General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Colin Lowe Pharmacy, 205 Perth Road, DUNDEE, Angus, DD2 1AT

Pharmacy reference: 1041743

Type of pharmacy: Community

Date of inspection: 28/04/2021

Pharmacy context

This is a community pharmacy beside other shops on a main road near the city centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. This pharmacy was inspected during the COVID-19 pandemic.

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 suitably identifies and manages the risks with its services, including reducing the infection risk during the pandemic. The pharmacy team members follow written processes for most of the pharmacy's services to ensure they provide them safely. The pharmacy keeps all the records that it needs to by law and keeps people's private information safe. Team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter, hand sanitiser at the premises entrance, and face masks to offer to people who entered the pharmacy not wearing one. The pharmacy had tape on the floor to encourage people to socially distance. Most people coming to the pharmacy wore face coverings and team members all wore masks. They also washed and sanitised their hands frequently. They cleaned surfaces and touch points several times during the day. Head office had asked the previous pharmacy manager to carry out a personal risk assessment with each team member to identify any risk that may need to be mitigated in the pharmacy. But this had not been done until recently when the superintendent pharmacist (SI) had done it. One team member could not wear fluid resistant face masks so was wearing a cloth face covering.

The pharmacy had standard operating procedures (SOPs) which had been put in place by the previous pharmacy manager. But these had been developed from templates and not personalised for this pharmacy. Some referred to English processes so team members were not following them all. And some were appropriate but not being followed e.g. auditing the running balances of controlled drugs (CDs) was not carried out weekly as the SOP stated. But the SI pharmacist who was working full-time in the pharmacy currently was in the process of reviewing and implementing new SOPs. The completed SOPs were appropriate and signed by relevant team members acknowledging that they were following them. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles. Under the previous management some of their skills had not been utilised in some areas e.g. carrying out CD running balances. The SI pharmacist was reviewing skills and competence and re-introducing some tasks to competent team members. A trainee dispenser described what tasks he was competent to complete and gave examples of processes that he was not yet involved in. Team members accurately explained which activities they could not undertake when the pharmacist was absent. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. And they recorded errors that had been identified after people received their medicines. They had only recently introduced this process after a period of not recording such information. They described the review process that they planned to follow to identify recurring themes or areas to address to reduce the risk of errors. The pharmacy had a complaints procedure and welcomed feedback.

The pharmacy had an indemnity insurance certificate, expiring 30 April 2022. The pharmacy displayed

the responsible pharmacist notice and had an accurate responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed specials records, a CD destruction register for patient returned medicines and controlled drugs (CD) registers including running balances. There were a lot of errors in the CD registers. The SI was in the process of investigating them and was working with the NHS CD accountable officer. The pharmacy had not submitted private prescriptions for CDs to the NHS agency which was a legal requirement. Prescriptions from several years ago were observed. The SI pharmacist had identified this and planned to submit them over coming days and keep copies in the pharmacy. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality and had all read a SOP. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members had also read information on safeguarding. They kept information in the dispensary about how to raise a concern locally. The SI pharmacist was aware of initiatives to support victims of domestic abuse. But the pharmacy did not display any information and team members were not familiar with these. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and team members in training to safely provide its services. Team members share information and make suggestions to improve ways of working. But the pharmacy does not support its team members by setting time aside in the working day to help keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist (the SI), one full-time pharmacy technician, two full-time dispensers, three part-time medicines counter assistants (one was Saturday only), and a part-time delivery driver. One dispenser was undertaking training and one medicines counter assistant had started recently. So, she did not yet have company workwear, and was not registered on a course. She was aware of the training she was going to have to complete. Team members were able to manage the workload. The SI pharmacist had recently reviewed staffing levels and recruited the new medicines counter assistant.

