

Registered pharmacy inspection report

Pharmacy Name: Well, 39-41 High Street, LOCHMABEN,
Dumfriesshire, DG11 1NG

Pharmacy reference: 1042015

Type of pharmacy: Community

Date of inspection: 22/08/2024

Pharmacy context

This is a community pharmacy in the town of Lochmaben in Dumfries and Galloway. 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.

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 | 1.6 | Standard not met | The pharmacy does not always maintain accurate records for all of its higher risk medicines. And it does not resolve problems with the accuracy of these records in a timely manner. |
| 2. Staff | Standards not all met | 2.1 | Standard not met | The pharmacy does not have enough suitably qualified team members to ensure it can operate safely and effectively. |
| 3. Premises | Standards not all met | 3.1 | Standard not met | The pharmacy premises is cluttered and has health and safety risks which does not allow for the suitable delivery of pharmacy services. |
| 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 does not always keep complete the records it needs to as required by law. Team members do not resolve, or report identified errors with some of its higher-risk medicines in a timely manner. The pharmacy's written procedures help team members manage risk and provide services safely. They have the necessary training to keep people's private information secure and 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), stock management and controlled drug (CD) management. The company's superintendent (SI) pharmacist team reviewed the SOPs every two years. Team members had completed quizzes for each SOP to confirm their understanding of them. The pharmacy had a business continuity plan for when the pharmacy was unable to open due to service disruption, such as not having a RP. There was evidence that the pharmacy had not opened regularly on Saturdays as there was no RP. Team members prepared signs which were displayed on the main windows and door which informed people of the closure and indicated where the nearest available pharmacy was open. Team members did not inform the Health Board of the closure themselves, and believed this was the responsibility of the area management team.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. Details about the mistakes were recorded electronically by the person who made the mistake. The form allowed team members to record the type of near miss, for example an incorrect quantity, but did not require the team member to record the medicine involved. This may mean that opportunities to identify common medicines may be missed. Team members could not access past records, so no examples were seen during the inspection. The pharmacy did not complete a formal review of the mistakes made but a team member explained how they reflected and learned from their mistakes. For example, they had identified they had made repeated mistakes which involved a specific form of a medicine. And they had identified steps to take to be more vigilant when selecting the medicine. The pharmacy recorded mistakes that were not identified until after a person had received their medicine, known as dispensing errors. The errors were also recorded electronically. They also could not be accessed by team members once recorded so none were seen during the inspection. The electronic form helped identify the root cause of the dispensing error. Team members discussed both near misses and errors informally with each other. They had started tidying the shelves where medicines were kept to help prevent medicines selection errors. However, some shelves remained untidy with different medicines and different strengths of the same medicine mixed up.

The pharmacy had a procedure for dealing with any complaints or feedback. Team members aimed to resolve any complaints informally. For any complaints that could not be resolved informally team members provided people with contact details for the pharmacy's head office team. The pharmacy had received a high number of complaints in the past few months regarding pharmacy closures, operational issues and staffing levels which the head office and area operations manager were aware of. People had also reported complaints to the GPhC. The company had employed a full-time pharmacist and a team leader to help provide a consistent service and improve staffing levels. And the team leader was

being mentored by an experienced team member from another of the company's pharmacies. Team members reported that complaints had reduced in the last six weeks and that feedback was improving. And their workload at the time of the inspection was up to date and they were working on prescriptions from the previous day. Team members had identified issues to resolve in the pharmacy, which included checking medicine expiry dates and tidying and organising shelves. And they had started work to address these points. They had received feedback that some of the chairs used for people waiting to collect their prescriptions were unhygienic. They had removed the chairs and were awaiting new ones in response to the feedback.

The pharmacy had current professional indemnity insurance. Team members had daily discussions to decide who would be responsible for the completion of specific tasks in the pharmacy. And they reviewed this during the day to ensure that tasks were being completed. Team members were aware of the tasks that could and could not take place in the absence of the pharmacist. The RP notice was displayed in the retail area of the pharmacy and reflected the correct details of the pharmacist on duty. The RP record was completed electronically with some pharmacists recording the details across two different records. Some records were on the patient medication record (PMR) system, and some were on a company platform.

