General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M. Farren Ltd t/a Paton & Finlay, 177 Bruntsfield Place, EDINBURGH, Midlothian, EH10 4DG

Pharmacy reference: 1042623

Type of pharmacy: Community

Date of inspection: 09/12/2020

Pharmacy context

This is a community pharmacy beside other shops on a main road close to the city centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It also 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, seasonal flu vaccination and travel vaccination. This pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	There are unmanaged risks that can impact people using pharmacy services associated with the condition of the premises. These include presence of mice and electrical risks.
2. Staff	Standards not all met	2.5	Standard not met	Pharmacy team members raise concerns relating to risks in the pharmacy. These are not always addressed.
3. Premises	Standards not all met	3.1	Standard not met	The lack of maintenance of the premises and electrical issues means there is a risk to the safe operation of the pharmacy. The pharmacy team members dispense in cramped conditions. And the space the pharmacy stores its medicines in creates an increased risk of error.
		3.3	Standard not met	The pharmacy does not have adequate hygiene measures in place due to an ongoing mouse presence and dirty carpeting
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 not all met**

Summary findings

The pharmacy identifies and manages the risks with some of its services, including working safely during the pandemic. But there are space, hygiene and electrical risks associated with the premises that could affect people using pharmacy services. The pharmacy team members follow written processes to ensure they provide services safely. Team members record and review their mistakes to learn from them and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to by law and keeps people's private information safe. Team members know who to contact if there 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 screen up at the medicines' counter and had hand sanitiser at the counter. The pharmacy only allowed two people on the premises at any time. Team members all wore masks and they washed or sanitised their hands regularly and frequently. They cleaned surfaces and touch points several times during the day, but this was challenging because dispensing benches were usually cluttered with dispensed medicines and other items as there was very little space for storage in the dispensary. A team member cleaned the consultation room immediately after use. The pharmacy had a standard operating procedure (SOP) documenting processes to be followed to reduce risks associated with COVID-19 infection. The pharmacy manager had carried out a personal risk assessment with each team member to identify any risk that may need to be mitigated in the pharmacy. No such risks had been identified. Due to the small size of the dispensary team members could not socially distance. Team members dispensing and checking had to work at the same bench and would often be touching, or very close to each other. The pharmacy did not have staff rest facilities, so team members had to take rest breaks in this area. So, there could be two working on the dispensing bench and another sitting a short distance away having lunch, so in close contact for prolonged periods.

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 every two years and signed them off. 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, in a methodical way, with coloured baskets used to differentiate between different prescription types and separate people's medication. But this was observed to be very challenging due to a lack of space. The dispensary was cramped, with limited dispensing bench areas. The pharmacy had a list of contact numbers for some maintenance issues, other branches and local pharmacies, suppliers and other services. Team members used this to contact contractors as necessary, for example they had called out a pest control company monthly over the past seven months (and previously). The presence of mice was an ongoing risk and concern.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. They recorded reasons often as lack of concentration. When asked about this team members gave examples of struggling with managing the available space, having to stop

sometimes and move other items to make space. They were also interrupted sometimes to assist people in the retail area. They recorded errors that had been identified after people received their medicines. A recent error had involved additional tablets being placed in a multi-compartment compliance pack. The team partially attributed this to the confined space and poor lighting. The bench was observed to be too small to lay out all the packs and medicines, and team members were working in their own shadow creating poor lighting in the area. They reviewed all near misses and errors each month to learn from them and they introduced strategies within their control to minimise the chances of the same error happening again. They had placed some shelf edge labels reminding them to take care with strengths and similar looking/sounding medicines. But the shelves were congested, and different strengths were stored on top of each other e.g. metformin tablets. The pharmacy had a complaints procedure and welcomed feedback. Several cards of gratitude were observed, and examples of grateful people described.

The pharmacy displayed an indemnity insurance certificate, expiring 30 April 2021. The pharmacy displayed the responsible pharmacist notice and accurately kept the following records: responsible pharmacist log, private prescription records including records of emergency supplies and veterinary prescriptions and unlicensed specials records. It kept the controlled drugs (CD) registers with running balances maintained and regularly audited, and a CD destruction register for patient returned medicines was in use. Team members signed any alterations to records, so they were attributable. 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. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had access to local safeguarding processes and contacts. But they would refer concerns to the pharmacist.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. And they know how to raise concerns and share information with head office. But these concerns are not always satisfactorily addressed, leading to ongoing and long-standing maintenance issues. Team members are trained and competent for their roles and the services they provide. But the pharmacy does not set aside time in the working day to help them keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one full-time and one part-time dispensers, and one full-time and one part-time medicines counter assistants. Typically, there were two or three team members and a pharmacist working at most times. At the time of inspection there was a locum pharmacist, the full-time medicines counter assistant and the full-time dispenser. The pharmacy manager also came in when he was told that an inspection was underway. Social distancing was impossible, there was not enough space in the dispensary for this number of people. On days at the end of the week, there were more people working in the dispensary when dispensing was busier, and the part-time dispenser assembled multi-compartment compliance packs. Team members were able to manage the workload. The pharmacy had reviewed and improved staff levels since the previous inspection two years ago.

