General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dears Pharmacy, 60 Lochleven Road, LOCHORE, Fife, KY5 8DA

Pharmacy reference: 1042109

Type of pharmacy: Community

Date of inspection: 21/06/2023

Pharmacy context

The pharmacy is in the rural village of Lochore, adjacent to a medical centre. Its main services include dispensing of NHS prescriptions, and it dispenses some medicines in compliance packs to help people take their medicines properly. Team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs). The pharmacy provides a range of private services including ear was removal and administration of vitamin B12 injections.

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 appropriately manages the risks associated with the services it provides for people. And its complete set of written procedures help the team carry out tasks consistently and safely. The pharmacy keeps the records it needs to by law. And it protects people's confidential information. Team members help support vulnerable people and protect their welfare. They record and learn from the mistakes that they make when dispensing. And they review these mistakes to identify any trends and patterns to reduce the risks of further mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) to help team members manage risks. The SOPs were kept electronically, and team members had printed copies to refer to. The pharmacy's superintendent (SI) reviewed the SOPs on a regular basis. Team members read the SOPs relevant to their role and signed a record of competence to confirm their understanding. The pharmacy had recently started using offsite dispensing hubs, where some people's medicines were assembled before being returned to the pharmacy. There were SOPs for these operations which team members confirmed they had read, but there was no record of competence available. Team members were aware of their roles and responsibilities and were observed working within the scope of their roles. They were aware of the responsible pharmacist (RP) regulations and of what tasks they could and couldn't do in the absence of an RP.

Pharmacy team members recorded any mistakes they identified during the dispensing process, known as near misses. These were recorded on an electronic near miss record. Team members could also access the record using a quick response (QR) code from smart phone devices. They explained that an error would be highlighted to them by the pharmacist, and it was their responsibility to enter it onto the record. This allowed them to reflect on the mistake. The pharmacy team had recently introduced a new process to ensure all near misses were recorded. Once the RP highlighted the error to the team member, they were stored in individual baskets according to the team member who made the error. The baskets were checked at the end of the week to ensure all errors had been entered onto the log. The pharmacy manager reviewed the near miss record monthly to identify any trends and patterns. This was recorded on a patient safety report which was reviewed centrally by the SI. A common trend found from this analysis included an increase in the incorrect dispensing of medicines which looked or sounded alike (LASA). The team had attached 'caution' stickers to the most common LASAs, for example to amlodipine and atenolol, to reduce the recurrence of this type of error. They also recorded details of any errors which were identified after the person had received their medicines, known as dispensing incidents. These incidents were recorded on an electronic platform and were then reviewed by the SI. An electronic tablet had recently been installed in the retail area for people to provide feedback and to rate their experience of pharmacy services. The feedback was reviewed by head office, but the pharmacy had not yet received any information to help improve their services. The team aimed to resolve any complaints or concerns informally. But if they were not able to resolve the complaint, they would escalate to the manager or SI.

The pharmacy had current professional indemnity insurance. The RP notice displayed contained the correct details of the RP on duty and it could be viewed from the retail area. The RP record was

generally compliant, there were some missed sign-out entries observed on the sample of the record examined. The pharmacy held its CD register electronically. And from the entries checked, it appeared to be in order. The team checked the physical levels of CDs against the balances recorded in the CD register every week. There was a record of patient returned CDs in an electronic register and this was maintained to date. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. Accurate electronic records of private prescriptions were maintained.

Team members were aware of the need to keep people's private information secure. They were observed separating confidential waste into a marked waste bin which was collected by a third-party contractor for secure destruction. The pharmacy stored confidential information in staff-only areas of the pharmacy. Pharmacy team members had completed learning associated with their role in protecting vulnerable people. They understood their obligations to manage safeguarding concerns well. They discussed their concerns with the pharmacist and had access to contact details for relevant local agencies. The pharmacist was a member of the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to manage its workload. It supports its team members to complete appropriate training for their roles and to keep their knowledge and skills up to date. Team members understand how to raise a professional concern if required.

Inspector's evidence

The pharmacy employed a full-time pharmacist who was completing the Post-Registration Foundation Programme and a full-time pharmacy manager who was also a trainee technician. There were two accuracy checking dispensers, a full-time dispenser, four part-time trainee dispensers, a full-time medicines counter assistant and a delivery driver. A second pharmacist supported a few days per week, and they were also an independent prescriber (IP). Team members had all completed accredited training for their role or were enrolled on an accredited training course. They were observed working well together and managing the workload. Planned leave requests were managed so that only one team member was absent at a time. Team members were able to rotate tasks so that all tasks could be completed effectively during absence periods. Relief dispensers were also used to help cover absences.

