General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 39 Main Street, KELTY, Fife, KY4 0AA

Pharmacy reference: 1042092

Type of pharmacy: Community

Date of inspection: 18/08/2021

Pharmacy context

This is a community pharmacy on the main street of a village, beside other shops including another pharmacy. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it assembles these for other Well pharmacies as a 'hub and spoke' model. And it supplies medicines to care homes. 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 medicines' use. And supplies a range of over-the-counter medicines. It offers services including smoking cessation, blood pressure measurement and seasonal flu vaccination. This pharmacy was inspected during the COVID-19 pandemic.

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 suitably identifies, and mostly manages the risks with its services including infection control during the pandemic. Team members follow written processes for the pharmacy's services to help ensure they provide them safely. They keep all the records that they need to by law and keep people's private information safe. Team members know what to do and who to contact if they have concerns about vulnerable people. They record some of their mistakes but do not always review them which means that they are missing learning opportunities.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter, hand sanitiser at the medicines' counter and tape on the floor to encourage people to socially distance. Most people coming to the pharmacy wore face coverings and a few team members wore masks. A few had exemptions. They washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points according to a rota. A team member cleaned the consultation room immediately after use. The area manager had carried out personal risk assessments with team members early in the pandemic which had resulted in some team members being furloughed twice, during the two lockdowns.

The pharmacy had standard operating procedures (SOPs) which team members followed. They had read them, and the pharmacy kept records of this. But the inspector could not confirm this as no-one in the pharmacy had access to all records. One team member (a previous manager) showed her own dashboard, confirming that she had read them all. A new team member described reading a few SOPs at home each night. The pharmacy could not give her protected time to read them during the working day. The pharmacy superintendent reviewed them every two years, or more often, and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles, and most could accurately explain which activities could not be undertaken in the absence of the pharmacist. They explained that they did not carry out any dispensing activities or sale of medicines during periods when there was no responsible pharmacist signed in. There had been several occasions over the past few months when there was no pharmacist. Team members followed a list of daily, weekly and monthly tasks that was displayed in the pharmacy. This ensured that during challenging times all important tasks were undertaken. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. An accuracy checking pharmacy technician checked dispensed medicines in multi-compartment compliance packs if a pharmacist had signed the prescription confirming that they had clinically checked the prescriptions. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. Team members explained that parts of this had been used over recent months when there had been no pharmacist. And when necessary, team members supplied medicines early to people and notified patients, GP practices and the health board.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. And they recorded errors that had been identified after people received their medicines on Datix, an electronic system that analysed the data. But the team did not have the opportunity to formally review errors to identify trends or training needs. The ACT or pharmacist

discussed errors with team members at the time if possible. The pharmacy had a complaints procedure and welcomed feedback. There had been a few complaints over the past few weeks related to closures when there was no pharmacist. Team members apologised to people.

The pharmacy had an indemnity insurance certificate, expiring 30 June 2022. The pharmacy displayed the responsible pharmacist notice although it was not visible to the public because of its location. It had an accurate responsible pharmacist log which showed that over the past few weeks there had always been a pharmacist working. Team members explained that often they did not know at night if there would be a pharmacist the following day. 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. Team members undertook the running balance audits on a rota. A dispenser had completed this earlier on the day of inspection. She had identified two discrepancies and resolved one. The pharmacist planned to help resolve the other later in the day. Team members described the system they used to ensure all records had been made correctly. This involved one team member making the record and another checking it had been done. The pharmacy had a CD destruction register for patient returned medicines. All records were accurate and up to date. 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 a SOP and signed company policies. They segregated confidential waste for secure destruction. 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 and had access to contact details and processes. The delivery driver working at the time of inspection provided several examples of highlighting concerns to the pharmacy and speaking to isolated people during the pandemic. Team members were aware of services for victims of domestic abuse and the pharmacy displayed information about these initiatives. The pharmacy was a ‘safe space’. The pharmacists were registered with the Disclosure Scotland ‘Protecting Vulnerable Groups’ (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy mostly has enough qualified and experienced team members to provide its services. The experienced team members work well together and support team members in training. They mostly manage the workload effectively. And they put strategies in place when they experience challenging workforce pressures. This helps to minimise the negative impact on people using its services. But there are times when they find this difficult. The pharmacy does not set aside time in the working day for team members to complete essential training or continue their learning.

