General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Prestonlinks Pharmacy, Unit 2, Prestonlinks Shopping Centre, 65c High Street, PRESTONPANS, East Lothian, EH32 9AF

Pharmacy reference: 1042038

Type of pharmacy: Community

Date of inspection: 11/10/2021

Pharmacy context

This is a community pharmacy on a main road through a coastal village close to a city. 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 the use of medicines. And supplies a range of over-the-counter medicines. It offers services including the NHS smoking cessation service, and both NHS and private seasonal flu vaccination. This pharmacy was inspected during the COVID-19 pandemic.

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 suitably identifies and manages the risks associated with its services, including the risk of infection during the pandemic. The pharmacy team members follow written processes for the pharmacy's services to help ensure they provide them safely. They record and review their mistakes to learn from them and make changes to avoid the same mistakes happening again. And they review processes and makes changes to improve them. The pharmacy keeps all the records that it needs to by law, and it keeps people's private information safe. Team members know who to contact if they have concerns about 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 a large screen up at the medicines counter, and hand sanitiser at the medicines counter for people to use. The pharmacy had tape on the floor to encourage people to socially distance. It allowed two people on the premises at any time. Most people coming to the pharmacy wore face coverings and team members all wore fluid resistant masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points several times during the day. A team member cleaned the consultation room immediately after use. The pharmacy manager had carried out a personal risk assessment with each team member to identify and address risks.

The pharmacy had standard operating procedures (SOPs) which were followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them approximately every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. The SOPs were currently under review, and the pharmacy owner had appointed a pharmacist to review and update the SOPs for all pharmacies within the group. Team members described their roles and accurately explained which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. Usually the pharmacist recorded them, and where possible the team member responsible for the mistake corrected it. And they recorded errors that had been identified after people received their medicines, although there had not been any recently. They reviewed all near misses and errors to learn from them and they introduced strategies to minimise the chances of the same error happening again. This included separating similar items. And when several issues with multi-compartment compliance packs had been identified, the team reviewed that process. Team members were all involved, and the result was improvements to the process. They introduced a checklist to ensure all stages of the process were completed. They had used this for a few months until the process was embedded, and no further issues were identified when reviewing near misses. And they introduced colour coding to better identify when each person's packs were managed and supplied.

The pharmacy had indemnity insurance, expiring 30 April 2022. The pharmacy displayed the responsible pharmacist notice and kept a responsible pharmacist log. But the pharmacist did not always record the time she signed out, which was a requirement. The pharmacy had private prescription records including

records of emergency supplies and veterinary prescriptions. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited. Two balances were checked and found to be accurate. It had a CD destruction register for patient returned medicines.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP. They segregated confidential waste and shredded it. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to raise a concern locally. They described examples of sharing concerns and making referrals to GPs, signposting people to 111 and they were aware of strategies in place for victims of domestic abuse. A team member described successfully responding to an ‘ask for ANI’ request.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. They are trained and competent for their roles and the services they provide. The pharmacy gives them time during the working day for training and development. Team members make decisions within their competence to provide safe services to people. They know how to make suggestions and raise concerns to help keep the pharmacy safe.

Inspector's evidence

The pharmacy had: one full-time pharmacist, three part-time dispensers, two part-time medicines counter assistants, and a part-time delivery driver. One team member had management responsibilities and was not present during the inspection. All team members had worked in the pharmacy for several years so were experienced, trained, and qualified for their roles. The pharmacy used locum pharmacists that were familiar with the pharmacy to cover the pharmacist's days off and annual leave. The pharmacy also had a 'Kick-start' trainee on placement. He had read some SOPs and the pharmacist had coached him on some processes. He accurately described the sale of medicines protocol, although he referred requests to the pharmacist. As the pharmacy was small, the pharmacist was able to hear and see people at the medicines counter so intervened as appropriate. Typically, there were two or three dispensers, and one medicines counter assistant working at most times. At the time of inspection there were three dispensers and the 'Kick-start' trainee. One team member was assembling multi-compartment compliance packs. The team undertook activities such as this at times when three dispensers were working. And they all rotated through the different tasks and processes to ensure they maintained skills in all areas. Team members were able to manage the workload. Part-time team members had some scope to work flexibly providing contingency for absence.

The pharmacy provided learning time during the working day for team members to undertake training and development when a need was identified. Each Monday morning the team discussed relevant topics which sometimes resulted in training and coaching on new services or products. And team members described the pharmacist 'testing' them on processes and pharmacy services. They explained this helped to keep their knowledge up to date. They had annual development meetings with the pharmacist and the manager to identify their learning needs which were addressed. One team member described training and coaching on computer systems including ordering processes. Team members were empowered to work autonomously and make decisions within their competence. The pharmacist was confident that they would not make decisions beyond the scope of their role or competence. For example, dispensers often contacted the GP practice to query changes or omissions on prescriptions, especially for multi-compartment compliance packs. They recorded outcomes, including the date and people involved, and shared the information with the pharmacist.

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 manager, pharmacist, or owner. A team member gave an example of raising a concern to the owner which was successfully resolved.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and suitable for the pharmacy services provided. It has suitable facilities for people to have conversations with team members in private.