Team members on an accredited training course received protected learning time each week. The manager had grouped trainees into buddy pairs who were able to support each other with completion of their training course. And they received support from the regular pharmacist. Team members also completed regular ongoing training that was relevant to their role such as training relating to hay fever treatment and over-the-counter consultation skills. They completed some of this training via an online learning platform. They were given some protected learning time to complete these and there was a rota displayed showing team members allocated learning time. The pharmacist and some dispensers had recently attended face to face training for delivery of a private ear wax suction service and they were observed delivering the service as part of the sign off process. The pharmacy team had also recently received training on utilising an offsite dispensing hub for dispensing of original pack prescriptions. They attended a training day held by an external provider and visited the hub to gain an understanding of the operation. A certificate of completion was awarded to all team members.

Team members were observed asking appropriate questions when selling medicines over the counter and referring to the pharmacist when necessary. They explained how they would identify repeated requests from people for medicines subject to misuse, for example, codeine containing medicines. And that they would refer repeated requests to the pharmacist.

The team attended weekly formal team meetings where they discussed alerts from head office and any learnings from near misses or dispensing incidents. These meetings were led by the pharmacy manager, and all team members contributed to the meeting. Team members felt comfortable to raise any concerns with their pharmacist or pharmacy manager in the first instance. They also felt comfortable to raise any concerns with the area manager and SI, who visited the pharmacy during the inspection. The area manager visited the pharmacy every two weeks and had informal reviews with team members. Team members received formal appraisals with the pharmacist and pharmacy manager every 6 months where they had the opportunity to identify individual learning needs. There were targets set for some pharmacy services and team members did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and the pharmacy maintains them to a high standard. It has private consultation rooms and other suitable facilities where people can have confidential conversations with a pharmacy team member.

Inspector's evidence

The pharmacy premises were clean and maintained to a high standard. Team members had ample space to dispense medicines. There were clearly defined areas used for the dispensing process and a separate area to dispense medicines into multi-compartment compliance packs at the rear of the dispensary. There was a separate bench used by the RP to complete the final checking process located at the front of the dispensary near the retail counter. The medicines counter could be clearly seen from the checking area which enabled the pharmacist to intervene in a sale when necessary. There was a tensor barrier to prevent people entering the dispensary. The pharmacy had enough space to store its medicines. Two good-sized consultation and treatment rooms were clearly signposted and able to be locked when not in use. Team members used a hatch between the dispensary and retail area that was protected by a screen to provide supervision of substance misuse services. There were chairs available in the retail area that provided a suitable waiting area for people receiving clinical services.

There was a clean, well-maintained sink in the dispensary used for medicines preparation and there were other facilities for hand washing. The pharmacy kept the room temperature to an acceptable level. And there was bright lighting throughout.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a wide range of private and NHS services that support local people's health needs. Overall, it manages it services well and they are easily accessible to people. The pharmacy receives its medicines from reputable sources and stores them appropriately. The team carries out checks to help ensure they are safe to supply to people.

Inspector's evidence

The pharmacy had good physical access with ramped access and an automatic door. It displayed its opening hours and pharmacy services at the entrance. It also kept a range of healthcare information leaflets for people to read or take away. There were several pharmacy service posters with QR codes for people to access more information about the services, for example private flu vaccination.

The pharmacy provided separate areas for labelling, dispensing, and checking of prescriptions. Team members used baskets to safely store medicines and prescriptions throughout the dispensing process. This helped manage the risk of medicines becoming mixed-up. The baskets were colour coded to enable team members to identify the type of prescription stored within and to manage workload. Team members signed dispensing labels to maintain an audit trail. The audit trail helped to identify which team member had dispensed and checked the medicine. The pharmacy gave owing slips to people when the pharmacy could not supply the full quantity of medicines prescribed. And it offered a delivery service and kept electronic records of completed deliveries.

Team members demonstrated a good awareness of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They explained how they would highlight any prescriptions for valproate for the attention of the RP. They knew to apply dispensing labels to the packs in a way that prevented the written warnings on the packs from being covered up. The pharmacy supplied patient information leaflets and patient cards with every supply. And they always supplied valproate in the original manufacturer's pack. Team members used various alert stickers to attach to prescriptions for people's dispensed medicines. They used these as a prompt before they handed out medicines to people which may require further intervention from the pharmacist.

