General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Fountainbridge Pharmacy, 179 Dundee Street, EDINBURGH, Midlothian, EH11 1BY

Pharmacy reference: 1042658

Type of pharmacy: Community

Date of inspection: 15/06/2022

Pharmacy context

This is a community pharmacy on a main road beside other retail premises. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. 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 sells and supplies a range of over-the-counter medicines. It offers services including smoking cessation, seasonal flu vaccination, travel vaccination and blood pressure measurement.

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 suitably identifies and manages the risks with its services. The pharmacy team members mostly follow written processes for the pharmacy's services to help ensure they provide them safely. They record their mistakes to learn from them and make some changes to avoid the same mistakes happening again. But they do not review them to identify trends, so they may be missing learning points. The pharmacy keeps all the records that it needs to by law, and it keeps people's 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, hand sanitiser at the premises entrance and a notice encouraging people to socially distance and follow other infection control guidance. Most team members wore fluid-resistant masks, and they washed and sanitised their hands frequently. And they cleaned surfaces and touch points several times during the day. At the start of the pandemic the pharmacy 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.

The pharmacy had standard operating procedures (SOPs) which were mostly followed. The pharmacy team did not review near miss errors as per the SOP, and team members did not complete controlled drug running balance audits monthly as required by the SOP. Staff roles and responsibilities were recorded on individual SOPs. Pharmacy team members had read SOPs, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Team members described their roles and accurately explained which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with baskets used to separate different people's medication and prescriptions. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. This included processes to follow in the event of the delivery vehicle breaking down, and loss of internet. And it had contact details for maintenance, suppliers, other pharmacies, and GP practices readily available.

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, although there had not been any recently. They didn't formally review near misses and errors to identify trends and learn from them. But the pharmacist discussed incidents at the time with team members and sometimes they introduced strategies to minimise the chances of the same error happening again. An example was changing the way they wrote instalment dates on dispensed medicines to provide greater clarity. The pharmacy had a complaints procedure which was displayed on the wall in the retail area. Team members were not able to recall any complaints.

The pharmacy displayed an indemnity insurance certificate, expiring 30 April 2023. And it displayed its employer's liability certificate which expired 31 March 2023. 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. It kept unlicensed specials records which were well filed by person, which enabled team members to easily see people's medicine supply history. And it kept controlled drugs (CD) registers with running balances

maintained but not audited in line with the SOP. It had a CD destruction register for patient returned medicines which accurately recorded items that were in the pharmacy. 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 and signed a SOP. They segregated confidential waste and shredded it. No person identifiable information was visible to the public. The pharmacy displayed information to the public on how it used personal data. Team members had also read a SOP and undertaken training on safeguarding and chaperoning. The pharmacy had a chaperoning policy in place and displayed a notice to this effect. Team members knew how to raise a concern locally and had access to contact details and processes. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained and experienced team members to safely provide its services. It supports team members by providing training and coaching during the working day. Team members make decisions within their competence to provide safe services to 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 a full-time pharmacist manager, a part-time dispenser, and two full-time and one Saturday only trainee dispensers, and two part-time delivery drivers. One of the trainees had many years' experience as a trained medicines counter assistant. The Saturday-only team member had scope to cover absence, so typically there were three team members and a pharmacist working. At the time of inspection, a relief pharmacist was working with three team members. They were managing the workload. Team members were competent in all dispensing tasks. This included some service delivery such as the NHS Pharmacy First Service. They described how the pharmacist manager had trained and coached them, so they were able to make decisions within their competence. The trainees undertook most of their coursework at home and explained that they discussed it with the pharmacist who answered their queries and supported their learning. The delivery drivers had undertaken training relevant to their role and the pharmacy kept records. All team members also undertook regular training on a variety of topics including chaperoning to keep their knowledge current. The pharmacy kept records of this.

