

Registered pharmacy inspection report

Pharmacy Name: Dears Pharmacy, 14 Wardlaw Way, OAKLEY, Fife,
KY12 9QH

Pharmacy reference: 1042125

Type of pharmacy: Community

Date of inspection: 16/12/2019

Pharmacy context

This is a community pharmacy beside a health centre in a village. It dispenses NHS prescriptions including supplying medicines in 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 medicines' use. And supplies a range of over-the-counter medicines. It offers smoking cessation, seasonal flu vaccination and has a travel clinic. The pharmacy changed ownership around six weeks ago and the superintendent pharmacist works here on Saturdays.

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. The pharmacy keeps all the records that it needs to and keeps people's information safe. Pharmacy team members know how to help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which had just been received. So, pharmacy team members had not yet read them. But there were some English ones included which were not relevant to this pharmacy. The pharmacy team were mostly following new processes which had been put in place over the past few weeks since the change of ownership. The pharmacy superintendent (SI) reviewed the company SOPs every two years but hadn't signed them off. 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. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. Accuracy checking technicians (ACTs) could check prescriptions that had been initialled by a pharmacist carrying out a clinical assessment. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. The pharmacy stored all company documents including SOPs on a Google drive, so they were accessible by all branches and team members.

Team members used electronic near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. Team members documented their own errors to help with the learning and reflection. The pharmacy had not yet undertaken reviews, but the company policy was monthly review, and this was overseen by the SI pharmacist.

The pharmacy had a complaints procedure and welcomed feedback. The pharmacist described changing a few people back to conventional multicompartment compliance packs if they did not like the new pouch packs that had started recently. This was observed during the inspection. A patient phoned and explained he was having difficulty with the pouches so had intended moving to another pharmacy. The pharmacist professionally discussed the concern then offered to supply the previous style of pack. 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. Three items were unaccounted for – the pharmacist believed they had been destroyed either by the previous owner or at the time of change of ownership, and not recorded. 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 in their contract of employment and were undertaking a mandatory GDPR training module. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had covered child protection and protecting vulnerable adults in their

accredited courses, but nothing more recently. The pharmacist was aware that local contact numbers were on the Community Pharmacy Scotland website. She was PVG registered.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is. And then it makes changes when required. This ensures skilled and qualified staff provide pharmacy services. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training. Team members can share information and raise concerns to keep the pharmacy safe. The pharmacy team members discuss incidents. And they learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time equivalent pharmacist; two full-time accuracy checking technicians (ACT); two full-time and two part-time dispensers; two part-time medicines counter assistants; two Saturday only medicines' counter assistants and a delivery driver. The pharmacy displayed their certificates of qualification. Typically, there were five or six team members working at any time, including a medicines counter assistant and at least one ACT. Team members were able to manage the workload. A pharmacist manager was due to start in two months. Meantime regular relief pharmacists were covering. One dispenser was currently absent and had been covered the previous week by a relief dispenser. A new but experienced dispenser was currently covering the absence while being trained in company procedures. She was due to move to another branch in two weeks. One of the Saturday assistants also worked one afternoon per week. Part-time team members had some scope to work flexibly providing contingency for absence. The company supported pharmacies with area support pharmacists overseeing each pharmacy, an office manager, administration staff and staff managing stock in branches and moving it around as appropriate.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development, using modules on Google drive. They were currently undertaking GDPR and vaping training. They were required to use assessments sent by head office to test understanding. The trainee Saturday medicines counter assistants were supervised by the SI pharmacist who was currently working every Saturday.

The various individuals 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. Team members were professional and polite when making phone calls.

