General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Eyemouth Pharmacy, 6 Church Street, EYEMOUTH, Berwickshire, TD14 5DH

Pharmacy reference: 1041940

Type of pharmacy: Community

Date of inspection: 19/08/2024

Pharmacy context

This is a busy pharmacy in the seaside town of Eyemouth in the Scottish Borders. Its main activity is dispensing NHS prescriptions and providing some people with their medicines in multi-compartment compliance packs to help them take their medicines effectively. It provides a range of NHS services including NHS Pharmacy First and it delivers medicines to people in their homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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's written procedures help team members manage risk and provide services safely. Team members record errors made during the dispensing process to learn from them and they make changes to help prevent the same mistake from happening again. They mostly keep the records required by law and they keep people's private information secure. Team members know how to respond effectively to concerns for the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. These included SOPs about the responsible pharmacist (RP), controlled drug (CD) management and dispensing. A sample of SOPs seen showed they had been reviewed by the superintendent (SI) pharmacist in October 2023. The SOPs had been moved to an electronic format from a paper-based format. Team members could not provide evidence that they had signed the most recent SOPs to confirm they understood and complied with them, and the pharmacist confirmed they would review this.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. The person who discovered the error recorded the details about it and discussed it with the person who made the error. Details were recorded on paper. Team members discussed common errors and discussed actions that could be taken to help prevent the same or a similar mistake from occurring. For example, team members had separated different pack sizes of codeine tablets as they were very similarly packaged. Records of the near misses made were shared with the company's head office team on a monthly basis. The pharmacy recorded mistakes that were not identified until after a person had received their medicine in the same near miss log. An example of a recent dispensing incident seen showed that action taken had also been recorded – the pharmacist discussed the error with team members and the cause of the incident was identified as similar packaging. Team members were alerted to the similarity and the importance of storing the medicine in the correct location was highlighted. The pharmacy had a procedure for dealing with any complaints or feedback. This involved aiming to resolve any complaints or concerns informally, and if necessary, people were supplied with details of the company's head office team to submit their complaint in writing. The pharmacist confirmed that some people submitted their complaints directly to the company's head office and they were dealt with by the SI. Team members had responded to a complaint about an out-of-stock medicine and as a result had reviewed their procedures for processing prescriptions with owed medication. The pharmacist reported the pharmacy received regular positive feedback from those using the pharmacy's services.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. And they had a rota of who was responsible for which task each day. The pharmacy's accuracy checking pharmacy technicians (ACPTs) worked within a companywide protocol which meant they did not check any prescriptions for CDs. Team members were aware of the tasks that could and could not take place in the absence of the RP. The RP notice was prominently displayed in the retail area and reflected the correct details of the RP on duty. The RP recorded their name and registration number in the patient medication record (PMR) system at the start of each day. But they did not record when their duties ended. And they could not produce a historical RP record on the day of

the inspection, however this was resolved following the inspection. The pharmacy recorded the receipt and supply of its CDs electronically. A sample of records seen showed they had been completed correctly. Team members checked the physical stock levels of medicines matched those in the CD register on a weekly basis. The pharmacy recorded details of CD medicines returned by people who no longer needed them at the point of receipt. And they were stored separately to ensure they were not mixed with stock medicines. The pharmacy kept certificates of conformity of unlicensed medicines known as “specials” and details of who the medicines were supplied to, which provided an audit trail. It kept paper-based records for the supply of medicines on private prescription and kept associated paper prescriptions. Records showed that, on occasion, the date of supply was not recorded. And some prescriptions were seen that were still awaiting recording, which was outside the requirement for timely recording.

The pharmacy had a NHS Community Pharmacy Services Data notice on display which informed people of how their data was used. Team members were aware of their responsibility to keep people’s private information secure. The pharmacy separated confidential waste for uplift to the company’s head office pharmacy where it was shredded on site. Team members were also aware of their responsibility to safeguard vulnerable adults and children. They knew to refer any concerns to the pharmacist in the first instance who had previously referred concerns to the GP surgery or appropriate authorities. The delivery driver would also report any concerns about people they were delivering to back to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large team of suitably skilled and competent team members to help manage the workload. Those in training receive appropriate support to complete their courses. And other team members are given training to continue developing their skills and knowledge. They suitably respond to requests for sales of medicines and support people with their healthcare needs.

Inspector's evidence

The RP at the time of the inspection was a base pharmacist employed by the company. They were supported by a large team, which included three ACPTs, three dispensers, a trainee dispenser and a medicines counter assistant (MCA). Team members who were not present during the inspection included two pharmacists, one of whom worked alongside the regular pharmacist once a week, and a second who covered every third Saturday. The three employed pharmacists covered the pharmacy's opening hours. And there was an additional two ACPTs, a dispenser, a trainee MCA and a Saturday sales assistant. The pharmacy also had a delivery driver. Team members had either completed or were in the process of completing accredited training for their roles. One of the ACPTs acted as a tutor for one of the trainee MCAs, and they were working together to review the trainees progress through the course. Team members who had completed their training were given opportunities to develop their skills and knowledge as and when required. For example, a recent update to the teams' skills and knowledge had been learning about issuing sodium valproate safely to people. And trained dispensers were now involved in general stock management, including ordering of medicines. Team members also received regular communications from the pharmacy's head office with information that was to be shared, including a recent update about a new supplier. The pharmacist had completed training to provide the NHS Pharmacy First service.