A large proportion of the pharmacy's workload involved supplying medicines in compliance pack pouches to help people better manage their medicines. Each individual pouch contained all the person's medicines to be taken at a particular time. These were dispensed at an offsite dispensing hub pharmacy. Team members used medication record sheets that contained a copy of each person's medication and dosage times. They were responsible for managing the ordering of people's repeat prescriptions and reconciled these against the medication record sheet. They documented any changes to people's medication on the record sheets and who had initiated the change. This ensured there was a full audit trail should the need arise to deal with any future queries. The prescriptions were clinically checked by the pharmacist at the pharmacy, and this was confirmed with a stamp. The information from the prescription was inputted into the system and accuracy checked in the pharmacy, then dispensed at the offsite hub pharmacy. Each pouch displayed printed information about its contents, including the name and quantity of each medicine, the day and time the medicines should be taken and the person's details. They were also annotated with detailed descriptions of the medicines which

allowed people to distinguish between the medicines within them. The pouches were transferred into a box with additional dispensing labels so people had written instructions of how to take their medicines. The pharmacy did not supply people with patient information leaflets, as required, so they may not have access to up-to-date information about their medicines. The packs were not always signed by the dispenser and RP so there was not a full audit trail of who had been involved in the dispensing process.

The pharmacy had recently started to send some of their prescription workload to be dispensed at the company's offsite dispensing hub pharmacy. Team members assessed the prescriptions to ensure they were suitable to be sent to the hub. Some prescriptions were unable to be sent to the hub and the team dispensed these locally. The information from the prescriptions were inputted into the system by team members, the RP completed an accuracy and clinical check of each prescription before submitting the data electronically to the hub. The dispensed medicines were received by the pharmacy approximately 48 hours after the prescription had been submitted. The pharmacy also dispensed medicines into multi-compartment compliance packs for some people, to help them take them at the right times. And it followed similar processes to the compliance pack pouch service. The pharmacy dispensed serial prescriptions as part of the Medicines: Care and Review (MCR) service. And it dispensed the medicines in advance of people collecting. Team members monitored compliance of people collecting these prescriptions and used tracker forms to ensure that prescriptions were supplied and claimed for correctly.

The NHS Pharmacy first service was popular. This involved supplying medicines for common clinical conditions such as urinary tract infections under a patient group direction (PGD). The pharmacist could access the PGDs electronically and had paper-based copies. The pharmacy provided a number of private services under PGD to support the supply of prescription only medicines. This included prescribing and administration of travel vaccinations and childhood immunisations. The pharmacist had a signed copy of all PGDs and a declaration of competence. They retained a copy of the consultation and details of the medicine supplied including batch number and expiry date. The pharmacist and some team members had recently started providing a private earwax removal service. They carried out a consultation using a hand-held electronic device and took photographs as part of the consultation. They obtained consent from people utilising the service to share data with their GP. The pharmacy received private prescriptions from a vitamin B12 prescribing service, that were mainly written for unlicensed indications. It dispensed the private prescription and administered the medication to people who had completed an online consultation. There was an SOP and service level agreement in place for the service, but the pharmacist did not have access to the patient's prescribing consultation information. The pharmacist completed their own risk assessment prior to administration of the injection, asking relevant questions about allergies and prior use. But this was not recorded. And this was completed using their own professional judgement rather than having anything written that all team members providing the service could use. An administration record was completed which contained the person’s details, GP details, consent declaration and details of the injection including batch number and expiry date. Copies of the private prescriptions were entered into the private prescription register.

The pharmacy stored pharmacy-only (P) medicines directly behind the pharmacy counter to prevent unauthorised access. It obtained medicines from licensed wholesalers and stored these tidily on shelves. And it used a medical grade fridge to keep medicines at the manufacturers' recommended temperature. Team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the accepted range of two and eight degrees Celsius. Team members carried out monthly expiry date checks of all medicines. Short-dated stickers were used to highlight medicines which were due to expire soon. A random selection of medicines were inspected and no out-of-date medicines were found. The pharmacy received notifications of drug alerts and recalls. And team members carried out the necessary checks and knew to remove and quarantine

affected stock. The pharmacy had medical waste bins. And this supported the pharmacy team to manage pharmaceutical waste.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to support the safe delivery of its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment appropriately to protect people's confidentiality

Inspector's evidence

Team members had access to up-to-date reference sources including the British National Formulary (BNF) and the BNF for children. There was access to internet and intranet services. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. There were separate cylinders to be used only for dispensing water which were marked. This helped reduce the risk of contamination. The pharmacy had a set of clean, well-maintained tablet counters. And it used a handheld dispensing pump for some CD liquids which was calibrated before use and regularly cleaned. The pharmacy had access to an electronic tablet and equipment for a private ear wax suction service which was serviced regularly by the external provider.

The pharmacy stored dispensed medicines awaiting collection, in a way that prevented members of the public seeing people's confidential information. The dispensary was screened, and computer screens were positioned to ensure people couldn't see any confidential information. The computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones so team members could move to a quiet area to have private conversations with people.

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.