General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tornagrain Pharmacy, 1 Hillhead Road, Tornagrain, Inverness, Highland, IV2 8AB

Pharmacy reference: 9011429

Type of pharmacy: Community

Date of inspection: 29/06/2021

Pharmacy context

This is a new community pharmacy in Tornagrain. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it offers a medicines' delivery service to vulnerable people. The pharmacy team members advise on minor ailments and medicines' use. And they supply 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 acts to help keep members of the public and team members safe during the Covid-19 pandemic. It keeps the records it needs to by law and keeps confidential information safe. Team members securely dispose of personal information when it is no longer required. The pharmacy's policies and procedures show how it identifies and manages risks to keep services safe. And team members make improvements to prevent dispensing errors.

Inspector's evidence

The pharmacy had introduced new arrangements to manage the risks and help prevent the spread of coronavirus. A poster on the entrance door reminded people visiting the pharmacy to wear a face covering as required by law. Another notice informed them the waiting area could only accommodate a maximum of two people to allow them to maintain a safe two-metre distance from each other. People were seen to be following the guidelines without any instruction from the pharmacy team members. Hand sanitizer was available in the waiting area and in the dispensary. A Perspex screen was in place at the medicines counter. This acted as a protective barrier between team members and members of the public. The responsible pharmacist and up to three team members were on duty at the one time. They wore face masks and kept a safe distance from each other and when speaking to people at the medicines counter. They changed their face masks every two hours and sanitised their hands before replacing them. Once removed they placed them in a disposable bag and waited three days before placing in the general waste bin. A separate kitchen area was available and used for comfort breaks. Only one team member at a time used the room so they could safely remove their face mask. The pharmacy used working instructions to define the pharmacy's processes and procedures. And the superintendent pharmacist was in the process of introducing new standard operating procedures, for example, to describe the roles and responsibilities of all the team members. The pharmacy had risk management procedures in place. Team members were required to sign medicine labels to show who had ‘dispensed’ and who had ‘checked’ each prescription. This was to help them learn about their near miss errors through feedback, and to help them avoid the same mistakes in the future. Sampling showed team members were signing labels and documenting their near miss errors. The pharmacist reviewed the records on an ongoing basis, and more formally at the end of the month. This helped monitor and manage safety risks. They also used the information as a learning tool for each of the trainee dispensers. Previous near-miss reviews showed the proportion of near misses had remained stable even though the workload was increasing. The reviews were displayed on a large notice board for team members to refer to. Learning points included; checking that multi-compartment compliance pack backing sheets matched prescriptions. And making sure that deliveries were added to the electronic delivery schedule. Team members had been focussing on optimising storage space to manage the risk of selection errors and to improve stock layout. This was due to prescription increases and the need to increase stock levels. Team members were involved in re-arranging the shelves on an ongoing basis to manage the risk of congestion. They had created a ‘top 50’ section for efficiency and had recently separated omeprazole 10mg and 20mg due to a dispensing error. The pharmacy used a template form to support team members to carry out investigations into dispensing incidents. The form was also designed to show any learnings and improvements to prevent a recurrence.

The pharmacy trained team members to follow its complaints policy so they were effective at handling

concerns. A notice in the waiting area provided contact details to help people raise a complaint should they need to. And a suggestions box on the medicines counter encouraged feedback which had been very positive with no areas highlighted for improvement. The pharmacy maintained the records it needed to by law, and the pharmacist in charge kept the responsible pharmacist record up to date. Public liability and professional indemnity insurance were in place and valid until 20 September 2021. The pharmacy used an electronic controlled drug register and team members carried out stock checks once a week. Sampling showed that actual stock matched the registered stock. The controlled drug cabinet had ample space to safely quarantine stock awaiting destruction. A controlled drug destruction register was being used to record controlled drugs that people returned for disposal. Signatures showed that the pharmacist witnessed the destructions. The pharmacy provided a prescription delivery service. This helped vulnerable people and those shielding to stay at home. The driver wore PPE at the time of delivery and kept a record of the deliveries they made. The pharmacy provided training so that team members understood data protection requirements and knew how to protect people's privacy. The pharmacy did not display a notice or inform people about how it used or processed information. Team members used large designated bags to dispose of confidential waste and spent records. An approved waste disposal company uplifted bags once filled for off-site disposal. The pharmacy provided training so that team members understood how to protect children and vulnerable adults. The superintendent pharmacist was in the process of developing and implementing a new policy. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. This helped to protect children and vulnerable adults. Team members 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. They complete training as and when required. And, they learn from the pharmacist to keep their knowledge and skills up to date. Pharmacy team members speak-up and make suggestions to help improve pharmacy services.

Inspector's evidence

The pharmacy's workload had been increasing steadily since it opened in October 2020. The responsible pharmacist (RP) was provisionally registered and was about to sit the pre-registration assessment at the end of July 2021. The superintendent pharmacist and the owner who was also a pharmacist worked there part-time. Another part-time locum pharmacist provided cover every Saturday. The superintendent and the owner had been supporting the RP, so they developed in their role as a pharmacist manager. One full-time trainee dispenser, one part-time trainee dispenser and a part-time recently qualified medicines counter assistant worked at the pharmacy. The RP had been supporting the trainee dispensers who were about to sit final exams in July 2021. They had also supported the medicines counter assistant to gain the necessary qualification. Two part-time drivers provided the pharmacy's delivery service. They had read and signed the standard operating procedure that defined the delivery process. And they had enrolled on an accredited course for delivery drivers to gain the necessary knowledge and skills. The RP used the training provider's feedback to identify knowledge and skills gaps. They had a arranged a training session with the pharmacy team when they identified gaps concerning the handling of medicine waste. This included a discussion around controlled drugs and sharps. It also led to the introduction of an aide memoir. This included instructions to inform people to take sharps to their medical practice.

