

Registered pharmacy inspection report

Pharmacy Name: Well, 91 High Street, TILlicOUNTRY,
Clackmannanshire, FK13 6AB

Pharmacy reference: 1041952

Type of pharmacy: Community

Date of inspection: 21/05/2024

Pharmacy context

This is a community pharmacy on the high street in the town of Tillicoultry. Its main services are dispensing NHS prescriptions including serial prescriptions. And it dispenses medicines in multi-compartment compliance packs to help people take their medicines at the right time. The pharmacy provides substance misuse services. And they supply over-the-counter medicines and prescription-only-medicines via the NHS Pharmacy First service.

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 adequately identifies and manages the risks of the services it provides. And team members understand their role in helping to protect vulnerable people. The pharmacy keeps the records it needs to by law, and it suitably protects people's confidential information. Pharmacy team members record and discuss mistakes made during the dispensing process and make changes to help prevent the same or a similar mistake occurring.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) available to its team members which were designed to help them work safely and effectively. SOPs were reviewed by the Superintendent Pharmacist (SI) and team members completed an online assessment and declaration to show they had read and understood them. Notification of new or updated SOPs were communicated with team members via email. The latest SOP to be actioned was slips, trips, and falls which the team had planned to complete over the coming week. Team members described their roles within the pharmacy and accurately described what activities they couldn't undertake in the absence of the responsible pharmacist (RP).

A signature audit trail on medicines labels showed who dispensed and checked each medicine. This meant the RP and accuracy checking pharmacy technician (ACPT) were able to help team members learn from dispensing mistakes. The pharmacy had a process in place to record dispensing mistakes which were identified before a medicine was supplied to a person, known as near misses. These were recorded at the time of the mistake on a paper-based log and included details such as the time and date the near miss happened, and any contributing factors. Mistakes that were identified after people received their medicines, known as dispensing incidents, were recorded on an electronic system and then reviewed by the SI. Team members discussed these and agreed actions which were put in place to manage the risks of similar mistakes happening again. This included separating stock of medicines with similar names or packaging to avoid selection errors. And using warning stickers on shelves where stock was stored to encourage care when dispensing higher-risk medicines such as gabapentin and pregabalin. And team members no longer attached bag labels to dispensing baskets during the dispensing process to prevent labels becoming attached to the wrong person's bag. This reduced the risk of medicines being supplied to the wrong person and protected people's confidential information. The pharmacy had a complaints procedure and welcomed feedback. Team members were trained to manage complaints and aimed to resolve them informally. But if they were not able to resolve the complaint they would escalate to the pharmacist or SI.

The pharmacy had current professional indemnity insurance. The pharmacist displayed an RP notice which was visible from the retail area and the RP record held electronically was up to date. Team members maintained complete electronic controlled drug (CD) registers and they checked the balances weekly. A random balance check of one CD was correct. The pharmacy had records of CDs that people returned for safe disposal. Records of private prescriptions and unlicensed medicines were up to date. Team members knew how to protect people's privacy and confidential waste was segregated for collection and safe disposal off-site by a third-party contractor. Team members had completed online training relating to the safeguarding of vulnerable people and they discussed any safeguarding concerns

with the pharmacist. Team members were able to provide examples of signs that would raise concerns and provided evidence of interventions the team had made to protect vulnerable people.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members have the necessary skills and qualifications for their roles and the services they provide. They manage their workload well and support each other as they work. And they feel comfortable raising concerns and discussing improvements to provide a more effective service.

Inspector's evidence

The pharmacy employed one full-time pharmacist manager, one full-time ACPT, one part-time technician, two part-time dispensers and a delivery driver who worked every day. At the time of inspection, the RP was a locum pharmacist and was supported by two dispensers as well as a dispenser who provided contingency cover in periods of absence. Team members were observed providing support to each other and managing the workload well. Annual leave was planned in advance to ensure staffing levels remained sufficient to manage the workload safely.

The pharmacy provided protected learning time for team members undertaking accredited courses. Team members did not plan regular learning time during the working day. But protected time was provided for specific continued learning and development. For example the introduction of new services or updated SOPs. The pharmacist manager attended face-to-face training for the NHS Pharmacy First service. And they communicated relevant information to team members verbally during informal staff meetings. Team members had appraisals with the pharmacist manager once a year to review progress and identify any individual learning needs. Team members asked appropriate questions when selling over-the-counter medicines. And they explained how they would handle repeated requests for medicines liable to misuse such as codeine-containing medicines by referring to the RP for supportive discussions or for further referral to their GP. The pharmacy had a close working relationship with the local GP practice and communicated any requests or notable information with a referral slip. This ensured that there was a clear audit trail of information exchanged and allowed any queries to be dealt with in a concise manner.

Team members were comfortable discussing suggestions to improve their ways of working. There was a whistle blowing policy in place. A team member explained that they were not sure of the information contained within it, but they would feel comfortable raising concerns with the RP or SI. Team members were set targets by the company but did not feel under pressure to achieve them or felt they compromised patient safety.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean, secure and provides a professional environment suitable for the services it delivers. It has a private consultation room where people can have confidential conversations with a member of the pharmacy team if needed.