Inspector's evidence

These were small premises incorporating a retail area, dispensary and limited storage space and staff facilities. The premises were clean, hygienic, and well maintained. Team members cleaned surfaces and touch points frequently. There were sinks in the dispensary, consultation room and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available in all areas. And each team member had their own which they kept on their person and used frequently. The pharmacy owner visited regularly and ensured there was stock of sanitiser. There was a large sanitiser dispenser in the consultation room used by team members and everyone who entered the consultation room.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean, and the door closed providing privacy. It was small, but team members ensured they socially distanced as much as they could when using the room. It had a hatch to the dispensary that was used for the pharmacist to supervise consumption of medicines as required, and for some consultations. This helped to enable social distancing. Some dispensed medicines were stored within view of the hatch, but the pharmacy used a blind to cover these and protect people’s private information. The door to the consultation room was kept locked to prevent unauthorised access. Team members unlocked it remotely to enable people to enter the room. Temperature and lighting felt comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with suitable information and 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 appropriately. 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 a wide door. There was good visibility of the door from the medicines counter and dispensary which enabled team members to help as required. The pharmacy listed its services and team members signposted people to other services such as needle exchange. The pharmacy could provide large print labels to help people with visual impairment. It provided a delivery service and kept records of controlled drugs it delivered. People signed to acknowledge the delivery, using their own pen. The driver carried hand sanitiser and used it frequently. Some deliveries were 'no contact' and people could phone and request this. The pharmacy kept records of these deliveries, and people were not asked to sign, and the driver placed the bag on the ground rather than handing it to people.

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. The pharmacy received prescriptions from the GP practice twice a day. A team member labelled these immediately. And then a team member dispensed them and passed to the pharmacist for checking. This process was interrupted as required for 'walk-in' prescriptions. The pharmacy tried to process all prescriptions received in the morning before it received the medicines' order. When the order arrived, there was an 'all hands on deck' approach to put stock away as quickly as possible to remove the totes from the dispensary. Team members then dispensed outstanding balances of prescriptions. Usually this meant there was no outstanding work when the pharmacy received the second batch of prescriptions. Team members processed them in the same way. There was usually a larger number of prescriptions in the afternoon. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these when people requested them, usually by phone. The pharmacy kept records of supplies but did not actively monitor compliance. Previously the pharmacy had led this service, registering suitable people. But it was now driven by the GP practice pharmacist. The pharmacist in the pharmacy carried out the first reviews within three months as the service required. And she carried out high risk medicines assessments. She had not identified any pharmaceutical care issues. The pharmacist was planning to meet the practice manager and pharmacist to discuss how this service could be better managed.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four (or sometimes eight) weeks' packs at a time, usually one week before the first pack was due to be supplied. They kept thorough

records using a colour coded system showing when prescriptions were ordered and processed, when packs were assembled and what day each person's pack was supplied either by delivery or collection. They also kept complete records of medicine changes and other communication with prescribers. These included the date and the names of the GP practice team member and pharmacy team member. The pharmacist or an experienced team member checked that medicines selected were correct before the team member removed tablets from packaging and placed them in the compliance packs. They did not keep a record of this. The pharmacist sealed the packs after she had checked them. Team members added controlled drugs to the packs on the day of supply. So, they left packs unsealed to enable this. The packs were observed to be safely and tidily stored. But the stability of the medicines was discussed, and the pharmacist was going to review this process. There was not enough space in controlled drug cabinets to store completed packs. Team members wrote tablet descriptions onto backing sheets and supplied patient information leaflets with the first pack of each prescription. They wrote people's names and date of supply onto the spine of the packs and marked them with the appropriate colour for day of supply. And they stored them methodically and tidily in a dedicated area. They stored packs for supply in the current week in boxes labelled for each day. This process was observed to be methodical and it worked well. All team members were familiar with it. The pharmacy supplied a variety of other medicines by instalment. A team member generated the labels on receipt of the prescriptions, then dispensed them weekly. The labels showed the instalment number and the date of supply. 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 or in locked cupboards.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. They or a team member supplied written information and record books if required. The pharmacy did not supply valproate to anyone in the high-risk group. The pharmacy followed the service specifications for NHS services. It had NHS patient group directions (PGDs) in place for all Scottish services including unscheduled care, the Pharmacy First service and seasonal flu vaccination. It also followed private PGDs for flu vaccination. 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. They referred to the pharmacist as required. The pharmacist was measuring people's blood pressure on request, often when the GP practice had asked them to have it measured. The GP practice had supplied the pharmacy with sample bottles to be given to people that did not meet the criteria for the pharmacist to treat a urinary tract infection.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. 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 were observed to be within 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 team members look 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, although it was not being used during the pandemic. And a blood pressure meter which was replaced as per the manufacturer's guidance. Team members kept crown-stamped, and ISO marked measures by the sink in the dispensary, and separate ones were used for methadone. And they had clean tablet and capsule counters in the dispensary. The pharmacist explained that she had ordered a second fridge to ensure there was sufficient space to store flu vaccines which had to be kept refrigerated.

The pharmacy stored paper records in the dispensary and in a staff area inaccessible to the public. 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.