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: 16/09/2021

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 the NHS smoking cessation service, supply of lateral flow COVID-19 tests and seasonal flu vaccination. The pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards 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 met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy suitably identifies and manages the risks with its services. The pharmacy team members follow written processes to ensure they provide services safely. They record and review their mistakes to learn from them. And they review processes and make changes to make them safer. The pharmacy mostly keeps the accurate records that it needs to by law and it keeps people's private information safe. Team members know who to contact if they have concerns about vulnerable people.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter and hand sanitiser for people to use. And it only allowed two people on the premises at any time. Most people coming to the pharmacy wore face coverings and team members all wore masks or face coverings. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points several times during the day. A team member cleaned the consultation room immediately after use, although it was seldom used. 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. Initially no such risks had been identified, and this was being continually reviewed as team members' circumstances changed. 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. The pharmacy superintendent (SI) reviewed them every two years and signed them off. Pharmacy team members read them, and the pharmacy kept records of this. Recently the SI had reviewed some SOPs and provided the pharmacy with updated versions. The team was in the process of working through these, so not all team members had read and signed them all yet. 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. This could be challenging at times as there was limited dispensing bench space. But at the time of inspection, it was clear and clean. 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.

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. They reviewed all near misses and errors each month to learn from them and they introduced strategies to minimise the chances of the same error happening again. They had placed labels on shelves adjacent to items involved in near misses and errors. And items that could potentially be mistaken such as some similar sounding or looking medicines. Team members described some identified causes of mistakes including interruptions such as telephone calls. So, they tried to avoid

interruptions, or start the dispensing process again when interrupted. The pharmacy reviewed processes when a need was identified. Recently the team had changed the way it stored dispensed medicines and prescriptions. This reduced the risk of medicines for people with similar names being stored close. The pharmacy had a complaints procedure and welcomed feedback. No examples were described.

The pharmacy had an indemnity insurance certificate, expiring 29 April 2022. The pharmacy displayed the responsible pharmacist notice and had an accurate responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. But some of these records were incomplete for example, prescribers not recorded on emergency supply records, and prescribers' addresses not recorded on private prescription entries. The pharmacy also kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited. It had a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. 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. 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. They would refer any concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough experienced team members and those in training to safely provide its services. Team members make decisions within their competence to provide safe services to people. And they use their professional judgement to help people. They know how to make suggestions and raise concerns if they have any to keep the pharmacy safe.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, two part-time dispensers, one full-time and one part-time medicines counter assistants and two part-time delivery assistants. Recently the pharmacy had recruited a trainee medicines counter assistant who was due to start the following week. There was currently some absence in the pharmacy, and this was being addressed by other team members working additional hours. They were able to manage the workload. Team members undertook some of the planned dispensing at times when two dispensers were working.

The pharmacy provided learning time during the working day for all team members to read relevant material such as new SOPs, Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts, and information about new medicines. Some team members were not yet trained and worked under the pharmacist's supervision. The pharmacy manager enrolled two team members on medicines counter assistants' courses following the inspection and the pharmacy provided evidence of this. The pharmacy manager explained that the pharmacy planned to provide them with at least one hour per week protected learning time. And they were both enthusiastic to undertake some learning in their own time. One delivery assistant was currently off. The pharmacy manager was planning enrolling the other onto a relevant training course. He had started this role recently, had signed SOPs and was working to an additional process put in place for delivering to people during the pandemic. The pharmacist had recently completed and passed the pharmacist independent prescriber course. He would in time be able to deliver the NHS 'Pharmacy First Plus' service and prescribe for people with respiratory conditions. He worked one day per week in the local GP surgery. A dispenser had recently completed an accuracy checking course but was not using this qualification currently.

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. But some aspects of the sale of medicines protocol were not correctly delivered, for example not providing advice when products were requested by name. The pharmacist was able to hear most conversations at the medicines' counter and frequently intervened. Team members with appropriate experience could work autonomously within their competence, for example calling prescribers for clarity or to request missing prescriptions.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the manager. Team members had discussed and agreed the change to the storage of dispensed medicines. They did not have formal meetings but continually discussed processes and services as they worked. They worked in a small space, so it was easy to have ad-hoc conversations. The company had introduced an electronic system 'jot-note' to enable the team to share information and raise concerns. Team members

described this mainly being used to submit monthly data such as number of near misses to the SI.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy has suitable facilities for people to have conversations with team members in private. The premises are mostly adequate for the services provided although the dispensary is small. And it does not have separate facilities for team members' rest breaks.