The pharmacist supported team members to continue to develop their knowledge and skills. For example, on a weekly basis, they would ask the medicines counter assistant to learn about five 'over the counter' (OTC) products. And they would be expected to know the questions they would be expected to ask people before making the sale. One of the trainee dispensers also provided support as they had worked in an MCA role in the past. The pharmacist selected a therapeutic area and asked the trainee dispensers about side-effects and contraindications to help them develop in their roles. For example, they had recently discussed anti-depressants. Team members had kept up to date with the relevant coronavirus guidance. This included how to keep themselves and other people safe. They understood the need for whistleblowing and felt empowered to raise concerns when they needed to. Team members were expected to provide feedback to improve services. One of the dispensers had introduced an extra week's worth of baskets so they could plan more of their workload in advance.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and is well maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members. It has made suitable changes to its premises to help reduce the risk of spreading coronavirus.

Inspector's evidence

This was a new purpose-built pharmacy. The premises was large and workstations were at least two metres apart. Up to four team members were on duty at the one time. They could keep a safe distance from each other for most of the day. Dispensing benches had been arranged for different tasks. The pharmacist used a dedicated area for carrying out final accuracy checks and other tasks. The dispenser used a separate dispensing bench to assemble prescriptions. They had ample space for multi-compartment compliance pack dispensing. A consultation room with an integrated hatch provided access to team members in the dispensary. This provided a safe and confidential environment to protect people's privacy. The consultation room was sound-proofed and was well-equipped with a sink and running water. Team members cleaned the room on a regular basis and in between consultations. A treatment room was available but was not being used during the pandemic. The pharmacist observed and supervised the medicines counter from the checking bench. They could intervene and provide advice when necessary. The pharmacy was clean and well maintained. The medicines counter assistant cleaned and sanitised the pharmacy at regular intervals throughout the inspection to reduce the risk of spreading infection. This included frequent touch points such as keyboards and telephones. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are accessible. It generally manages its services to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and it mostly stores them properly.

Inspector's evidence

The pharmacy had a step-free entrance which provided access for people with mobility difficulties. It advertised its services and opening hours in the windows at the front of the pharmacy. And it displayed leaflets at the medicines counter for people to select. The pharmacy used dispensing baskets to manage the risk of items being mixed-up. Dispensing benches were organised and clutter-free. Team members kept the pharmacy shelves neat and tidy. Two large controlled drug cabinets had ample storage space. They were well-organised to manage the risk of selection errors. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members carried out weekly expiry date checks and highlighted products that were short dated. They recorded the checks, so they knew when the next one was due. No out-of-date medicines were found after a check of around 12 randomly selected medicines. A medical fridge was used to store medicines. Team members monitored and recorded the fridge temperatures every morning. The records showed that the temperatures had remained between two and eight degrees Celsius.

The drivers delivered medicines across Inverness and Nairn to people in their homes. They had read and signed the standard operating procedure. Due to coronavirus they knew not to ask people to sign to confirm receipt of their medication. They kept an electronic record of the deliveries so they could respond to queries. Deliveries of controlled drugs were also kept as hard copies. The pharmacy used a standard operating procedure to define the risks associated with valproate supplies. But only the superintendent pharmacist had signed it. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. The pharmacist knew to contact prescribers if they received new prescriptions for people in the at-risk group. Team members supplied warning cards each time they made a supply. The pharmacy used a standard operating procedure to define the assembly process for dispensing medicines in multi-compartment compliance packs. Team members used separate shelves to store the packs. They were kept organised and tidy, so that packs were easy to locate. Supplementary records were used to support the team members to safely assemble and dispense the packs. Records were kept up to date with a list of the person's current medication and dose times. Team members checked prescriptions against the ‘backing sheets’ before they started dispensing and discussed any changes with the relevant prescriber. They annotated descriptions of medicines in the pack and supplied patient information leaflets with the first pack of the four-week supply. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Team members accepted unwanted medicines from people for disposal. They only handled the packages and processed the waste after they had been quarantined for three days. The pharmacy had defined the process for handing ‘drug alerts’. The standard operating procedure had only been signed by the superintendent and responsible pharmacist. Drug alerts were printed, and team members knew to check for affected stock so that it was removed and quarantined. A sample drug alert for losartan was seen to show when the checks had been carried out and what the outcome had been.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy’s equipment is clean and well-maintained. It uses equipment appropriately to protect people's confidentiality. It takes precautions so that people can safely use its facilities when accessing its services during a pandemic.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used crown-stamped measuring equipment, and an elastic band was used to differentiate the measures used for methadone. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team members. The pharmacy had a cordless phone, so that team members could have conversations with people in private. 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 and gloves.

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.