General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Longniddry Pharmacy, 27 Links Road, LONGNIDDRY, East Lothian, EH32 0NH

Pharmacy reference: 1042029

Type of pharmacy: Community

Date of inspection: 06/02/2020

Pharmacy context

This is a community pharmacy set in a row of shops in a village. The pharmacy dispenses NHS prescriptions and advises on and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartment compliance packs. It offers NHS flu vaccination as part of a local pilot. The regular full-time pharmacist is the pharmacy superintendent.

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 team members follow written processes for all services to ensure that they are safe. They record mistakes to learn from them. And they make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. She was in the process of re-writing some. She had recently introduced new SOPs for the management of controlled drugs. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. Although they had not been consistently doing this over the past few weeks. The pharmacy did not follow a formal review process, but the small number of team members discussed incidents and made some changes to avoid the same errors happening again. They placed labels on shelves to identify medicines in similar packaging e.g. gabapentin. Their main errors were with quantities and forms and the pharmacist was reminding them to take more care, read prescriptions carefully and check items before passing for the final accuracy check. They had separated different Salamol inhaler preparations. And they had noticed the number of errors decreasing since they had changed their dispensing process. The team had identified that the dispensary was busy on Tuesdays and the medicines counter was quiet. So, two team members worked in the dispensary, one labelling and one dispensing which improved efficiency and safety. The pharmacy had used the previous inspection report to identify areas for improvement. This included the dispensing process. Team members discussed this and made some changes. They now selected medicines before labelling. This meant that they could identify and set-up 'owings' when labelling. And they were making fewer errors as often a different team member was labelling and seeing the selected medicines. Team members had also reviewed the process followed for the management of multi-compartment compliance packs. They had concluded that the process used was safe and efficient so had not made any changes.

The pharmacy had a complaints procedure and welcomed feedback. Team members could not think of any complaints but gave several examples of positive feedback. This included people being grateful for the pharmacy delivering their medicines to them when they were unable to get out or unwell.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. 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. They had all read information on

the topic when they had started work in the pharmacy. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members had awareness of safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The delivery driver alerted the pharmacist if he had any concerns about the health or welfare of people he delivered medicines to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified or team members in training to safely provide its services. Team members have access to training material to ensure that they have the skills they need. And the pharmacy gives them time to do this training. All pharmacy team members make decisions appropriate to their role. And they use their professional judgement to help people. They can share information and make suggestions to improve ways of working and keep the pharmacy safe.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager (superintendent pharmacist), two part-time trainee dispensers, one part-time trainee medicines counter assistant, one trainee Saturday only medicines counter assistant and a delivery driver. The medicines counter assistant worked three days per week and both dispensers worked the other two days. This meant that the pharmacy always had two team members and a pharmacist working. Team members were able to manage the workload. And the dispensers working on the medicines counter ensured that their 'over-the-counter' medicines skills were retained. The trainee medicines counter assistant had completed her training and was waiting for results of her final test. The pharmacy gave the trainee dispensers two hours each week to complete their training courses. And the Saturday only medicines counter assistant, who had started in the pharmacy about six weeks ago, had started her accredited course. The pharmacist supervised and coached all team members as required. The pharmacy had recently introduced a learning planner to identify areas and activities where coaching or training was required. And team members used training modules in regular publications such as 'pharmacy matters' and 'training matters' to keep their knowledge up-to-date. They undertook the learning quizzes in these which recorded their score electronically. But they were mainly focusing on their coursework currently.