Inspector's evidence

The pharmacy had the following staff: one full-time accuracy checking technician (ACT), two part-time pharmacy technicians (PT), three full-time and two part-time dispensers, one full-time and one part-time medicines counter assistants, and three part-time delivery drivers. One of the full-time dispensers was leaving in a few weeks. And one had recently started in this pharmacy. Both medicines counter assistants had started their role within the past two weeks so had not yet been registered for accredited training. Staff levels had been badly affected during the pandemic, with some long-term absence and three people being furloughed twice. There had not been a regular pharmacist or a manager for several months. So, the lack of continuity and leadership had adversely affected the pharmacy. Team members explained that ideally there would be one pharmacist and three qualified dispensing team members in the back dispensary (where multi-compartment compliance packs were managed). And one pharmacist, and at least one qualified dispenser and one qualified medicines counter assistant at the front of the premises. This was the staffing at the time of inspection and team members were managing the workload. But some team members were very inexperienced and not yet trained. One team member was working under close supervision as she had only started in the pharmacy the previous week. She had not started training yet but was working through SOPs at home. Team members described a day the previous week when they had been short-staffed which had led to a backlog of routine dispensing. One team member who had recently qualified as a dispenser explained that she had completed her course at home as there was no time during the working day. All team members had access to SOPs and training modules at home. Currently the biggest staffing challenge was the lack of a regular pharmacist. The pharmacy was recruiting for two pharmacists. The pharmacy's staffing levels was to have two pharmacists two days per week, and when this was planned the team organised the workload accordingly. But often pharmacist cover was arranged at short notice. This was an additional challenge for the team and the decisions team members made to continue services. For example on one occasion the pharmacist used their professional judgement to supply an additional day's instalment dose so people could continue their treatment. This proved unnecessary as a pharmacist was sourced at short notice and so the increased risk to patients had been unnecessary. 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 an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The new untrained team member referred all requests to the pharmacist in a polite and confident manner.

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. The ACT described how she discussed errors with other team members and kept records. A few people had had errors with medicines dispensed in multi-compartment compliance packs. These were recorded on Datix but often the team members involved could not be identified as the locum pharmacist's signatures were not recognised and the date on the label did not always correspond with the date of assembly or checking. This meant that not all team members could learn from their mistakes. The pharmacy team discussed incidents when errors were identified when the team members responsible were present. Team members and locum pharmacists could raise concerns to the area manager. Recently these had been mainly staffing issues. One of the team members working at the time of inspection was a relief dispenser. The company had a whistleblowing policy that some team members were aware of. The company set targets for various parameters. Team members explained that they did not do anything special to meet targets but tried to offer services to people who would benefit. The pharmacy team had a good relationship with the team in the other pharmacy in the village. They shared information and obtained stock from each other when required.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for the services it provides. It has suitable facilities for people to have conversations with team members in private. The pharmacy is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area, two dispensaries and back shop areas including storage space and staff facilities. The main dispensary was laid out in a way that separated dispensing and checking tasks. And the other dispensary was in a separate room with no external distractions. It was used for the management, assembly, checking and storage of multi-compartment compliance packs. Following feedback from team members, the pharmacy had installed a raised shelf on the dispensing bench to enable team members to have better posture when assembling packs. This prevented some symptoms such as back pain. The premises were clean, hygienic and well maintained. Team members cleaned surfaces and touch points frequently following a rota. There were sinks in the main dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available at the medicines counter and in both dispensaries.

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 tidy, and the door closed providing privacy. This room was large enough for social distancing and this was managed by positioning of chairs. The pharmacy also had a separate area at the medicines' counter for specialist services such as substance misuse supervision. The team members used this area for discreet conversations with people who did not need or want to use the consultation room. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services which it provides safely. Pharmacy team members mostly 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 mostly stores them properly. But it temporarily stores some of its medicines outside the manufacturers' packs without always having the necessary safeguards in place. Pharmacy team members know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had one step at the entrance, so team members helped people if needed. It listed its services and had leaflets available on a variety of topics. It provided a delivery service which had been busier during the pandemic due to people shielding and self-isolating. Three delivery drivers covered different areas and worked different hours and days for this pharmacy. They each had their own storage box where team members placed some items for delivery. They also attached messages for the drivers and notes of people whose medicines were stored in locked cupboards. And there was a labelled shelf in a fridge for items for drivers to deliver. The drivers were all clear about where to look for items for delivery in addition to speaking to team members.