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 superintendent (SI) pharmacist had access to records and monitored recording. Team members could make suggestions and raise concerns to the manager or SI pharmacist. They gave appropriate responses to scenarios posed. Pharmacists used 'slack', a secure electronic group to share information. Typically, they used this to discuss stock availability, meaning they could often access medicines quickly that were in short supply. The SI pharmacist had recently used the group to remind all pharmacists that they must bag medicines they had checked themselves.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy's services. 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 premises incorporating a reasonably sized retail area, dispensary and back shop area including limited storage space and staff facilities. The dispensary was small. Recently the pharmacy had installed an additional 11m of shelving, new computers and iPads. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. 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 computer which was clean and tidy, and the door closed providing privacy. Temperature and lighting were comfortable.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team 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 team members helped with the door when required. It listed its services and had leaflets available on a variety of topics. The pharmacy provided a delivery service and people signed electronically to acknowledge receipt of their medicines. The system recorded date and time of delivery. The driver stored items requiring cold storage in a cool box. He delivered to a remote collection point – a post-office in another village. People used codes rather than their names to collect their medicines. The pharmacy kept records of whose medicines had been delivered to the post office. But the post office did not keep records of people collecting their medicines. The post-office sent uncollected medicines back to the pharmacy, but the team did not know how long medicines lay in the post-office before being returned.

Pharmacy team members followed a logical and methodical workflow for dispensing. They were allocated daily tasks to ensure they were all competent to undertake all dispensing types. They dispensed prescriptions for people walking into the pharmacy at the front of the dispensary, and collection service prescriptions at the rear. Three team members were involved with all prescriptions; one labelled, one gathered stock and a third applied the labels and checked for accuracy before passing to the pharmacist or ACT for the final accuracy check. A pharmacist carried out clinical assessments on prescriptions before a team member labelled, and initialled the prescription form. If there were new items or changes this was marked on prescriptions by the person labelling. And prescriptions were returned to the pharmacist for another clinical assessment before the ACT could carry out the final accuracy check. The team used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. They also initialled prescriptions to provide an audit trail of who had dispensed, clinically checked and accuracy checked. Dispensed medicines were placed on defined retrieval shelves waiting for collection, but these were very congested. This was despite the pharmacy having installed additional shelving.

The pharmacy usually assembled owings later the same day or the following day. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these as people requested them. The pharmacy had recently changed computer system and the new system did not highlight when medicines were due to be supplied. It kept records of supply and there was no evidence of issues with compliance. The pharmacy was working closely with the local GP practice to improve the management of serial prescriptions. The surgery had also undergone changes recently.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. They were assembled at an offsite hub using a robot and pouch style packs. The pharmacy had packs ready around two weeks before the first supply of each prescription was due. Pharmacy team members had demonstrated how to use these packs to each person receiving them. Some people needed two pouches per dose if they had several or large tablets. Team members

explained this clearly to them. Each pouch was labelled with its contents and tablet descriptions. The hub pharmacy labelled the box containing pouches with a dose regime like a backing sheet. The pharmacy kept comprehensive records of changes and other interventions. Some people did not like the pouch system, so the pharmacy had changed a few people back onto traditional multicompartiment compliance packs. The pharmacy stored completed packs in labelled boxes on dedicated shelves in the back-shop area. The pharmacy supplied patient information leaflets (PILs) with the first pack of each prescription.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. He 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. The practice pharmacist had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled them appropriately. The pharmacy had not yet implemented the phase 2 non-steroidal anti-inflammatory drug (NSAID) care bundle or 'sick day rules' for people on certain medicines. The SI pharmacist had discarded the material as it was damaged. He explained that both initiatives would be re-implemented when new material was received. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, and emergency hormonal contraception. It also followed private PGDs for flu and travel vaccinations. Pharmacists followed SOPs and PGDs provided by Pharmadoc. The pharmacy had access to the full range of PGDs, but this pharmacy did not deliver the full range of services yet. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. 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 pharmacy had recently started offering vaccination, since the change of ownership. All employed pharmacists were fully trained. The pharmacist and the dispenser who was currently absent delivered the smoking cessation service. The pharmacy was planning training other team members.

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. 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. But the fridge was very congested. 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 had information at the front of the SOP folder with a list of medicines that must only be sold by the pharmacist e.g. sleep aid products, codeine continuing products and pseudoephedrine products. There was also a warning about care required when providing advice and medicines for children, pregnant women and breastfeeding women.

The pharmacy actioned MHRA recalls and 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. It 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 a blood pressure meter. The team did not know how old the meter was so were not using it. The pharmacist also stored sundries required for the travel clinic and vaccination, including emergency adrenaline, in the consultation room. Team members kept BS marked measures by the sink in the dispensary, and separate marked ones were used for methadone. And they had a pump for methadone which was cleaned, and test volumes poured daily. 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. Prescription medication waiting to be collected was stored 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.

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.