The pharmacy did not provide regular protected learning time during the working day for team members to undertake regular training and development. An experienced medicines counter assistant described reading material that was available, including publications such as ‘Training Matters’. The dispenser present during the inspection was undertaking an accuracy checking course. She explained that she completed course work in her own time at home. She was ambitious and keen to further develop, perhaps becoming a Pharmacy Technician. The pharmacy manager was training to become an independent prescriber which would enable him to deliver Pharmacy First Plus. 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.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. There was an openness to sharing and learning within the team. All were aware of the recent dispensing error, and other issues. They described a great working relationship and support offered by colleagues. This had been particularly beneficial during the pandemic when they had enjoyed coming to work and being able to share concerns with other team members in a safe and supported way. They could make suggestions and raise concerns to the manager. But concerns raised or shared with head office were not always addressed in a timely fashion. When asked, examples were described of sharing pest control reports and an electrical safety report. These had not been acted upon. And some maintenance issues, including water penetration from the premises above, damaged ceiling, and loose electric cables had not been addressed. And a serious damp problem in the basement that had been raised at previous inspections had not been addressed. Team members had moved stock out of this area to avoid damage, but this had put more pressure on

the confined space in the dispensary. The company did not set targets.

Principle 3 - Premises **Standards not all met**

Summary findings

Areas of the pharmacy premises are small for the workload. And they are cluttered making it difficult sometimes for team members to provide services safely. The pharmacy premises are not well maintained with ongoing risks due to electric issues and mice on the premises.

Inspector's evidence

As noted above, the pharmacy had installed a Perspex screen to offer some protection from infection between team members and members of the public. And it had put a physical barrier in place at the other end of the small medicines counter/entrance to the dispensary to prevent people going too close to these areas.

These were average-sized premises incorporating a reasonably sized retail area selling a variety of medicines, vitamins and premium toiletries. There was a very small dispensary which was congested with stock due to lack of space for storage and limited dispensing areas. Team members frequently 'bumped into each other' due to lack of space. This was observed and the inspector was in their way during the inspection. There was no staff rest area, so team members took their breaks in the dispensary. A team member expressed concerns about potential allergens from their food contaminating surfaces or dispensary equipment. She described the care taken cleaning surfaces and trying to contain food to a small area while being consumed. Another team member described the unprofessional environment created by food smells in the pharmacy during/after lunch breaks. The pharmacy was open all day. Team members had to use the dispensary sinks for personal dishwashing. There was a double sink, so one was used for dispensary tasks and the other for personal dishes and cutlery. The sinks were observed to be very clean and the area tidy, with cleaning materials available. There was a cleaning rota on the wall and instructions on handwashing during the pandemic. Team members stored their dishes and cutlery in sealed plastic boxes to protect them from the mouse infestation which was evident behind the fridge in the dispensary. A team member described seeing a mouse run under the dispensary fridge, and another described finding a dead mouse in the dispensary sink. Team members had sent photos of a dead mouse in the basement to the pharmacy superintendent a few months previously. A pest control company had visited monthly and the inspector saw reports. There was rodenticide in the dispensary between the fridge and the safe. The dispensary fridge was located beside a large heavy safe used to store cash. There was not adequate space between them, and team members had to adjust the angle of the safe to open its door. Some team members did not have the physical strength to do this as the safe was very heavy. Sometimes its door had hit the fridge causing visible damage. There was damage to several areas of the premises. This included missing pavement tiles allowing rainwater into the basement where the fuse-box was located, posing electrical/fire risk. It also posed a risk to people walking on the pavement immediately outside the pharmacy. The metal frame for a false ceiling on the ground floor was damaged and was now leaning at an angle. Part of a grid had fallen off, no-one was injured. Several damaged and missing ceiling tiles and power points had become detached from the wall in the dispensary, observed by the inspector. The pharmacy used extension cables e.g. at the medicines counter running to the second fridge. The pharmacy had had an electrical installation inspection carried out in July 2020 that had identified some risks. Team members had recorded a few accidents, mostly relating to congestion and space restraints. One involved a team member tripping over boxes on the dispensary floor and colliding with a colleague.

Both sustained facial injuries including bruising and lacerations. Other incidents resulting in bruised ankles from bumping into these boxes were described. Team members cleaned surfaces and touch points frequently throughout the day but could not always reach all areas of dispensing benches due to items being stored there. The pharmacy had a carpet that looked dirty, unhygienic and unprofessional. The large basement was damp, had evidence of mice and was very cluttered with a variety of old equipment, show material, archived records and other folders, and a lot of cardboard. It included a staff toilet which was clean and had running hot water, soap and towels.