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. And they drew the pharmacist's attention to prescribing changes and new medicines. This supported the pharmacist when clinically checking prescriptions. The pharmacists initialled prescriptions they had clinically checked to enable an ACT to carry out the final accuracy check. This was mainly for multi-compartment compliance packs. Team members initialled dispensing labels on most dispensed medicines to provide an audit trail of who had dispensed and checked all medicines. They did not do this on some medicines supplied by instalment. The pharmacy usually assembled owings later the same day or the following day. Most of the pharmacy's dispensing came from repeat prescriptions. The GP practices did not accept phone requests from people but directed them to the pharmacy. This could be time consuming, so pharmacy team members were encouraging people to use the prescription repeat forms rather than phoning. That was also more accurate and provided an audit trail of the medicines people had requested.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these seven weeks after it made the previous supply. Team members recorded when they supplied medicines then filed prescriptions by date seven weeks later. A team member checked this file each week and the medicines due were dispensed. Team members did not give examples of how compliance issues were dealt with and they did not know if pharmaceutical needs assessments had been carried out in line with the service specification. These tasks were clinical so would usually be carried out by a pharmacist. But this was not happening currently due to lack of consistency of pharmacists.

The pharmacy was a 'hub' for multi-compartment compliance packs, assembling these for several other branches. It managed the dispensing and the related record-keeping for these on a four-weekly cycle.

Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. But due to staffing challenges over recent months they were currently only two days ahead. The locum pharmacist explained that although this was not ideal, and not in keeping with the SOP, he did not feel under too much pressure. He was able to take his time concentrating and checking thoroughly. The ACT agreed. At the time of inspection, they were both checking packs due out two days later. Team members kept thorough records which were neat, legible and included dates, and prescribing and pharmacy personnel involved with changes. They included tablet descriptions on the backing sheets, and people's name, address and date of supply on the spine of the pack. There were dedicated shelves for storing packs waiting to be checked and for prescriptions that had been labelled but not yet assembled. The ACT or pharmacist carrying out the final accuracy check sealed the packs. The open packs enabled them to properly see all tablets when checking. They then stored completed packs in individual box files which were neatly stored in shelves arranged by day of supply. And they supplied patient information leaflets with the first pack of each prescription. The pharmacy also provided pharmaceutical services to care homes. It mostly supplied medicines in multi-compartment compliance packs, so they were managed in the same way as those for people at home. The pharmacy supplied some medicines by instalment. Recently the pharmacy had changed its process and pharmacists dispensed some of these. Some instalments seen did not have initials on the labels so there was no audit trail of who had dispensed or checked.

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 had put the guidance from the valproate pregnancy prevention programme in place. Team members demonstrated awareness of this, and they knew where patient information was stored. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation and emergency hormonal contraception (EHC). 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 recently started team member knew what information to record on a template before referring to the pharmacist. Several forms were observed where team members had made a referral or given advice, in addition to medicines prescribed. During the pandemic pharmacists had delivered some services remotely by phone. This had ensured service delivery while minimising footfall on the premises. Services delivered in this way included smoking cessation, urinary tract infection (UTI) treatment and supply of emergency hormonal contraception (EHC). The pharmacist had carried out the consultation remotely and if appropriate, the team had prepared medication ready for collection when the person came to the pharmacy. There were currently no people accessing the smoking cessation service or requesting blood pressure measurement. The pharmacy was supplying lateral flow Covid test kits to people in line with the NHS service specification.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. The pharmacy stored most medicines in original packaging on shelves, in drawers and in cupboards. Some shelves were observed to be untidy. Team members removed some tablets from original packs and placed in large plastic containers such as empty confectionary boxes. They labelled the boxes with tablet name, batch number and expiry date, but they had no information about the tablets' stability when removed from packaging. And they did not keep records of who had undertaken this or when. Team members explained that tablets would be unlikely to be stored in this way for more than a week. The labels had fallen off one box so there was no information available about the tablets stored inside. At the time of inspection, a large quantity of paracetamol was stored on and beside the machine that removed the tablets from the blister packaging. Following discussion, the locum pharmacist explained that this

process would be reviewed and improved. Team members used space well to segregate stock, dispensed items and obsolete items. The pharmacy stored items requiring cold storage in two fridges and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action 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. A new untrained team member referred all requests to the pharmacist or a trained colleague. The pharmacy had continued to accept returned obsolete medicines from people during the pandemic and followed a process to minimise the chance of spreading infection. This flow chart was on the dispensary wall for team members to refer to.

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 the team looks after the 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, and a blood pressure meter which was replaced as per the manufacturer's guidance. The team was not using this equipment during the pandemic to reduce the chance of spreading infection. Team members kept crown-stamped measures by the sink in the dispensary, with separate marked ones were used for methadone. And they kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in the dispensary and office 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.