General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: A L Laing, Kantersted Road, Shetland, ZE1 0RJ

Pharmacy reference: 9010983

Type of pharmacy: Community

Date of inspection: 20/10/2022

Pharmacy context

This is a community pharmacy in Lerwick. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers 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

The pharmacy identifies and manages the risks associated with its services effectively. And team members have discussions to help reduce risks following mistakes made during the dispensing process. The pharmacy keeps people's private information secure. And it keeps the records it needs to by law. Pharmacy team members understand how to recognise and respond to safeguarding concerns.

Inspector's evidence

The pharmacy had introduced control measures to manage the risks and help prevent the spread of coronavirus. Since the last lockdown, team members had removed the plastic screen at the medicines counter, and they had stopped wearing face masks.

The company used documented standard operating procedures (SOPs) to define the pharmacy working practices. And team members annotated records to show they had read and understood them. The procedures showed a review date of 1 January 2022. And this meant a review was overdue. The pharmacist confirmed there had been little change and the SOPs were still relevant. But they undertook to contact the superintendent's office for an update. Sampling showed relevant procedures which included 'responsible pharmacist' and 'controlled drug' SOPs. It also showed SOPs for the operation of the automated dispensing machine that the pharmacy used to dispense original packs. A dispenser had recently qualified to carry out final accuracy checks. And the regular pharmacist was in the process of sourcing a procedure that defined the accuracy checking process for dispensers. They had also recently ordered a 'quad stamp' for the pharmacist to annotate to show they had clinically checked and approved suitable prescriptions. Dispensers signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist and the 'accuracy checking dispenser' were able to help individuals to learn from their dispensing mistakes. The pharmacist and the 'accuracy checking dispenser' were also responsible for recording the near miss errors, where a dispensing error occurred and was identified before the medicine was handed to a person. But near misses had last been recorded in June 2021. The pharmacist was confident that the automated dispensing machine had significantly reduced the likelihood of selection errors. And most of the errors were labelling mistakes. For example, records from 2021 showed that dispensers had labelled a few topical preparations 'to be taken' instead of 'to be applied'. And team members had agreed to take greater care whilst producing labels. The pharmacist had been reflecting on the benefits of team members recording their own errors. And how this would reinforce learnings. The pharmacist confirmed they had not experienced any dispensing incidents since the pharmacy's relocation four years previously. And the current process was to add a note to the 'patient medication record' (PMR). But this did not allow for the recording of the learnings or any improvements to prevent the same mistake in the future. The pharmacy used a policy to define its complaints handling procedure. And team members knew to refer to the policy for information.

Team members maintained the records they needed to by law. And the pharmacy had current public liability and professional indemnity insurances in place. The pharmacist displayed a responsible pharmacist (RP) notice which was visible from the waiting area. And they kept the RP record up to date. It showed the name and registration details of the pharmacist in charge. The pharmacy used electronic controlled drug (CD) registers. And team members checked and verified the balance at the time of

dispensing. The pharmacist was unable to show the CD records. This was due to a major incident and communications failures including phones, internet, and computers that were in shutdown after a subsea cable was cut. People returned controlled drugs they no longer needed for safe disposal. And these were recorded in a register with the pharmacist countersigning. Team members filed prescriptions so they could be easily retrieved if needed. They kept records of supplies against private prescriptions and supplies of unlicensed medicines up to date.

The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. And they used a designated container to dispose of confidential waste. An approved provider collected the waste for off-site destruction. The pharmacy trained its team members to manage safeguarding concerns. And they had contact details for the local safeguarding agencies. Team members knew to speak to the pharmacist whenever they had cause for concern. And a team member provided an example of liaising with a local agency when people did not arrive to collect their medications.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. The pharmacy supports team members in training to obtain the skills they need. And it provides relevant training as and when required to develop the necessary knowledge and skills for their roles.

Inspector's evidence

The pharmacy's prescription workload had increased significantly since its relocation four years previously. The superintendent pharmacist carried out regular staffing reviews. And they had recruited new team members to help with the increased demand. A regular pharmacist manager was in post. And local pharmacists that resided on the island provided regular cover. In some circumstances the pharmacy needed to arrange locum pharmacists from the mainland. And this had not impacted on service continuity. Occasionally the superintendent pharmacist provided cover. Team members were mostly long-serving experienced staff. And the following people were in post; two full-time dispensers, two part-time dispensers, one part-time medicines counter assistant, one newly recruited Saturday assistant and two part-time delivery drivers.

