General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Buckpool Pharmacy, 12 St. Andrews Square, Buckpool, Buckie, Moray, AB56 1BU

Pharmacy reference: 9010656

Type of pharmacy: Community

Date of inspection: 21/05/2019

Pharmacy context

This is a community pharmacy set among other shops in a town. 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.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.2	Standard not met	The pharmacy does not monitor and review dispensing accuracy. So it may be missing opportunities to learn and improve accuracy.
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 not all met**

Summary findings

The pharmacy team members follow processes for all services to ensure that they are safe. They do not record mistakes, so cannot review these and learn from them. The team is missing learning opportunities. The pharmacy team members use feedback from people to improve services. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place. And pharmacy team members followed these for all activities/tasks. They had all read and signed them, except the Saturday only assistant. The pharmacy manager reviewed the SOPs every two years. There was an SOP describing staff roles and responsibilities. Pharmacy managed dispensing, a high-risk activity, in a logical manner with smooth workflow. Team members used baskets to separate patients' medicines. There was an audit trail in place for dispensed medicines in the form of dispensed and checked by signatures on labels.

The pharmacy had a business continuity plan, but it was out of date. The NHS had provided it 10 years previously and personnel had changed. The pharmacy did not review this with other procedures. The pharmacy did not currently use near miss logs to record and review mistakes. Pharmacy team members had previously used near miss logs but over the past year this had stopped. The pharmacy team described the pharmacy becoming busier. And records changing from paper-based to electronic, which made it more time-consuming to make the entry. The pharmacy had one computer for labelling prescriptions and accessing other records including near miss logs. If it was in use or labelling, other functions such as near miss logs could not be accessed easily. The pharmacist highlighted errors to dispensers, describing any reason or consequences. The team member that had made the mistake corrected it where possible. Pharmacy recorded dispensing errors reaching patients on a similar template. Pharmacy team members described always doing this. The pharmacist shared these with the superintendent pharmacist if the error was serious.

The error logs were very basic, like near miss logs. The pharmacy did not carry out any significant event analysis or reflection. Pharmacy team members could not describe any changes or improvements that they had made following incident. They explained that in the previous premises they had sometimes put shelf edge labels up to highlight items involved in incidents - tThe pharmacy had relocated 18 months before.

Staff members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist.

The pharmacy had a complaints procedure in place. It did not actively encourage feedback but responded when feedback was received. Several people had requested items for symptomatic relief of chickenpox symptoms. The pharmacy now stocked two products which were popular with people.

Indemnity insurance certificate was in place, expiring April 2020. 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 audited weekly. Pharmacist explained weekly audits being of benefit a few months previously when there had been an error involving a controlled drug; controlled drug (CD) destruction register for patient returned medicines; and the electronic patient medication records (PMR) were backed up each night.

Team members were aware of the need for confidentiality. They had not read any policy or procedure but had been told of the importance of this. No person identifiable information was visible to the public. Confidential waste was segregated and shredded. Similarly, there was no policy or procedure in place for safeguarding. Contact details to raise safeguarding concerns were on the community pharmacy Scotland website. The pharmacist described an incident that had been raised and resolved. Both pharmacists that worked in the pharmacy were PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its service. But the trainee still must undertake an appropriate accredited course. The pharmacy is currently reviewing training providers and material available. This is with a view to putting structured training and development into the pharmacy. Pharmacy team members currently have access to topical training material. Team members have an open environment where they can share information and incidents amongst themselves. But they do not share across the wider organisation, so some learning opportunities may be missed. They know how to raise concerns if they have any.

Inspector's evidence

The pharmacy had a full-time pharmacy manager and a part-time pharmacist who worked every Saturday, two trained dispensers, two trained medicine counter assistants and one Saturday only assistant who was not trained. He worked under the pharmacist's supervision. He had worked for the company for around a year. One dispenser worked Monday to Friday, and the other worked Tuesday to Friday. The pharmacist was monitoring this because Monday's were becoming busier. The medicines counter assistant worked part-time, one working at a time. There was some flexibility for part-time staff members including the Saturday assistant to cover for absence. Certificates of qualification were displayed. Staff members were observed to manage the workload.

The pharmacy did not provide any structured training and development. The pharmacist described looking into the different training modules and providers that were available with a view to introducing something that would be of value to pharmacy team members. They were mostly experienced. They read relevant material that came into the pharmacy, particularly relating to new products. Around two months previously the pharmacy had started selling cannabis oil products (CBD). Team members had all read a training booklet and were able to describe contraindications and interactions with other medicines. They kept this booklet close to the medicines counter for reference. It had the appearance of being used, and there were some pencil annotations in it.

