General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Torlum Pharmacy, 22 High Street, Crieff, PH7 3BS

Pharmacy reference: 9012142

Type of pharmacy: Community

Date of inspection: 19/01/2024

Pharmacy context

This is a recently relocated community pharmacy in the town of Crieff in Perthshire. It mainly dispenses NHS prescriptions, including dispensing medicines in multi-compartment compliance packs to help people take them at the right time. And it dispenses serial prescriptions as part of the Medicines: Care and Review service. Team members advise on minor ailments and they deliver the NHS Pharmacy First service.

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	1.1	Standard not met	The pharmacy doesn’t adequately identify and manage all risks associated with its services. It does not update written procedures when it significantly changes its way of working. This includes for the automated dispensing of medicines multi-compartment compliance packs. And not all its team members know how to use the machine, creating a potential risk of error or a delay to people's treatment.
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 doesn't adequately identify and manage all of the risks associated with its services. It does not have up-to-date written procedures for using its automated dispensing machine. And not all team members know how to use it. Team members record and learn from the mistakes they make when dispensing. And they keep the records they need to by law. Team members have knowledge and experience to help support vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage risks. Team members had signed a record of competence to show they understood these. The pharmacy superintendent (SI) reviewed the SOPs regularly, however some SOPs were past their review date. This included the SOP for dispensing medicines in multi-compartment compliance packs. The pharmacy had introduced an automated dispensing machine for dispensing of compliance packs, but the SOP had not been updated to reflect this change in process. Therefore, there was a risk that team members were not following a consistent process for dispensing the compliance packs and potential risks in the dispensing process may not have been mitigated. On the day of inspection no team members were able use the machine. And the regular pharmacist was due to leave the pharmacy over the coming weeks. The SI was contacted following the inspection and confirmed that the SOP had not yet been completed. And a risk assessment had not been completed.

Pharmacy team members recorded mistakes they identified during the dispensing process, known as near misses. They explained errors were highlighted to them by the pharmacist, and the pharmacist would enter it onto the record after discussion with the team member involved. This allowed them to reflect on the mistake. The pharmacist explained that after an error, together with the team, they would implement actions to reduce the likelihood of a similar error happening again. Recently there had been an increase in errors involving the incorrect strength of co-codamol being dispensed. The team had separated the medicines to reduce the recurrence of this type of error. Team members also recorded details of any errors which were identified after the person had received their medicines, known as dispensing incidents. These incidents were recorded and then reviewed by the SI. The pharmacy team aimed to resolve any complaints or concerns informally. But if they were not able to resolve the complaint, they would escalate to the pharmacist manager or SI.

The pharmacy had current indemnity insurance. The RP notice displayed contained the correct details of the RP on duty, and it could be seen clearly from the retail area. The paper RP record was compliant. The pharmacy had a controlled drug (CD) register and the entries checked were in order. Team members checked the physical stock levels of CDs against the balances recorded in the CD register on each dispensing and they completed regular additional audits. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. Accurate records of private prescriptions were maintained electronically.

Team members were aware of the need to keep people's confidential information safe. They were observed separating confidential waste into dedicated containers which was then shredded. The pharmacy stored confidential information in staff only areas of the pharmacy and in secure locked cupboards within the consultation room. Pharmacy team members had completed learning associated

with their role in protecting vulnerable people. They understood their obligations to manage safeguarding concerns. They knew to discuss any concerns with the pharmacist and had access to contact details for relevant local agencies. The pharmacist was a member of the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the appropriate skills and knowledge for their roles. They work well together and communicate effectively. And they are comfortable providing feedback and raising concerns should they need to. But not all team members complete regular ongoing learning to keep their knowledge up to date.

Inspector's evidence

The pharmacy employed a full-time pharmacist who was also the manager. Other team members who worked in the pharmacy included two part-time dispensers, a trainee medicines counter assistant, and a relief dispenser from another pharmacy in the same company who provided support on one day each week. On the day of the inspection the pharmacist was working alone with the sales assistant as a member of the dispensary team was absent. The pharmacist was observed prioritising workload and managing urgent requests from people requiring access to pharmacy services.

Most team members had completed accredited qualification training. One team member, who at the time of the inspection, had not been enrolled on qualification training for their role was subsequently enrolled. Prior to this, they had been supported with informal in-house training. One dispenser had completed training on how to operate the recently installed automated dispensing machine. The pharmacist advised that there were plans to train the other team members, but this had not been completed. This meant that there was a lack of contingency planning of available team members who could operate the machine during periods of planned or unplanned leave. And during some periods of absence no additional staffing hours were provided to allow team members to dispense the packs manually. For example, on the day of inspection no team members were familiar with how to operate the automated dispensing machine. So there was a risk that the pharmacy may not be able to dispense multi-compliance packs using the automated dispensing machine during this time. The pharmacist advised that team members were not currently completing any additional planned ongoing training. So there was a risk that the knowledge and skills for their roles would not always be kept up-to-date.

Planned leave requests were managed by the pharmacist manager. Part-time and relief staff supported by working additional hours during periods of planned leave, but these additional hours had to be authorised by the pharmacy’s head office. The pharmacy team received regular visits from the superintendent pharmacist. They felt comfortable to raise any concerns with their SI. There was no formal appraisal process, but members of the team received regular feedback as they worked.

Team members were observed asking appropriate questions when selling medicines over the counter and referring to the pharmacist. They explained how they would identify repeated requests from people for medicines subject to misuse, for example, codeine-containing medicines. And that they would refer them to the pharmacist. There were some targets set for pharmacy services, but the team felt that these were appropriate and did not feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and the team maintains them to a high standard. It has a private consultation room where people can have confidential conversations with a pharmacy team member.