The pharmacy recorded the receipt and supply of its CDs electronically but not all the entries were accurate as there were discrepancies between the quantity recorded in the register and the physical quantity held. Team members were aware of the discrepancies and the need to investigate them. A review of randomly selected controlled drug registers showed that team members had last completed a check of the physical stock levels against the quantity recorded in the register in May 2024. And another register was last checked in January 2024. A discrepancy of one CD had been recorded in the register in May 2024, but there was no evidence of any action taken in response. Team members were informed of the need to identify and investigate discrepancies and report any unresolved discrepancies to the Health Board CD accountable officer (CDAO). The pharmacy recorded CDs returned by people who no longer needed them at the point of return. Patient-returned and out-of-date medicines were generally kept separately from stock medicines in the CD cabinet. But overall, the cabinet was cluttered and included medication prepared in instalments which may have no longer been required. This increased the risk of medicines becoming mixed up with routine stock or medicines being issued that were no longer required. Team members could not confirm if CD prescriptions found next to the pharmacy computer had been supplied. There were no entries recorded in the CD register for these prescriptions. The pharmacy provided one example of a completed certificate of conformity for medicines known as "specials", which included details of who the medicine was supplied to for audit trail purposes. Team members did not know where previous records were kept. The pharmacy kept complete records of the supply of medicines against private prescriptions and kept associated prescriptions. Two examples were seen from 2023 of private CD prescriptions which had not been submitted to the relevant NHS authority.

The pharmacy had a company privacy notice and NHS data processing notice displayed in the retail area informing people of how their data was used. Team members had completed training about information governance in the form of SOPs, on an online company portal and through their accredited training. The pharmacy separated confidential waste for uplift by a third party for shredding. Team members were aware of their responsibility to safeguard vulnerable adults and children. They would refer to the team leader and the pharmacist in the first instance if they had any concerns. And the pharmacist would refer to the SI team. The pharmacy had contact details displayed on the dispensary wall for relevant authorities, but team members were unsure if they were up to date. The pharmacist was registered with the protecting vulnerable groups scheme.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy does not always have enough team members to manage all aspects of the pharmacy's workload. This means that sometimes the pharmacy has to unexpectedly close and therefore people struggle to access the pharmacy's services. Team members are supported by more experienced colleagues to develop their skills and knowledge. They suitably respond to requests for sales of medicines and support people with their healthcare needs appropriately.

Inspector's evidence

The RP at the time of the inspection was a locum pharmacist who had previously worked in the pharmacy. They were supported by a qualified dispenser and a trainee dispenser. The pharmacy employed a pharmacist who worked in the pharmacy full-time but was not present on the day of the inspection. Additionally, the pharmacy had a relief dispenser who worked in the pharmacy one day a week. The qualified dispenser had been seconded to the pharmacy as a team leader and was being supported in the role by an experienced team member from another pharmacy in the company. The pharmacy had a delivery driver who worked part-time. Annual leave was planned in advance. Team members from other pharmacies in the company could support during periods of absence. But this was only possible if the other pharmacies had sufficient team members to provide support, which wasn't often. Company-employed delivery drivers or agency drivers covered driver absences.

The pharmacy currently only had two full-time team members, one of whom was the pharmacist. There was a vacancy advertised for either a trained or trainee dispenser, but the contracted number of hours had not yet been confirmed. The pharmacy operated on a Friday after 3pm with just the pharmacist and one dispenser to manage the workload. The resident pharmacist worked every second Saturday. And the pharmacy regularly struggled to employ a locum for the other Saturday. This meant that the pharmacy had repeatedly closed on Saturdays. And complaints about this had been received by the GPhC and NHS Health Board. Team members were generally not made aware that there was no pharmacist to cover a Saturday until the day before. This meant that they were unable to provide the local community with advance notice of the closure. Team members were focussing on dispensing during business hours to ensure that it was up-to date which meant that some other tasks such as date checking were completed by team members outside of business hours. And other administration tasks such as CD balance checks and resolution of discrepancies were not completed in a timely manner. The trainee dispenser mostly completed their training at home. Their accredited training had been paused and was due to be reactivated. The team leader was due to have a performance review as part of their 12-week secondment. Team members worked well together to try and complete the workload but seemed under pressure.

Team members were aware of the appropriate questions to ask people when they sold medicines over the counter and referred anything they were unsure about to the pharmacist. They knew to be vigilant to repeated requests for medicines liable to misuse and referred these to the pharmacist or GP. The pharmacy set its team members targets which team members sometimes felt under pressure to achieve but ensured they did not compromise patient care in order to achieve the targets.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy premises are cluttered which creates a significant risk of team members tripping or falling. The dispensary's bench space is also cluttered which may increase risks to patient safety. Access to the fire assembly point is difficult for the pharmacy's team members. Team members use a screened area of the medicines counter to provide privacy for people accessing services. The pharmacy's consultation room is untidy and unclean and not routinely used for consultations.