The pharmacy did not provide learning time during the working day for team members to undertake regular training and development. Team members were aware of learning modules that they could undertake, and the SI pharmacist described how they were planning implementing these, with some mandatory. The trainee dispenser described completing his coursework at home. The SI pharmacist supervised trainees and other team members supported them and answered questions. Team members were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. An experienced medicines counter assistant described her role assisting in the delivery of the Pharmacy First service, and the SI was observed intervening appropriately.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the SI pharmacist. An example was described which demonstrated that the SI pharmacist was open to suggestions and adopted new process. The pharmacy did not set targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for the pharmacy services provided. It has suitable facilities for people to have conversations with team members in private. And team members respect and manage people's confidentiality. The pharmacy is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a spacious retail area, dispensary and small back shop area including storage space and staff toilet facilities but no rest area. Team members often ate their lunch in a corner of the dispensary. This did not have a negative impact on dispensing workflow. The premises were clean, hygienic and well maintained. But the consultation room and back shop area were untidy and cluttered with stock and boxes. There were sinks in the dispensary and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available in the dispensary and at the medicines' counter.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a large consultation room with a desk, chairs, and computer. But team members could not use it currently as it was too untidy. The SI pharmacist described how she used a quiet corner of the retail area for private consultations. The pharmacy had a discreet area between the dispensary and medicines' counter for specialist services such as substance misuse supervision. It gave people a degree of privacy. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services. And it provides safe services. Pharmacy team members mostly follow written processes. They support people by providing them with information and suitable advice to help them use their medicines. And they provide extra written information to people taking higher-risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. Pharmacy team members know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. And it could provide large print labels for people with impaired vision. The pharmacy provided a delivery service which had been busier during the pandemic.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. And they recorded dates serial prescriptions were due for supply, and the dates the medicines were collected. But they did not reconcile medicines when serial prescriptions started, so could not monitor compliance accurately. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day. The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. They stored completed packs on designated shelves in the dispensary, arranged by the week in which they were managed. This provided team members with visual information such as uncollected packs, and how many had to be assembled each week. They wrote people's names and date of supply on the spine of packs, facing out which helped to identify which packs were due for supply each day. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. They were stored alphabetically in individually named baskets on labelled shelves. The team had recently reviewed this process and improved storage which reduced the risk of errors. The pharmacy also supplied medicines and appliances to several surgeries on stock order forms. The pharmacy did not have a wholesale dealer's licence, but the SI explained that this was not required in Scotland. The inspector advised her to confirm this with MHRA as there was no exclusion on the MHRA website for Scotland. And pharmacies were required to hold a licence WDA(H) unless 'the wholesaling takes place on an occasional basis, the quantity of medicines supplied is small and the supply is made on a not for profit basis'.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. Team members followed the service specifications for NHS services. They had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, and smoking cessation. The pharmacy team members

were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. The pharmacy had arranged formulary items onto one section of the back wall at the medicines counter. This enabled team members to know immediately if an item was in the formulary and therefore suitable for supply within the service. They referred to the pharmacist as required, using a template to record the person's details, symptoms and any other relevant information. This was observed during the inspection. During the pandemic the pharmacist had delivered some services remotely by phone. This had ensured service delivery while minimising footfall on the premises. Services delivered in this way included smoking cessation , urinary tract infection (UTI) treatment and supply of emergency hormonal contraception (EHC). The pharmacist carried out the consultation remotely and if appropriate, the team prepared medication ready for collection when the person came to the pharmacy. Currently there were several people accessing the smoking cessation service and they were coming to the pharmacy. Either the pharmacist or one trained team member undertook the consultation discreetly in a corner of the retail area.

The pharmacy obtained medicines from licensed wholesalers such as Phoenix, AAH, Unichem and Ethigen. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. And team members used space well to segregate stock, dispensed items and obsolete items. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records. Team members contacted people who had received 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 to deliver its services. And it looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had resources 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 people accessing its services. This included a carbon monoxide monitor maintained by the health board, which was used by people accessing the smoking cessation service. But they were not using it during the pandemic for infection control. The pharmacy kept sundries required for vaccination in the consultation room, but it was not offering a vaccination service currently. It had a vaccine fridge in the consultation room which was not in use following a fault. Vaccines were destroyed when team members discovered the temperature had been out with the normal range. They kept crown-stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy used a pump for measuring methadone solution. Team members poured test volumes when they used it and cleaned it after use. The pharmacy kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets. It stored paper records in the consultation room and dispensary which were inaccessible to the public. And it stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave them unattended unless they were locked.

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.