New team members undertook a three-month probationary period. During this time, they read the pharmacy's policies and procedures and shadowed colleagues to help them consolidate learning. Once they successfully completed their induction period, the company enrolled them on a training course that led to a relevant pharmacy qualification. The pharmacy supported team members during qualification training. And the newly qualified accuracy checking dispenser and dispenser completed all their training during working hours. The pharmacist kept team members up to date with changes and new initiatives. They held a meeting on alternate weeks to discuss the pharmacy's working practices. This ensured team members complied with standard operating procedures. For example, they had recently discussed the pharmacy's ordering system, and how to manage out of stock items. The pharmacist had recently completed a prescriber's course. And they were waiting on receipt of their qualification. A staff rota was displayed on the dispensary wall. And the pharmacist had authorised only experienced team members to carry out higher-risk activities. This included operating the automated dispensing machine for supervised consumptions. The pharmacy provided access to online learning. But team members had not taken the opportunity to undertake any of the learning. Pharmacy team members discussed near miss errors to help them learn about dispensing risks. And they agreed on improvements to manage the risk of them happening again in the future.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises support the safe delivery of its services. And team members effectively manage the space for dispensing medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy had relocated around four years previously. And was in a large modern purpose-built premises. An automated dispensing machine was off to one side of the pharmacy. And dispensing chutes were located above three separate dispensing benches. Team members organised the dispensary benches for different dispensing tasks. They assembled multi-compartment compliance packs on a bench with sufficient space. And the pharmacist and the 'accuracy checking dispenser' used separate benches to carry out accuracy checks. The pharmacist was able to supervise the medicines counter. And they also supervised a separate booth that team members used to supervise the consumption of some medicines. People accessed the booth via a separate entrance. Team members used a dedicated room in the main pharmacy which provided a confidential environment for private consultations. Team members used the dispensary sinks for hand washing and the preparation of medicines. And they cleaned and sanitised the pharmacy on a regular basis to reduce the risk of spreading infection. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate rest room provided the space for team members to remove their face masks without being at risk of spreading infection.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are no longer fit for purpose. The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care.

Inspector's evidence

The pharmacy had a step-free entrance, an automatic main door, and a separate side entrance. This helped people with mobility difficulties access services. Team members kept most of the pharmacy stock in an automated dispensing machine. And it kept some stock on open shelves, in pharmacy fridges and in secure cabinets. Team members kept stock the neat and tidy and well-organised. The fridges kept medicines at the manufacturers recommended temperature. Team members monitored and recorded the temperatures every day. And this provided assurance that the fridge was operating within the accepted range of 2 and 8 degrees Celsius. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members assigned a six-month expiry date to stock they placed in the automated dispensing machine. Team members checked the machine for stock that was about to expire. And they removed it well in advance, checked the dates and disposed of it or placed it back inside the machine if appropriate. Team members manually date-checked the stock that they did not put in the robot once a month. But they did not keep records to show when subsequent checks were due. Sampling showed that items were within their expiry date. The pharmacy had contingency arrangements in place for poor weather conditions and ferry disruptions. And the team members monitored the weather, kept stock levels high and ordered extra quantities of some medications such as antibiotics and inhalers when necessary. On the day of the inspection a subsea cable had been damaged and internet and telephone communications had been cut. Team members could still process prescriptions and stock levels had not been affected. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They also knew to supply patient information leaflets and to provide warning cards with every supply.

The pharmacy dispensed serial prescriptions for a significant number of people that had registered with the ‘medicines: care and review’ service (MCR). The pharmacy had a system in place for dispensing. And they retrieved prescriptions a week before they were due so they could order items in advance. Team members contacted the practice pharmacist if people did not collect their medication on time, or if they had general queries. The pharmacy supplied medicines in multi-compartment compliance packs for people that needed extra help with their medicines. And the pharmacy had defined the dispensing process in a documented SOP. Team members referred to supplementary records that listed each person's current medication and dose times. And they checked for accuracy before they started dispensing packs. Team members provided descriptions of each medication on the pharmacy labels, and they provided ‘patient information leaflets’ (PILs) with new medications. Team members mostly supplied four packs at the one time. And only when authorised by a GP. The pharmacy dispensed original packs and provided ‘medicine administration charts’ (MAR) charts for people in care homes. Team members followed a tracker that showed when dispensing was due.

The pharmacy provided a prescription delivery service. And the delivery driver kept an audit trail of deliveries in the event of future queries. Team members used an automated dispensing system for instalments of some medicines. And the pharmacist carried out a clinical check and an accuracy check at the time new prescriptions were entered onto the system. They carried out another accuracy check at the time of supply. Team members used dispensing baskets to assemble medicines during dispensing. And this managed the risk of items becoming mixed-up.

The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Team members prioritised drug alerts and they knew to check for affected stock so that it could be removed and quarantined straight away. The pharmacist filed the original email in a separate folder. But they did not keep annotated records of the drug alerts they had acted on.

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, so they were used exclusively for this purpose. The pharmacy used an automated dispensing system to dispense methadone doses. The pharmacist or a senior dispenser calibrated the system each morning to ensure accuracy of doses.

The pharmacy used an automated dispensing machine to dispense original packs. The pharmacy did not have a service contract. But the engineer responded to requests to carry out repairs. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could 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.