General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Crimond Pharmacy, Suites B&F Crimond Medical Centre, Logie Avenue West, Crimond, Fraserburgh, Aberdeenshire, AB43 8QJ

Pharmacy reference: 9010087

Type of pharmacy: Community

Date of inspection: 05/06/2019

Pharmacy context

This is a community pharmacy on the outskirts of a small village. 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-compartment compliance packs.

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	1.2	Good practice	The pharmacy regularly and comprehensively reviews near misses. It keeps records of what has been learnt and improvements made. The owner has oversight of these and provides feedback and sharing across all branches.
		1.4	Good practice	The pharmacy pro-actively encourages feedback from service users. It can show how it has used feedback to improve services.
2. Staff	Standards met	2.2	Good practice	The pharmacy has training and development. It shares training with other healthcare professionals as appropriate. And provides protected time and a range of training material to team members. And it provides training sessions on topical subjects.
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 compare the number and types of mistakes over several months, and with other pharmacies. They review these and make changes to reduce them. The pharmacy asks people for feedback. Team members discuss this to make pharmacy services better. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place for all activities/tasks. Team members read, signed and followed these. The owner/director who was a pharmacist reviewed SOPs every two years and signed them off. The superintendent pharmacist agreed them. Staff roles and responsibilities were recorded on individual SOPs. The superintendent and other team members reviewed one SOP each month. There was a contents page at the front of the folder making it easy for team members to locate SOPs. The pharmacy archived previous versions to avoid confusion, but they were readily available if there was a need to refer to them. The pharmacy listed controlled drug regulations close to the labeller to assist team members checking that prescriptions were legally compliant when labelling.

Dispensing, a high-risk activity, was observed to follow a robust and logical process. Team members used coloured baskets to segregate patients' medication and prescriptions and highlight different prescription types e.g. people waiting or calling back. They attached labels to prescriptions to highlight high-risk items, those requiring storage in a fridge or controlled drug (CD) cabinet, or those requiring input from the pharmacist. They signed most dispensing labels to provide an audit trail of who had dispensed and checked medicines.

The pharmacy had a business continuity plan in place to address maintenance issues or disruption to services.

Team members recorded near miss errors and reviewed these monthly. They were sent to the owner pharmacist, who collated data for all the branches in the wider organisation. She sent a newsletter and displayed the data in graphical form to help the pharmacy team members compare themselves to other branches and their own accuracy each month. They were usually accurate but discussed trends and individual incidents. Each month, the team picked one incident to discuss in detail. Recently, the team members had discussed a wrong strength being selected. This was believed to be related to untidy shelves. They tidied the shelves and discussed that they should never assume the position of any item. The recent newsletter reminded all team members to doublecheck all dispensed items before passing for the final check. The pharmacy had a monthly checklist on the wall to ensure that all regular activities were completed.

Staff members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy technician had additional responsibility including dispensing methadone instalments and updating computerised patient care records for onward sharing.

The pharmacy had a complaints procedure in place and encouraged feedback from people on social media. People had recently given positive feedback about the new premises which were very much larger than a temporary Portakabin that had been in place for around two years. The pharmacy had provided additional seating in the Portakabin following feedback, but space was restricted. People had told pharmacy team members that the water in the tap in the consultation room in this premises was warm. A team member had brought this up at a meeting with the owner of the building. This had been investigated, a fault discovered and repaired.

Indemnity insurance certificate was displayed, expiring October 2019.

The following records were maintained in compliance with relevant legislation: Responsible Pharmacist notice displayed; Responsible pharmacist log; Private prescription records including records of emergency supplies and veterinary prescriptions; Unlicensed specials records; Controlled drugs registers, with running balances maintained and regularly audited. Controlled drug (CD) destruction register for patient returned medicines. The electronic patient medication record was backed up each night to ensure that data was not lost.

Team members were aware of the need for confidentiality and had all read and signed an SOP. They segregated confidential waste and shredded some items and placed others in a bag for secure destruction. Team members took bags across to the GP practice where they were stored in a locked area until they were uplifted weekly. No person identifiable information was visible to the public.