Inspector's evidence

The pharmacy had recently moved to new premises that were secure and maintained to a high standard. It was clean and organised throughout. The pharmacy workspace was well organised with designated areas for completion of pharmacy tasks and suitable storage of prescriptions. The dispensary was comprised of two main areas. One area was used to label and dispense prescriptions, including serial prescriptions. The other area of the dispensary had an automated dispensing machine which was installed three months before the inspection and was used for dispensing multi-compartment compliance packs. There was a separate area to the rear of the pharmacy to store medicines that were dispensed into multi-compartment compliance packs. A bench used by the RP to complete the final checking process was at the front of the main dispensary near the retail counter. The medicines counter could be clearly seen from the dispensary which enabled the pharmacist to intervene in a sale when necessary. The good-sized consultation room was suitably equipped and fit for purpose. This space allowed team members to have private conversations with people. The consultation room was lockable to prevent unauthorised access when not in use.

There was a clean, well-maintained sink in the dispensary used for medicines preparation and there were other facilities for hand washing. And team members regularly cleaned pharmacy workspaces and staff facilities. The pharmacy kept heating and lighting to an appropriate level in the dispensary and retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to support people's health needs. Overall, it manages its services well and they are easy for people to access. The pharmacy receives its medicines from reputable sources and stores them appropriately. And team members carry out checks to help ensure they keep medicines in good condition.

Inspector's evidence

The pharmacy had a level entrance with an automatic door to the main retail store. The pharmacy displayed its opening hours and some pharmacy services in the window. The team also kept a range of healthcare information posters for people to read.

The dispensary had separate areas for labelling, dispensing, and checking of prescriptions. Team members used dispensing baskets to store medicines and prescriptions during the dispensing process to prevent them becoming mixed-up. Team members signed dispensing labels to maintain an audit trail. Prescriptions waiting to be checked by the pharmacist were stored on shelves. This allowed the dispensary benches to remain clear. The pharmacy provided owing's slips to people when it could not supply the full quantity prescribed. Team members contacted the prescriber to source an alternative medicine if a manufacturer was unable to supply the medication prescribed. The pharmacy offered a delivery service and kept records of completed deliveries. The driver kept an additional record of all CD deliveries.

Team members demonstrated an awareness of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate, and of the associated risks. And the pharmacist was aware of the most recent patient safety alert relating to valproate. The pharmacist explained that they did not have any patients who were in the at-risk group prescribed valproate.

A large proportion of the pharmacy's workload involved providing medicines in multi-compartment compliance packs to people to help them take their medication correctly. A dedicated team member in the main dispensary managed this process. They used medication record cards that contained each person's medication and dosage times. And they ordered people's repeat prescriptions and matched these against the medication record card. The pharmacist advised that the prescription data was entered into the patient medication record (PMR) by the only trained dispenser. The data was clinically checked, and accuracy checked by the RP. And then transferred to the computer system attached to the automated dispensing machine for assembly. This process was not demonstrated as no team members present were able to operate the automated dispensing machine. A description of each medication was written onto the labels and attached to the packs so people could differentiate between the different medicines in the pack. Patient information leaflets were routinely supplied so people had access to up-to-date information about their medicines.

Team members removed medicines from their original packaging and placed them into canisters for use in the automated dispensing machine. The pharmacist checked the accuracy of the medicines in the canister and signed a log sheet to confirm completion of the accuracy check. Each canister contained the same batch number and expiry dates so that there were no mixed batches. The team kept a record of all batch number and expiry dates of stock in the canisters so that medicines could be identified in

the event of a product recall.

The pharmacy supplied medicines in their original packs and multi-compartment compliance packs to people living in local care homes. And it provided accompanying medication administration records. The care homes were responsible for ordering the medicines for people living within the homes and the pharmacy team matched the prescriptions against the order requests on receipt of the prescriptions. Team members managed the dispensing of serial prescriptions as part of the Medicines: Care and Review (MCR) service. The team recorded the date each prescription was due to be collected which allowed the team to dispense medicines in advance of people collecting. The NHS Pharmacy First service was popular. This involved supplying medicines for common clinical conditions such as urinary tract infections under a patient group direction (PGD). The pharmacist could access the PGDs electronically. The pharmacist advised that the medicine counter assistants asked people relevant consultation questions and then referred to an approved list of medicines before suggesting a treatment option to the pharmacist. The pharmacist then completed the consultation.

Pharmacy-only (P) medicines were stored behind the pharmacy counter to prevent unauthorised access. The pharmacy obtained medicines from licensed wholesalers and stored these tidily on shelves. And it used a medical grade fridge to keep medicines at the manufacturers' recommended temperature. Team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the required range of between two and eight degrees Celsius. The pharmacist advised that team members checked the expiry dates of medicines regularly and were up to date with the process, and there was an audit trail to demonstrate completion. Medicines due to expire soon were highlighted. A random selection of medicines were checked and all were found to be within their expiry date. The pharmacy received notifications of drug alerts and recalls via email. Team members carried out checks and knew to remove and quarantine affected stock. They returned items received damaged or faulty to manufacturers as soon as possible. The pharmacy had medical waste bins for pharmaceutical waste.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to support the safe delivery of its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources including the British National Formulary (BNF), the BNF for children. And there was access to internet services. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. And it had a set of clean, well-maintained tablet counters. The automated dispensing machine for multi-compartment compliance packs had recently been installed and had planned regular servicing due by the external provider. And engineer support was available via an instant messaging platform for the machine. The pharmacy stored dispensed medicines awaiting collection, in a way that prevented members of the public seeing people's confidential information.

The dispensary was screened, and computer screens were positioned to ensure people couldn't see any confidential information. The computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones so team members could move to a quiet area to have private conversations with people.

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.