People were not able to see the detail of activities being undertaken in the dispensary. But they could see team members on their rest breaks and smell food they were eating in the dispensary. At the time of inspection, the temperature in the pharmacy felt comfortable but lighting in some areas, especially over dispensing benches was ‘gloomy’. The pharmacy had a small consultation room with a desk, chairs and sink which was clean and tidy, and the door closed providing privacy. As this room was not large enough to allow social distancing the team was not currently using it, other than for flu vaccinations.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access services, using different approaches during the Covid 19 pandemic. And it provides safe services, including infection control during the pandemic. Team members support people by providing them with information and advice to help them safely use their medicines. And they provide extra written information to people taking high-risk medicines to help them take them safely. The pharmacy obtains medicines from reliable sources. It mostly stores them properly but on cluttered shelves due to issues with space. The pharmacy team knows 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 power assisted automatic door. It listed its services and had leaflets on a variety of topics available in the consultation room. And it could provide large print labels for people with impaired vision. The pharmacy provided a basic delivery service by a team member on foot or by bus.

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. But due to very restricted space, baskets were stacked at the end of the dispensing and checking bench. The dispenser and pharmacist worked side by-side at this bench. 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. Some people who did not use email, phoned their repeat prescription requests to the pharmacy and team members ordered them by emailing the surgery on people's behalf. Sometime people forgot to order their medicines in this way, so the pharmacist used the provision of the urgent supply patient group direction (PGD) to ensure people were not without their medication.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. The pharmacist labelled, carryied out a clinical check and signed prescriptions to provide an audit trail of this. Team members, usually the part-time dispenser, assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. They placed controlled drugs into packs on the day of supply because there was not enough space in the controlled drug cabinet to store complete packs. And there was no space to install an additional cabinet. This meant that these packs were not sealed at the time of assembly. They were stored neatly on shelves in a way that minimised the risk of contamination or spillage. The pharmacist carried out accuracy check and sealed the packs prior to supply. The pharmacy supplied all four packs at a time to some people to suit people's domestic arrangements. But all prescriptions stated, 'dispense weekly' and there was no authority from prescribers to do this. The pharmacist had carried out a risk assessment for all people supplied with compliance packs, and the pharmacy was supplying three packs to some people to ensure they had their medicines over the Christmas holiday period when the pharmacy was closed.

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 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, emergency hormonal contraception (EHC), and chlamydia treatment. It also followed private PGDs for flu and travel vaccinations. Currently the pharmacy was not providing a travel service as there was no demand. It had exhausted its supply of NHS flu vaccination but was still providing the private service. The pharmacist was appropriately trained. He encouraged people to complete their paperwork before coming to the pharmacy. If they had to do it in the pharmacy, they used their own pen. The pharmacist administered the vaccination in the consultation room in as short a time as possible to minimise contact. The room was small and social distancing was not possible. 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. During the pandemic the pharmacist 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 carried out the consultation remotely and if appropriate, the team prepared medication ready for collection when the person came to the pharmacy. The Pharmacy First service was busy and accounted for a reasonable part of the pharmacist's day. He also spent time providing advice on a premium vitamin and food supplement range. He had reference material to refer to ensuring information provided was accurate and appropriate.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. When medicines arrived in the pharmacy the boxes caused a trip hazard and were 'in the way' in the cramped dispensary. Once they were emptied team members moved them to the retail area. They placed them as discreetly as possible, but they were also a trip hazard there. The pharmacy was required to obtain as much stock as possible from the company warehouse. This arrived weekly in boxes. Often there was not enough space on shelves to store the medicines, so the boxes were in the dispensary, on the floor, for several days, which was observed. Team members tried to move as many packets of medicines as possible to shelves to empty and remove the boxes. This led to very cramped shelves and some items hanging off the shelves. And the strengths of some items were stored together which was a risk when selecting medicines for dispensing e.g. metoprolol and metformin tablets. Team members described how they were trying to re-organise shelves to address this, but space was an issue. 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. One fridge was in the dispensary close to a safe as noted above. The other was at the medicines' counter, with an extension cable used to access a power point. Team members had placed a flooring strip over this to reduce the trip hazard. 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 is fit for purpose.

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 sundries and emergency adrenaline required for vaccination and a carbon monoxide monitor which was maintained by the health board, although the team was not using it during the pandemic. Team members kept crown stamped measures in a sealed box to prevent contamination by mice, in the dispensary. The pharmacy team kept clean tablet and capsule counters in the dispensary. As methotrexate tablets were supplied in blister packaging, the pharmacy no longer kept a separate counter for these.

The pharmacy stored paper records in the dispensary inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented people's 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.