Team members demonstrated high awareness of various aspects of safeguarding and had read and signed an SOP. They knew where to find information regarding local contacts and processes for raising concerns. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is. And it has more staff on busier days. This ensures skilled and qualified staff provide pharmacy services. Pharmacy team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training. Team members can share information and raise concerns to keep the pharmacy safe. They discuss incidents. And they learn from them to avoid the same thing happening again.

Inspector's evidence

Staff numbers in the pharmacy were: one full-time pharmacist (superintendent); one part-time pharmacy technician, three days per week; one full-time and two part-time dispensary/medicines counter assistants; one part-time medicines counter assistant working Thursday and Friday when the pharmacy was busier.

Typically, there were three team members and a pharmacist working, and two days per week when the pharmacy was busier there were four team members. Team members could manage the workload. Part-time team members were sometimes able to work additional hours to cover absence. Staff members were observed to manage the workload.

The pharmacy displayed certificates of pharmacy team members qualifications in a public facing area. Training and development were embedded within the organisation. All team members had access to online training modules, some were mandatory, and they could choose to do others. They each had a personal login to training modules and records were kept electronically. Each month the owner pharmacist notified the team of mandatory training – the most recent one had been health and safety. The pharmacy gives team members protected time to undertake these – typically 20 to 30 minutes. Team members also participated in external trainings, sometimes locally and sometimes in another branch. There was a room above the pharmacy that was used for meetings and training sessions. Topics that they had covered recently included naloxone, stoma products and management and ear piercing. Pharmacists sometimes suggested training topics relevant to the pharmacy and the owner pharmacist was receptive to this. Team members had annual development meetings. They described the format of these. Usually talks about achievements through the year and aspirations for the coming year including any training or development. The pharmacy encouraged individuals to continue developing to meet their own needs and those of the business. An example was described of a dispenser who was keen to complete NVQ 3 training but not immediately due to personal circumstances will stop the pharmacy was understanding to this and the belief was that over coming months she would embark on this. The pharmacist had recently completed the independent prescribing qualification. She had discussed it with the owner during her development meeting to see how this could be used to develop further services in the pharmacy. They had also discussed other services and the training and development required for these.

All team members went about their tasks in a systematic and professional manner. They asked relevant and appropriate questions when selling medicines over-the-counter and demonstrated awareness of products liable to misuse. Each month the pharmacy had a ‘patient safety topic of the month’. The team chose the topic and designed a simple poster as a reminder which was displayed within the

dispensary. At the time of inspection, the topic was methadone storage and missed doses. This was discussed with all team members. A previous topic had been inhaler technique and the pharmacy had invited a representative from the drug company GSK to deliver training told team members over lunchtime (the pharmacy closed at lunchtime). This empowered team members enabling them all to give robust and accurate information to people using inhalers without relying on the pharmacist. They sometimes participated in training sessions with the GPs in the adjacent practice.

When the NHS launched information regarding 'sick day rules' all team members were trained by the pharmacist. They selected an affected drug each month to focus on, ensuring all team members were competent to give advice, and all people supplied with these medicines were given the information they needed.

The pharmacy had a very open environment where all team members felt able to share learning and mistakes to improve services and accuracy. They understood the importance of reporting mistakes and were comfortable owning up to their own. The whole team was aware when an error had occurred – reflection was shared. There was sharing from head office across the organisation with a newsletter providing updates including incidents and errors and reminding team members to undertake mandatory and additional training.

The members described feeling empowered and able to raise concerns and make suggestions to the superintendent pharmacist, the owner of the pharmacy business, and the owner of the building that the pharmacy was in. Meetings were held quarterly with all stakeholders within the building. The dispenser attended these meetings, and there were examples of issues and concerns being raised, discussed and addressed. The pharmacy team members knew how to raise concerns about controlled drugs with the NHS controlled drug accountable officer.

The pharmacy did not set targets, but team members were encouraged to promote services that would benefit patients.