The various individuals were observed going about their tasks in a systematic and professional manner. Pharmacy team members asked appropriate questions when supplying over-the-counter medicines. The medicines counter assistant working at the time of inspection gave appropriate responses to scenarios posed. She was aware of products of abuse and referred some requests to the pharmacist. The pharmacy team shared information with other pharmacies if people were trying to make frequent purchases of certain products.

Team members described having an open and honest working environment where they could share information. They understood the importance of learning from mistakes although these were not always recorded. They were comfortable owning up to the mistakes. The pharmacy did not share information regarding mistakes outside the pharmacy. So, the other branch the organisation did not have an opportunity to learn from these. Similarly, there was no sharing from the other branches. The pharmacist always told team members if they had made mistakes, including other pharmacists. The pharmacy had no structured approach to feeding back within the pharmacy or the wider organisation and there were no meetings held. Individual team members knew how to raise concerns with the pharmacist or the superintendent pharmacist. They also described how they would contact a colleague

in another pharmacy for advice as necessary.

The gave appropriate responses to scenarios posed. The pharmacist had contacted the NHS controlled drug accountable officer team following an error was a controlled drug. The NHS authorised which is attended the pharmacy to destroy the medicines.

The pharmacy did not have targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean, and suitable for its services. The premises require some maintenance in staff areas. Pharmacy team members use a private room for some conversations with people. People cannot see private conversations. The pharmacy is secure when closed. Sometimes the temperature in the pharmacy is uncomfortable.

Inspector's evidence

The pharmacy premises included a small open plan dispensary, reasonably sized retail selling a range of medicines, baby products, toiletries, greeting cards, sundries, and household products, and a spacious back-shop area. The pharmacy kept stock in this area. And there was a large area taken up with obsolete items waiting to be uplifted. The dispensary was cramped with limited storage space. The pharmacy stored some medicines beside windows, so they were visible from outside. Pharmacy team members made sure that these were not 'desirable' medicines. These windows were at the side of the building which was accessed through a locked gate. The pharmacy kept some bags of dispensed medicines on the floor as there were no shelves available for them.

There were sinks in the dispensary, staff/consultation room, back-shop area and toilet. These had hot and cold running water, soap, and clean hand towels. The toilet flush was broken. The flush did not work, and pharmacy team members had to put their hands into the cistern to enable this. The pharmacist had notified the superintendent pharmacist/owner several weeks previously.

People were able to see activities being undertaken in the dispensary. Pharmacy team members managed this to protect people's private information and details. The pharmacist checked prescriptions at the back of the dispensary where he was less likely to be interrupted by people.

The premises were clean and hygienic. 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. The pharmacy team members also used this as a staff room. They used an area in the back shop for rest breaks if the Consultation room was being used.

The pharmacy was alarmed and had CCTV. It had a back door which was locked and on the alarm system when the pharmacy was closed. It opened on to an area that was only accessed through a locked gate. The pharmacy kept the door open during warm weather for ventilation. The windows to the rear of the premises were protected by bars.

Temperature in the pharmacy was dependent on the weather as there were large windows at the front of the premises. During the inspection the sun was shining, and the pharmacy was uncomfortably warm. The light from the windows was also very bright, causing slight eye discomfort. When asked, team members explained that during cold weather the premises often felt very cold. The pharmacy had plans to attach film to the windows to provide some shade. This had been planned several months previously.

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 stores them properly.

Inspector's evidence

The pharmacy premises had good physical access by means of a level entrance and an automatic door. It listed its services and displayed posters promoting community events and information. Leaflets on a small range of topics were available.

Dispensers provided large print labels on medicines for people with impaired vision. They repacked tablets into bottles for people with dexterity issues. Pharmacy team members signposted people to other services if appropriate e.g. the pharmacist arranged for a prescription to be dispensed in another pharmacy for a person who had breached their daily medicine supply agreement.

Dispensing work flow was logical and smooth. The pharmacy used baskets to separate each patient's medication. One dispenser labelled, while the other dispensed. Once labelling was complete both dispensers dispensed, working on benches opposite each other. They worked sideways on to the front shop, reducing distraction from people who could see them working. They moved dispensed medicines to one end of their dispensing benches, for the pharmacist to take to the checking bench as he had capacity to check. This avoided the checking bench becoming cluttered. The pharmacy had designated dispensing and checking areas. Dispensing audit trails were in place in terms of initials on dispensing labels of personnel who had dispensed and checked medicines. The pharmacy team members usually assembled owings later the same day or the following day.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Both dispensers were trained and competent to do this. They kept records of progress for each patient's medicines. And they kept records of changes. They used a bespoke template to record changes, including details of when the change was to be made, and who requested it. Patient information leaflets (PILs) were supplied to people who wanted them. The pharmacy kept records of people who did not want these regularly.