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. They had an open environment in the pharmacy where they could share and discuss these. Throughout the working day team members communicated with each other, sharing relevant information about prescriptions and processes. This ensured that all daily and weekly tasks were completed, with all team members undertaking all of these. And they explained that they could make suggestions and raise concerns to the pharmacist manager although no examples were discussed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and suitable for the pharmacy's services. The pharmacy has suitable facilities for people to have conversations with team members in private. And the pharmacy is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary, and basement, including storage space and staff facilities. When the pharmacy changed ownership around four years previously it was refitted and had a bright and professional appearance. The premises were clean, hygienic, and well maintained. The pharmacy was inspected by a pest control company regularly, which reported that there was no evidence of pest activity. There were sinks in the dispensary, staff area and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available in the retail area and around the dispensary and basement.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, and sink which was clean and tidy, and the door closed providing privacy. It had a hatch to the dispensary, which was used for some conversations between people and team members. And team members supervised self-administration of medicines at this hatch when appropriate. The door was kept locked to prevent unauthorised access, and team members released the lock remotely to enable people to enter. Temperature and lighting felt comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with suitable information 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. Pharmacy team members 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 if required. It listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as travel services if the regular pharmacist was not working. Team members wore badges showing their name and role, and locum pharmacists wore corporate badges showing their role. The pharmacy provided a prescription collection service, and a medicines' delivery service. The pharmacy and delivery driver had linked electronic devices showing when prescriptions had been collected from surgeries. This was useful for team members to tell people when their medicines were likely to be available for supply.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to differentiate between different prescription types and separate people's medicines and prescriptions. The pharmacy received prescriptions from several surgeries twice a day. A team member immediately separated these into prescription types, and checked stock availability, ordering medicines if required. The pharmacy dispensed and supplied most medicines the same day. Team members monitored the surgeries' time to supply prescriptions, and when this increased, they told people that their medicines would take an extra day to be ready. This meant that people's expectations were nearly always met. The team members dispensed 'walk-in' prescriptions immediately, so people seldom had to wait longer than a few minutes for their dispensed medicines. Team members checked people's medicines' records as they labelled prescriptions and told the pharmacist if there were any new medicines, omissions, or changes. This enabled the pharmacist to carry out a clinical check on each prescription. 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 received medicines from 'Medicines Care Review' (MCR) serial prescriptions. Team members checked prescriptions and highlighted anything unusual, such as unusual supply interval, when the pharmacy received them. The pharmacy dispensed these when people came in, and kept records of when medicines were due, and when they were supplied. A team member checked these each Monday, to ensure that people had collected their medicines due the previous week and ensure stock availability for medicines due to be supplied that week. Team members explained that people collected their medicines as expected, but if they had not, the pharmacy would call them to ensure they had enough medicine, or identify any pharmaceutical care issues.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time, at

least one week before the first pack was due to be supplied. The pharmacy had a checklist on the wall in the area team members assembled these to ensure all parts of the process were completed. They placed prescriptions, patient information leaflets (PILs) and packaging into a basket which was given to the pharmacist with the packs to help the accuracy check. The pharmacist sealed the packs after they had completed the final checks. Team members labelled the spines of each pack with date of supply and instalment number which helped ensure the correct pack was supplied each week. And they included tablet descriptions on packs and supplied a PIL with the first pack of each prescription. The pharmacy kept comprehensive records of interventions and medicines' changes, including dates, prescriber names and a record of who actioned the change in the pharmacy. The pharmacy also kept hospital discharge information. This provided a robust record of medicines' supplies and helped the pharmacist undertake clinical checks. The pharmacy also provided pharmaceutical services to care homes. The homes ordered their own prescriptions and the pharmacist carried out the usual professional checks. The pharmacy followed a designated timetable for dispensing and supplying medicines to the homes, and this was on the dispensary wall as an aide memoir. Sometimes the pharmacy received faxed prescriptions for urgent items such as antibiotics for people in the care homes. It dispensed and delivered these the same day. The surgery or care home supplied the legal prescriptions within the required time. And the pharmacy had a robust process in place to ensure any outstanding prescriptions could be followed up.

The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. They were stored in individually named baskets on labelled shelves. A team member dispensed some daily instalments in the morning for the following day and after the pharmacist had checked them, she stored them appropriately. All team members were trained and competent to supervise self-administration of medicines and they ensured people were well enough to take their medication. And sometimes they referred people to the pharmacist if they were unsure.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. S/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. It had undertaken a search for people in the 'at-risk' group. The pharmacy did not supply valproate to anyone in this group. Team members were all familiar with this and gave good responses to a scenario posed. 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. The pharmacist used the unscheduled care PGD regularly to help people access medicines appropriately and in a timely manner. The regular pharmacist also followed private PGDs for flu vaccination and travel vaccinations. She described the service and was familiar with the PGDs. The PGDs were provided by 'Pharmadoctor' and included templates that the pharmacist completed during consultations to capture relevent information to ensure that she gave people correct advice and appropriate vaccinations. Relief and locum pharmacists did not offer these services. The relief pharmacist present during the inspection signposted a person to another pharmacy for travel services required that day. 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. They all recorded consultations as required on the electronic system. Where possible, the pharmacist always handed out dispensed medicines and asked people if they knew how to take them or had any questions. The pharmacist measured people's blood pressure on request, but this was not a frequent service. And the smoking cessation service was

delivered by the pharmacist and one other team member who was fully trained and competent. This was not a busy service.

The pharmacy obtained medicines from licensed wholesalers such as Alliance, AAH, Phoenix, and Target. The pharmacy mostly stored medicines in original packaging on shelves, and in cupboards. It had very few items that were not in manufacturers' packaging and were incompletely labelled. But this could result in the pharmacy supplying a medicine that was not fit for purpose. Team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy stored items requiring cold storage in a fridge 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.

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 it 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 (CO) monitor maintained by the health board, a blood pressure meter which had been obtained within the past few weeks, and sundries required for vaccinations, including adrenaline which was stored securely in a cupboard. The pharmacy was not currently using the CO monitor as part of its infection control measures. Team members kept ISO marked measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets. The pharmacy kept records of vehicle maintenance and MOT certificate to demonstrate that the delivery vehicle was fit-for-purpose.

The pharmacy stored paper records in the dispensary and basement 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.