Team members were observed to work well together and were managing the workload. There was an open and honest culture, and they felt comfortable to raise professional concerns with the pharmacist if necessary. And they were able to contact the pharmacy's SI if necessary. The company had recently employed a new human resources team member who was due to complete performance reviews with team members. If team members wanted to develop their skills and knowledge by undertaking additional qualifications, they were able to request this.

Team members knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. They referred such requests to the pharmacist or the person's GP. They were observed asking appropriate questions when selling medicines to people over the counter. The pharmacy did not set its team members targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. It has appropriate facilities for people requiring privacy when accessing services.

Inspector's evidence

The pharmacy comprised of a large front retail area and the main dispensary positioned behind this. There were rooms to the rear of the premises which were used for the preparation of multi-compartment compliance packs, for the storage of medicines and for team members to have their breaks. There was a medicines counter which acted as a barrier to the dispensary. There were different bench spaces in the dispensary for the completion of different tasks, including dispensing and checking of medicines. The pharmacist's checking bench was situated in way which meant they could supervise the main dispensary and medicines counter easily. And they could intervene in conversations at the medicines counter if required. There was a small area adjacent to the main dispensary where people were able to have their medicines supervised privately. The dispensary had a sink which provided hot and cold water. Toilet facilities were clean and had separate handwashing facilities. Lighting provided good visibility throughout and the temperature was comfortable.

The pharmacy had a consultation room which was accessed from the retail area for people and from the dispensary for team members. The room had a desk and chairs for consultations to be provided comfortably. The room had a sink, but this was not routinely used.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages the delivery of its services safely and effectively. Team members generally complete suitable checks on medicines to ensure they remain fit for supply. They mostly provide people with relevant information to help them take their medicines safely. And they respond appropriately to alerts about the safety of medicines.

Inspector's evidence

The pharmacy had two main entrances. At the front door there was a step up into the retail area from the street. And to the side there was a flat entrance for people using wheelchairs or with prams. The doors were not automatic and team members assisted anyone who required it by opening the door for them. The pharmacist also confirmed that the level entrance door usually remained open to allow air into the pharmacy. The pharmacy provided people who had visual difficulties with large print labels. They signposted people to other pharmacies to access services they did not offer. The pharmacy displayed a range of healthcare leaflets in the consultation room for people to read or take away.

Team members used baskets to keep people's prescriptions and medicines together and reduce the risk of them becoming mixed up. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Team members were aware of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicine effectively. They were aware of the requirement for dispensing valproate in original packs but had not yet completed risk assessments for those who received their medication outside the manufacturers original pack. Team members asked appropriate questions when handing out medication to people to ensure they were provided to the correct person.

The pharmacy provided the NHS Pharmacy First service. The service was underpinned by PGDs, and the pharmacist accessed the most up to date versions of these online. The pharmacy supervised the administration of medicines for some people. The pharmacist managed the provision of the service. They prepared doses in advance on the day before supply, so they were ready for people to collect. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. Team members ordered the prescriptions in advance so any queries regarding a person's medication could be resolved. Each person had a medication record sheet which detailed the medicines and administration times. Team members recorded any changes to a person's medication which were communicated from the GP surgery and updated the person's record. Team members submitted the information about the packs to a central hub pharmacy in the company where the packs were prepared by automation. And packs that contained CDs were made up manually in the pharmacy. The compliance packs were checked by ACPTs at the hub pharmacy and again when they were returned to the pharmacy. Compliance packs prepared at the hub pharmacy were supplied with descriptions and pictures of the medicines in the pack so they could be easily identified. The pharmacy provided patient information leaflets for packs that were prepared in the pharmacy, but they were not routinely provided for packs that were made at the hub pharmacy. The pharmacy provided a delivery service. Drivers delivered medicines to people in their homes or to two local community shops where people were able to collect them more easily. The pharmacist explained the community shops were provided with a sheet to sign confirming people had collected their

medicines. For home deliveries, the pharmacy's driver signed to confirm people had been given their CDs. Multi-compartment compliance packs and CDs were not left at the community shops, but medicines requiring refridgeration were, and they were stored in the shop's fridge. The fridge at the shop was not subject to temperature checks and the importance of ensuring that medicines were stored appropriately was discussed.

The pharmacy sourced its medicines from licensed wholesalers. Medicines were stored neatly on the dispensary shelves. Pharmacy only (P) medicines were stored behind the medicines counter which ensured the sales of these medicines were supervised by the pharmacist. Team members completed checks on the expiry dates of medicines, with each team member responsible for a different area of the dispensary. Checks were completed every three months. Records showed the last recorded date checking had been completed in February 2024, but team members thought it had been completed after this. Any medicines that were expiring in the next six months were highlighted for use first. And liquid medicines with a shortened expiry date on opening were marked with the date of opening. Team members checked the expiry dates when dispensing and checking medicines. A random selection of ten medicines found none past their expiry date. The pharmacy had two fridges to store medicines that required cold storage. Team members recorded the temperatures daily. The fridges showed a current temperature between the required two and eight degrees Celsius during the inspection. Team members received notifications about drug alerts and recalls via email. They printed and actioned the alerts and signed to say it had been completed. The pharmacy kept medicines returned by people who no longer needed them separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to paper copies of the British National Formulary (BNF). And it accessed electronic resources including the electronic medicines compendium (EMC) to ensure up to date information was used. It had crown-stamped measuring cylinders which were marked to identify which were for water and which were for liquid medicines. It had clean triangles used to count tablets.

The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines awaiting collection in the dispensary in a way that ensured people's private information was secured. Confidential information was secured on computers using passwords. And they were positioned in way that meant only authorised people could see the information the screens.

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.