Inspector's evidence

The pharmacy premises were clean and provided a professional image. There was a well-presented retail area which led to a healthcare counter and dispensary. And a small waiting area with a chair.

The dispensary was laid out in a way which allowed the pharmacist to supervise the sale of medicines and intervene in a sale where necessary. But also allowed for privacy to prevent distractions during the dispensing and checking of prescriptions. The dispensary was small with limited bench space and floor space. Stock and prescriptions awaiting collection were stored on the floor which posed a potential trip hazard, but team members were aware and managed the space well. The dispensary had a sink with access to hot and cold water for professional use and hand washing. There was a small area which provided further space with a computer for team members to work and complete different tasks. And a retrieval area provided storage for prescriptions awaiting collection. Staff facilities were hygienic with access to hot water. The pharmacy had a consultation room that was secure, appropriate in size, clean and fit for use. It also had a separate private area for specialist services such as substance misuse supervision. Lighting and temperature were kept to an appropriate level throughout the premises.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services that are easily accessible to people. And it provides them safely. The pharmacy suitably sources its medicines from recognised suppliers, and it stores them appropriately. Team members conduct appropriate checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy had good physical access via a low step and an automated door activated by a touch pad. The pharmacy advertised its opening hours in the main window. It had a range of healthcare leaflets for people to read or take away relating to different conditions. And it advertised different services available in the local community such as wellbeing services. The pharmacy had the facilities to provide large-print labels to help people with visual impairment take their medicines safely. It purchased medicines and medical devices from recognised suppliers. And team members conducted appropriate monitoring to ensure they were fit for use. This included a date checking rota to identify medicines that were due to expire. And stickers were attached to stock to indicate it was short dated and should be used first. The pharmacy used one fridge to store medicines and prescriptions awaiting collection. The pharmacy checked and recorded temperatures daily to show that the temperature remained within the recommended limits of 2 and 8 degrees Celsius. The fridges were well organised with prescriptions awaiting collection separated from stock.

Team members used baskets during the dispensing process to separate people's prescriptions and prevent medicines becoming mixed-up. And they highlighted the inclusion of a fridge line or CD on a prescription by attaching coloured stickers to the outside of the bag of the dispensed medicines. The pharmacy provided a delivery service and people signed to acknowledge receipt of their prescription. Some people received serial prescriptions under the Medicines: Care and Review (MCR) service. Team members stored these prescriptions alphabetically. And they prepared them in advance of the expected collection date. The pharmacy maintained records of when people collected their medicines. This meant the pharmacist could easily identify any issues with people not taking their medicines as they should. The team used an offsite pharmacy hub for dispensing people's repeat prescriptions which helped manage the workload within the pharmacy. Team members entered the prescription electronically onto the patient medication record which was clinically checked by the RP before being assembled at the hub pharmacy. The completed prescriptions were delivered within three working days. An accuracy check was performed on a random sample of prescriptions dispensed at the hub. Some medicines were not suitable to be dispensed at the hub pharmacy. These included CDs, higher-risk medicines and medicines which required to be removed from the manufacturers original packaging.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested to help them with their medicines. Team members worked two weeks in advance of supply to allow time to resolve any issues. The pharmacy maintained a record of each individual's current medicines on a master sheet. This was checked against prescriptions received before dispensing. Team members attached backing sheets to each pack and these included warning labels for each individual medicine, instructions for use and a description of what each medicine looked like. Patient information leaflets (PILs) were routinely supplied every month to ensure people had up-to-date information relating to

their medicines.

The NHS Pharmacy First service was popular. This included providing medicines to people for minor conditions such as urinary tract infections and skin infections under a Patient Group Direction (PGD). PGDs were accessed electronically, and team members were trained to ask the appropriate questions. Team members used consultation forms to gather information with the patient before they referred to the pharmacist for treatment. The pharmacy kept consultation records to record treatment or referral decisions. And team members communicated these to people's GP to ensure their medical records were kept up to date. But these paper records were stored loosely and had become mixed-up on top of other folders in the dispensary. This may make it difficult to refer to information in the future.

The pharmacy attached labels to prescriptions that indicated further counselling was required for higher-risk medicines such as methotrexate. And pharmacy team members were aware of the risks associated with valproate-containing medicines and the Pregnancy Prevention Programme. The pharmacy actioned Medicines Healthcare and Regulation Authority (MHRA) product recalls and safety alerts on receipt and kept records electronically of action taken.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Pharmacy team members have access to appropriate equipment that is fit for purpose and safe to use. And team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available which included the British National Formulary (BNF). And team members were able to access online resources to obtain up-to-date information and guidelines to support them in their roles.

A blood pressure monitor in the consultation room was visibly free from wear and tear. The pharmacy had tablet counters for dispensing loose medicines and CE-stamped glass cylinders for dispensing liquids. They had highlighted specific measures to be used solely for substance misuse medicines. The pharmacy also used an automated dispensing pump for measuring substance misuse medicines. The RP calibrated it every morning to ensure it accurately measured the required doses.

Prescriptions awaiting collection were stored on shelves in a retrieval area and confidential information was not visible to people in the waiting area. Computers were password protected and computer screens were positioned in a way that protected them from unauthorised view. Team members used cordless telephones to enable private conversations in a quieter area.

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.