Inspector's evidence

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 meant that the inspector was in the team's way during the inspection. The dispensary was observed to be tidy and clean. But one shelf unit was free standing and nearly fell when the inspector leaned on it. There was no staff rest area, so team members took their breaks in the dispensary. A team member described the care taken cleaning surfaces and trying to contain food to a small area while being consumed. Another team member described the environment sometimes created by food smells in the pharmacy during and after lunch breaks. The pharmacy was open all day. 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 hand washing during the pandemic. Team members stored their dishes and cutlery in sealed plastic boxes.

At the last inspection there was a lot of evidence of mouse infestation in all areas of the premises, but mainly in the basement. A pest control company that visited regularly had commented on the risk this posed to people, and made recommendations to help eradicate this. Since then, the pharmacy had undertaken work to improve half of the basement, blocking mouse access points. But the infestation had not been totally eradicated. The pest control company was still visiting monthly and placing fresh rodenticide and leaving reports in the pharmacy. Reports seen for the past few months noted mild mouse activity but did not record an ongoing risk to people. At the last inspection the basement was also noted to be damp and dirty. The work the pharmacy had undertaken in the basement included re-fitting part of it to make it suitable for the storage of medicines. The other half of the basement, which was accessed through a door, remained cluttered and dirty but this did not impact people using the pharmacy. The basement was accessed by stairs from the dispensary and did not have any other doors or access points. The pharmacy had clean staff toilet facilities with running hot water, soap, and towels. The dispensary was carpeted. It had been cleaned since the last inspection but was still stained and did not portray a professional image.

Since the last inspection the pharmacy had also improved the electric cabling and lighting in the pharmacy. Loose sockets and extension cables had been replaced. And better ceiling lighting created a bright environment. And a lamp had been installed above the bench where multi-compartment compliance packs were assembled. This helped to prevent errors attributed to working in a gloomy environment.

People were not able to see activities being undertaken in the dispensary. But they could see team members on their rest breaks. After the previous inspection the company had committed to re-fitting the dispensary in June or July. The superintendent pharmacist explained in June that due to the pandemic it had been delayed. But it had not yet started (mid-September). The pharmacy had a small

consultation room with a desk, chairs and sink which was clean and tidy, and the door closed providing privacy. The door was kept locked to prevent unauthorised access. As this room was not large enough to allow social distancing the team was only using it when necessary. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with relevant 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 and stores them properly. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy was not open to the public when the inspector arrived. It opened an hour later due to staffing shortages. The pharmacist had thought this was allowed under NHS provisions in the pandemic. But after clarification from the NHS following the inspection, they realised this not to be the case. 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. The pharmacist and dispenser had worked for two hours prior to opening to complete routine tasks. The limited bench space was clear from prescriptions during the inspection. 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. And they used a stamp to capture initials of clinical checks. The pharmacist often labelled and undertook clinical checks at this point. This would enable the dispenser with the accuracy checking accreditation to undertake the final accuracy check. But due to work patterns and absence she often dispensed so could not check. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. The pharmacist labelled, carried out a clinical check and signed prescriptions to provide an audit trail of this. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. This process was carried out in a small area of the dispensary where the packs were also stored. A team member had installed a lamp to improve visibility in the area. They explained there were no controlled drugs prescribed and supplied in compliance packs. The pharmacist carried out accuracy checks and sealed the packs prior to supply.

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 had private PGDs for flu and travel vaccinations. Currently the pharmacy

was not providing a travel service as there was no demand. And the seasonal flu vaccination programme had not started yet. The pharmacy expected to receive stock over the next few weeks. Some 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. Other team members took the person's details and referred the consultation to the pharmacist. He could hear most conversations at the medicines counter, so it was straightforward to take over the consultation. As the consultation room was small, the pharmacist had private discussions with people in the retail area which was spacious, if it was appropriate and there were no other people on the premises. He explained this to people and sought their consent first. This included consultations for urinary tract infection (UTI) treatment and supply of emergency hormonal contraception (EHC). The Pharmacy First service was busy and accounted for a lot of the pharmacist's time.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH and stored them correctly. The pharmacist segregated and labelled potent high strength medicines to ensure they were not supplied in error. 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. The pharmacy was required to obtain as much stock as possible from the company warehouse. This arrived weekly in boxes. Team members stored excess stock in the newly refurbished storage area in the basement. This prevented shelves in the dispensary being overloaded. 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 and the other was at the medicines' counter. 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 mostly 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 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. Team members carried out visual inspections of equipment such as fire extinguisher, fire signs and fire exit lights weekly and kept records of this. 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.