The pharmacist poured methadone instalments weekly, and a dispenser checked them. They stored the instalments in a controlled drug cabinet. The pharmacy labels had the date of dispensing but not the date of supply on them.

The pharmacist undertook clinical checks, and gave people receiving high risk medicines additional advice. These medicines included valproate, methotrexate, lithium, and warfarin. Written information and record books were provided if required. The valproate pregnancy prevention programme was in place. There were no people who may become pregnant being supplied with valproate. The non-steroidal anti-inflammatory drug (NSAID) care bundle had been implemented and written and verbal information had been given to people supplied with these medicines over-the-counter, or on prescriptions. There was no written material left but information was on the dispensary wall for

reference, and verbal information and advice was still given. The pharmacist 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. It had patient group directions (PGDs) for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, chloramphenicol ophthalmic products and flu vaccination. These were current, and the pharmacists had been trained and signed them.

There were around 120 patients receiving medicines on chronic medication service (CMS) prescriptions. The pharmacy stored these alphabetically in a box file and dispensed them when patients requested. The pharmacist promoted the service and explained the process to people before registering them. People were asked to complete a questionnaire themselves and bring it back to the pharmacy. One person had improved the form by slightly changing and formatting it, and the pharmacist had adopted this. The pharmacist had not identified pharmaceutical care issues when registering patients. He attempted to synchronise medicines where possible, providing an appropriate number of tablets to enable this. The pharmacist checked the electronic records every two or three weeks to identify any compliance problems such as overdue prescriptions or to frequent ordering. When he identified an issue, he called the surgery. And usually prescribers had made changes and not notified the pharmacy. If the surgery gave no reason, the pharmacist contacted patients.

Pharmacy team members generally referred all minor ailment requests to the pharmacist. They started the counselling, finding out what the symptoms were and checking that the preferred product was available before referring. Often the medicines' counter assistant would hand the medicine out to the person after it had been dispensed.

The pharmacy provided sexual health services such as emergency hormonal contraception and free condoms. People could help themselves to packs of condoms as they were on the medicines counter, but the pharmacy asked that they only take one pack at a time.

Both pharmacists were trained to deliver NHS and private flu vaccination which they had done during flu season. They had undertaken training the previous year. The pharmacist delivered the smoking cessation service and currently had around eight people accessing this. Some people were prescribed nicotine replacement therapy and others were prescribed Champix. There had been some recent successes with people stopping smoking.

The pharmacy got medicines from licensed suppliers such as Phoenix, Alliance, and AAH. The pharmacy did not yet meet the requirements of the Falsified Medicines Directive (FMD). It had the hardware on the premises, and the software had been installed, but it was not yet functioning. The pharmacy did not keep records of date checking. But pharmacy team members explained that they undertook this from time to time. And items inspected were found to be in date, although a few were short dated and not marked.

The pharmacy stored medicines in original packaging on shelves. It kept items requiring cold storage in two fridges with minimum and maximum temperatures monitored. It took appropriate action taken if there was any deviation from accepted limits. The pharmacy used one fridge for stock and the other flu vaccines and dispensed medicines.

The pharmacy protected pharmacy (P) medicines from self-selection.
Sale of P medicines was as per sale of medicines protocol. The pharmacy had stocked CBD oil products for the past few months. Team members had read some training and reference material and

demonstrated that they could not make medical claims about these products. People were interested in this product range and purchasing items for various symptoms. No one had returned for second at subsequent supplies to team members did not know if they were benefiting.

The pharmacy took appropriate action on receipt of MHRA recalls and alerts. But it did not keep records. Pharmacy team members contacted people following patient level recalls. Sometimes they had to contact the GP practice to get in touch with people if they did not have contact details. The pharmacy scanned medicines as they were received which enabled a search to be undertaken electronically to identify any affected stock. Items received damaged or faulty were returned 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 reference books including current editions of the British National Formulary (BNF) and BNF for Children. It also had Internet access allowing online resources to be used.

The pharmacy kept a carbon monoxide monitor in the consultation room where it was used with patients accessing the smoking cessation service. It had Crown stamped measures by the sink in the dispensary, and ISO marked measures in the back-shop area for methadone. These were all clean and washed after use. The pharmacy had tablet and capsule counters in the dispensary. It had a separate marked one for cytotoxic tablets.

The pharmacy kept paper records in the dispensary and cupboards in the consultation room, inaccessible to people. Pharmacy team members never left computers unattended, and they were password protected. People were not able to see computer screens. Pharmacy team members moved to the back-shop area to take phone calls to avoid conversations being 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.