The pharmacy provided work placements for a local school and was accredited for this. School students spent a week in the pharmacy, one at a time during school hours twice a year. They signed a confidentiality agreement and then observed all aspects of the working of a community pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for its services. The pharmacy team members use a private room for some conversations with people. People cannot overhear private conversations. The pharmacy is secure when closed.

Inspector's evidence

This was a modern purpose-built building incorporating a GP practice, pharmacy, district nurses base, café, gym, a beautician and some other private and charity services. The pharmacy was located on the ground floor opposite the GP practice. The pharmacy had an office/staff area and consultation room within the registered premises. It shared other staff facilities with other service providers. The premises were clean, hygienic and well maintained.

There were sinks in the dispensary, consultation room and toilet. These had hot and cold running water, soap, and clean hand towels.

People could see into the dispensary but were unable to see activities being undertaken. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers.

The pharmacy had a consultation room with a desk, chairs, sink and computer which 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. It provides services that the community needs such as smoking cessation. And it engages with the community through social events and fund raising. 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 high-risk medicines. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

There was good physical access by means of a level entrance and wide door. The pharmacy displayed a list of its services and it had leaflets on a range of topics available. Pharmacy team members provided labels with large print on dispensed medicines for people with impaired vision. They used the consultation room to have conversations with people hard of hearing.

The pharmacy was part of the local community and throughout the year organised events locally to raise money for charity. Events included a tea party, sponsored cycle, quiz night and tribute night. Each year the pharmacy chose a different charity with team members making suggestions. It raised significant amounts of money for charities and provided social events for the local village community.

All team members wore badges showing their name and role. Dispensing work flow was methodical and linear. Team members used coloured baskets to segregate different patients' medication and identify different types of prescription. The pharmacy had designated dispensing and checking areas, had a process in place for highlighting new medicines to the pharmacist, and used labels to highlight new medicines, high-risk items or those requiring storage in a fridge or controlled drug (CD) cabinet. The pharmacist described checking repeat medication ordering forms when carrying out a clinical check – this gave her information about compliance and enabled her to offer advice to people. Team members followed robust and distinct processes for different prescription types.

They scanned (commissioned) products that complied with the falsified medicines directive (FMD) when they were dispensed and scanned again (decommissioned) when they were supplied. Medicines that were stored on retrieval shelves for collection were highlighted and a barcode on the bag was scanned. This process worked well for the team – they had been well trained in it. The software provider had run a training session on the premises for pharmacy and GP practice staff, so they all understood all aspects. The pharmacist explained that near miss errors had decreased over the past few months since scanning was in place. She attributed this to team members looking more closely at packaging when checking for 2-D barcodes.

Team members signed dispensing labels to provide an audit trail of who had dispensed and who had checked all medicines.They usually assembled owings later the same day or the following day. A team member checked retrieval shelves monthly and removed medicines that had been uncollected. People were notified if appropriate to collect their medicines, but there were only a few and these were usually owings that were no longer required.

The pharmacy provided a delivery service and the driver obtained signatures from people receiving controlled drugs. He had all deliveries listed in a diary and highlighted these as he made the deliveries

so there was an audit trail. He delivered very few items requiring cold storage but always delivered these first so that they were out of the fridge for a short time.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. A robust and thorough process was followed, and full records of changes and other interventions kept. A dispenser ordered prescriptions well in advance to allow adequate time for any queries or changes to be implemented. She was empowered to follow-up queries without reference to the pharmacist. The pharmacy included tablet descriptions on backing sheets, and patient information leaflets were supplied with the first pack of each prescription. Some people received four packs at a time and there was written and signed authority from prescribers to allow the pharmacy to supply in this manner. The pharmacy kept medicines packaging including expiry date and batch number for the life of each prescription. This enabled medicines to be retrieved in the event of a recall. The pharmacy provided pain relief in these packs to people who were on prescribed reducing doses to help them manage their medicines. The pharmacy and GP practice pharmacist liaised to arrange this.

A dispenser poured methadone instalments weekly and these were checked by a pharmacist, although not all labels were signed. The pharmacy stored instalments in baskets labelled for each day in a controlled drug cabinet.