Inspector's evidence

The pharmacy had a spacious retail area to the front and a small dispensary positioned behind this. The retail area was tidy and floorspaces were clear, and there was a barrier at the medicines counter which prevented unauthorised access to the dispensary. The dispensary was narrow and much of the floor space was taken up with cardboard boxes which contained consumables and medication that was waiting to be stored on the pharmacy shelves. Cardboard boxes covered a rear fire exit which were moved during the inspection. The garden area to the rear of the premises where team members were to assemble if there was a fire was overgrown with no way to access the assembly point, which presented a health and safety risk. And cardboard boxes were routinely discarded outside the back door and were wet. There was a shed in the garden and an unlocked cabinet which contained consumables. And some of the boxes were wet. Heaters used within the retail area and dispensary had left marks on the floor which indicated the floor had been subject to excessive heat. The pharmacy's workbenches were filled with dispensed prescriptions, although there were separate areas where team members were able to work. The pharmacist's checking bench was situated so they were able to effectively supervise the medicines counter and dispensary easily. There was a sink in the dispensary which provided hot and cold water. There was a toilet which provided separate handwashing facilities. A small staff area was also untidy, and access to the toilet was difficult due to the volume of clutter on the floor. The temperature was comfortable, and lighting provided good visibility throughout.

The pharmacy had a consultation room where people could speak privately with team members. There was a desk, chairs and a computer. The room was untidy, dirty and the space to move around was reduced as there were two additional chairs, removed from the waiting area, just inside the door. The sink in the room did not work. Team members stored returned medicines bins in the consultation room as there was insufficient space in the dispensary for the number of bins they currently had. Team members did not routinely use the consultation room. A frosted partition at the medicines counter provided a degree of privacy for people to have conversations with team members about their health.

Principle 4 - Services ✓ Standards met

Summary findings

Overall, the pharmacy suitably manages the delivery of its services. Team members generally complete appropriate checks on medicines to ensure they remain fit for supply. They 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 a small step up from the street. Team members assisted people at the front entrance if needed. And they provided large print labels to people with visual difficulties. Team members signposted people to other pharmacies for services they did not offer.

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. They used stickers to highlight the inclusion of a fridge item, CD or if the pharmacist wanted to speak to a person when they collected their medication. 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 medicines effectively. There were no risk assessments seen for people who received their valproate outside the manufacturer's original pack, although team members confirmed they did not have anyone in the at-risk category. Team members were observed asking appropriate questions when handing out medication to people to ensure they were provided to the correct person. Team members provided people with owed medication a slip which was a record of the medication that was to be supplied. They reviewed owed medication daily and for medicines that were out of stock at the manufacturer, they requested alternatives from the GP surgery.

The pharmacy provided the NHS Pharmacy First service. The service was underpinned by patient group directions 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 and prepared doses weekly, 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 time. Team members ordered the prescriptions in advance so any queries regarding the medication could be resolved. Each person had a medication record sheet which detailed the medicines and administration times. Team members received communication about changes to a person's medication from the GP surgery and a record of these was kept. Packs were supplied with descriptions of the medicines so they could be easily identified. And people were supplied with patient information leaflets, so they had information about their medicines. The pharmacy provided a delivery service. The driver used an electronic device as a record of the deliveries to be made and signed electronically to confirm the delivery had been made. The pharmacy used the company's central hub pharmacy to dispense some of its medicines. The pharmacist completed a clinical and data accuracy check of the prescriptions before the information was transferred to the hub pharmacy. The prescriptions were then matched to the bags of completed medicines by team members once they returned from the hub pharmacy two days later.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were

stored behind the medicines counter which helped ensure the sales of these medicines were supervised by the pharmacist. Team members completed checks on the expiry date of medicines. And records showed date checking of some sections of the dispensary had been completed in August. Medicines that were expiring in the next 6 months were highlighted for use first. A random selection of 15 medicines found none past their expiry dates. One liquid medicine with a shortened expiry date on opening was found not marked with the date of opening and this was removed during the inspection. The pharmacy had a fridge to store medicines that required cold storage. Team members recorded the temperatures daily and records showed the temperatures were within the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls via email. They printed, actioned and signed the alerts and marked on an electronic platform they were complete.

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 online versions of the British National Formulary (BNF). It had crown marked measuring cylinders which were marked to identify which were for water and which were for liquid medicines. It had triangles used to count tablets which were cleaned after use.

The pharmacy had a cordless telephone so that conversations could be kept private. Team members reported it had stopped working during the inspection. They had attempted to report this, but it had not been resolved by the end of the inspection. Confidential information was secured on computers using passwords. And they were positioned in a way that meant only authorised people could see information screens. Medicines awaiting collection were stored in way which protected people's private information.

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. |