The various 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 awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. During the inspection an example was observed of a team member providing accurate and effective advice following a request for an over-the-counter product. She used the sale of medicines protocol well to determine what other medicines the person was taking and used this information to advise 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 pharmacist. All team members had been involved in changing the dispensing process over the past few months. The owner sometimes visited the pharmacy, but it could be difficult to have meaningful conversations as the pharmacy team members were busy with day-to-day pharmacy activities. They had mentioned challenges with cramped conditions and limited dispensing bench space.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average-sized pharmacy premises incorporating a retail area and small medicines counter, very small dispensary and basic staff facilities. Space in the dispensary was challenging and some medicines waiting to be checked had to be stored on the floor. Team members were careful not to place baskets of dispensed medicines on the floor in case other items fell into them. The dispensary had an old-fashioned and ‘tired’ appearance. The retail area was spacious. And items for sale included general household and garden items, as well as medicines, toiletries and sundries. The premises were clean and hygienic. There were sinks in the dispensary and toilet area. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs and sink, and the door closed providing privacy. Lighting was appropriate. But the pharmacy felt cold, and the consultation room was colder.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team members help people to ensure that they can all use the pharmacy's services. The pharmacy provides safe services. Team members 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. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had a step and heavy door at its entrance. Team members helped people as they required. The pharmacy displayed its services and had leaflets available on a range of topics. Team members signposted people to other services such as private flu vaccination. The pharmacy could provide large print labels to help people with impaired vision. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines. The driver took items requiring cold storage immediately to people's addresses – most were quite local. The pharmacy labelled the bag so that it was clear that the item required to be stored in the fridge.

Pharmacy team members followed a logical and methodical workflow for dispensing. When prescriptions were received from the GP practice, a team member sorted them into alphabetical order and separated prescriptions for medicines supplied in multi-compartment compliance packs. The GP practice marked prescriptions that had been requested too early. The pharmacy retained these and made the supply at the appropriate time. The pharmacist explained this to people. An example was described of the surgery not issuing a prescription because their records showed that the medicine had been supplied recently. The pharmacist checked the patient medication record (PMR) and had no record of the supply. She explained that it was possible, but very unlikely that this person had received the medication from another pharmacy. So, she called the GP practice and arranged to have the prescription re-issued. She explained that it was possible that the prescription had been misplaced and was still in the GP practice or had been sent to the wrong pharmacy in error. The pharmacy and GP practice worked closely and had a good relationship. The pharmacy had recently reviewed and changed the dispensing process as noted above which made it more efficient. Team members used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. They highlighted any changes to the pharmacist that they noticed when labelling prescriptions. The pharmacist looked at the (PMR) to inform her if any counselling or intervention was required. 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 using a documented owings system. Team members had reviewed this process when the pharmacy installed new software. This enabled them to record owings now, ensuring that all items were dispensed when people expected them. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when people came to the pharmacy. The pharmacy did not have a structured process for monitoring compliance. But the pharmacist explained that this was a small community and she knew all the people receiving medicines from serial prescriptions. She would be aware if there were any issues. She described identifying pharmaceutical care issues for some people.

An example was given that resulted in medicines being supplied in multi-compartment compliance packs. This had been arranged following discussions with the patient, family and GP.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time the week before the first pack was required. Both dispensing team members were competent to manage this process. They kept complete records of changes and interventions. They used a folder to list these chronologically and documented them in a communications book. And they checked this book daily, recording when actions had been completed. Team members kept individual patient records and prescriptions with completed packs. They put instalment numbers on backing sheets, and people's details and date of supply on the front and the spine of the packs. And they supplied patient information leaflets with the first pack of each prescription. The pharmacy attached additional labels to packs if there were warnings that could apply to other people e.g. carers or family members. This included certain groups of people not handling some medicines due to potential risks.

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. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled them appropriately, ensuring they were on a pregnancy-prevention programme. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for the flu vaccination pilot, unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, and chlamydia treatment. The pharmacist was involved in all requests for the minor ailments service. As the dispensary and medicines counter were very close, she could overhear all requests.

As noted above, this pharmacy was part of the NHS pilot to administer flu vaccination to people registered with certain GP practices. The pharmacist had completed the required training at a hospital in the nearby city. She had administered some vaccinations to local people.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. The pharmacy was not part of the local palliative care network but kept most items on the palliative care list to ensure people had access to these when required. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken 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 for the delivery of its services. The pharmacy looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts 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, and emergency adrenaline and sundries required for flu vaccination. Team members kept crown stamped measures by the sink in the dispensary and kept separate marked ones for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary inaccessible to the public. The pharmacy stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left them unattended unless they were locked. They ensured screens were not visible to the public. And they were careful with phone conversations to avoid them being overheard.

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.