following the pharmacist's advice.

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. They gave appropriate responses to scenarios posed. A team member had suggested that 'training Tuesdays' could be for everyone, not just medicines counter team members. The pharmacist had agreed and was planning to action this. The superintendent sent a quarterly newsletter which team members read. And the company organised annual meetings for pharmacists where information and initiatives were shared. The pharmacy team did not have formal meetings but shared information 'on-the-job'. This included information about prescriptions, stock availability and sometimes inappropriate requests for over-the-counter medicines.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for its services. The pharmacy team members use a private room for some conversations with people. Other people cannot hear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were small premises incorporating a retail area, dispensary and basic staff facilities. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, and toilet. These had hot and cold running water, soap, and clean hand towels. The premises had benefited from a refit four years ago upgrading the dispensary and medicines counter and providing a consultation room.

People were not able to see activities being undertaken in the dispensary. The pharmacy furnished the consultation room with a desk and chairs. It was clean and tidy, and the door closed providing privacy. 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 to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources. And it stores them properly. The pharmacy team knows what to do if medicines are not fir for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a low step and team members helped with the door if required. It listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order and could provide large print labels. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their controlled drugs. The driver had previously tried to obtain signatures for all deliveries, but this had proved challenging. The driver initialled and kept records of all deliveries made. The driver knew all the people who had deliveries and reported anything unusual to the pharmacist. If people did not answer the door the driver left a card and either the pharmacy called the person or people phoned the pharmacy to re-arrange the delivery.

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. And they used labels to highlight items requiring stored in the fridge, controlled drugs, pharmacist counselling required or to share other information. When the dispenser labelled, she highlighted new items to the pharmacist by writing on prescriptions. And she printed interaction labels when there were new items to facilitate the pharmacist's clinical assessment. She also highlighted new patients to the pharmacist. The dispenser demonstrated how she checked the previous date of supply and she compared doses on previous supplies with the current prescription. This ensured that she printed the correct directions and told the pharmacist if there were changes. The dispenser and pharmacist worked on an island dispensing bench facing each other which worked well for sharing information. When one team member was dispensing multi-compartment compliance packs, the other dispenser and pharmacist worked side by-side which also worked well. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy had a file with processes to be followed and information to be provided to people. It had templates to record due date and dates of collection. The pharmacist used urgent prescription forms to synchronise medicines when people started this service. The team dispensed medicines the week before they were due. And they placed them on retrieval shelves labelled with the due date. The team had not identified compliance issues, but team members monitored when medicines were collected. Sometimes people collected at unexpected times due to their work patterns. The pharmacy reminded people who tended to forget to collect their medicines. The pharmacy was actively registering people for this service. The pharmacist identified pharmaceutical care issues when discussing people's medicines with them. These included side effects e.g. muscle pain and coughs. She targeted questions depending on the medicines people were taking. And she asked about smoking status and whether people had any intention to stop. Depending on the response, she signposted or counselled appropriately. The pharmacy managed multi-

compartment compliance packs on a four-weekly cycle with four assembled at a time. A team member assembled them the week before the first one was due to be supplied. The team followed a robust process and kept records of changes. Team members included tablet descriptions on packaging and supplied patient information leaflets with the first ack of each prescription.

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 pharmacy did not supply valproate to anyone in this group. 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 had placed NSAID labels adjacent to over-the-counter products as a reminder. 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 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 supply of chloramphenicol ophthalmic products. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence and under her supervision. 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.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not comply with the requirements of the Falsified Medicines Directive (FMD). Team members were highly aware of the requirements, but the pharmacy did not yet have the equipment. They thought it was being introduced over the next few months. 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 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 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 team kept 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 and in the dispensary. People were not able to see personal information on prescription medication waiting to be collected. 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.