Clinical checks were undertaken by a pharmacist and people receiving high risk medicines including valproate, methotrexate, lithium, and warfarin were given appropriate advice and counselling. Pharmacy team members provided written information and record books if required. They had implemented the valproate pregnancy prevention programme and the non-steroidal anti-inflammatory drug (NSAID) care bundle. They provided written and verbal information to people supplied with NSAIDs over-the-counter, or on prescriptions. 'Sick day rules' were also discussed with people on certain medicines, so that they could manage their medicines when they were unwell. A team member had searched the electronic patient medication records to identify any relevant patients prescribed valproate – there were none.

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 chloramphenicol ophthalmic products. The pharmacy provided medicines to a lot of patients from chronic medication service (CMS) serial prescriptions. It stored these on separate retrieval shelves after dispensing to enable constant review to monitor compliance. Pharmacy team members completed a tracker with the date medicines were next due and which medicines had been supplied. They monitored compliance and discussed any issues with people. They also contacted the GP practice when there were concerns, and one example was described of a patient stopping serial prescriptions as the system was not working for her. A team member synchronised all medicines with the first prescription to ensure that people had an adequate supply but there was not excess which could cause confusion. The pharmacist completed the registration questionnaire with people and identified pharmaceutical care issues e.g. people forgetting to order prescriptions, forgetting to take their medicines or suffering side-effects. She offered advice and, in some cases, discussed issues with the GP.

All team members were empowered to deliver the minor ailments service (eMAS). The pharmacist described the service as busy and she was confident that all team members were competent to advise people appropriately and referred to her as necessary. Several examples were observed during inspection and these were well-managed. All team members except the medicines counter assistant were trained and competent to deliver the smoking cessation service. She had not undertaken training but promoted the service and talked about it with relevant people. The pharmacy was currently providing the service to around 30 people. It was promoted using show material in the pharmacy and

on social media. The pharmacist explained that all team members promoted the service to people in the pharmacy whenever there was an opportunity. She described several examples of people completing the course successfully. One dispenser provided an ear-piercing service. She had seen this provided in another pharmacy and suggested it. The pharmacist was amenable to this and arranged for the dispenser to be trained. The dispenser explained that she felt that the pharmacy was an appropriate professional environment to have this service where quality advice could be given to people. And she explained that she had had feedback from people that they agreed this was an appropriate professional environment for the service. The dispenser had her own criteria to maintain professionalism and safety – she would not pierce the ears of children less than five years old and would only pierce ear lobes. She also explained that this brought people into the pharmacy where other services such as smoking cessation could be promoted at the same time.

The pharmacy obtained medicines from licensed suppliers such as AAH and Alliance. Records of date checking were observed, and items inspected were found to be in date. The pharmacy stored medicines in original packaging on shelves and in cupboards. Items requiring cold storage were stored in a fridge with temperature monitored and recorded once daily. An alarm sounded if it went out of range.

The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. The NES consultation skills information was on the wall as an aide memoir. Team members had all been reminded that if they did not have an item in stock that somebody required they should offer to obtain it or provide an alternative.

Pharmacy actioned MHRA recalls and alerts on receipt and records kept. They contacted people who had been supplied with 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 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 equipment required to deliver pharmacy services in the consultation room where it was used with patients accessing these services. This included a blood pressure meter which had been obtained recently, and a carbon monoxide monitor maintained by the health board. Team members always showed people the new mouthpiece before they used it to reassure them of hygiene. The pharmacy had Crown stamped measures which were kept by the sink in the dispensary, and separate marked ones were used for methadone. It also had a pump used for methadone solutions. A team member poured test volumes and cleaned it thoroughly after use. The pharmacy sent it for full calibration annually.

Clean tablet and capsule counters were also kept in the dispensary. As methotrexate tablets were supplied in blister packaging there was no longer a separate counter kept for these.

Pharmacy kept paper records in the dispensary, inaccessible to the public. Team members never left computers unattended and passwords. They ensured that screens were not visible to the public. Care was taken to ensure phone conversations could not be overheard.

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.