General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 1 Restalrig Road, Leith, EDINBURGH, Midlothian, EH6 8BB

Pharmacy reference: 1042678

Type of pharmacy: Community

Date of inspection: 03/03/2020

Pharmacy context

This is a community pharmacy beside other shops in a city suburb. It dispenses NHS prescriptions including supplying medicines in multi-compartment 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 the NHS smoking cessation service, seasonal flu 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 team members follow written processes for all services to ensure that they provide them safely. They record mistakes to learn from them. And they review these and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to and keeps people's private information safe. Team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. This was an improvement from the previous inspection when some SOPs were not 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. Staff roles and responsibilities were recorded on individual SOPs. Each team member accessed these on their 'e-expert' training platform. Head office dictated a SOP to be read each month. These were new, amended or simply refreshing knowledge. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. Trainees were clear that they did not undertake all tasks e.g. supervising methadone consumption and measuring blood pressure. The team had devised a rota for some tasks, particularly front shop activities. This ensured that they all had the knowledge and skill for all tasks, and these did not get forgotten e.g. date checking and dealing with patient returned medicines. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. It displayed information (Well support) on the dispensary wall of contact numbers for maintenance and other internal services, and other branch phone numbers.

Team members used electronic near miss logs (DATIX) to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month and introduced some strategies to minimise the same error happening again. Recently wrong strengths were the most common mistake. And the pharmacy had supplied the wrong strength of a medicine to a patient. A team member had apologised, supplied the correct strength and explained to the person what the pharmacy did in such cases. She explained that the incorrect medication was retained for two years and an investigation and analysis of the mistake was undertaken. And the team member provided the person with a customer service leaflet and head office phone number. The team had discussed the incorrect strengths the previous week. And team members had started highlighting strengths on labels to help them focus on selecting the correct strength. They had ordered 'caution' labels to attach to shelves containing medicines involved in errors. The team had also identified more errors occurring on Tuesdays and Fridays. One team member started later on these days, so team members felt they were possibly rushing as they were under pressure to meet company targets for dispensing times. They used a 'patient safety wall' in the dispensary to draw attention to medicines potentially involved in incidents e.g. similar looking and sounding medicines.

The pharmacy had a complaints procedure and welcomed feedback. Several people had recently complimented the pharmacy team on better organisation. Team members were continually working to maintain and improve efficiency in the pharmacy. When they told people how long their prescription would take to process, they ensured that it was ready within this time. New team members had been

making efforts to build relationships with local people. There had been several changes of team members over the past few months.

The pharmacy had an indemnity insurance certificate, expiring 30 June 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 three CD destruction registers for patient returned medicines. Following discussion team members were going to archive two registers to ensure only one was in use. The pharmacy had records of some patients' returned items but no record of their destruction. And these items were not observed. Team members were going to investigate this and report to the NHS CD accountable officer if necessary. The pharmacy had some instalment prescriptions for controlled drugs that were not legally compliant as they did not have the instalment amounts stated. They were not ambiguous, so this did not pose a risk to people. 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 recently - this was done annually. They segregated confidential waste for secure shredding. No person identifiable information was visible to the public. Team members had also undertaken training on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacy had a chaperone policy in place and displayed a notice telling people. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified or in-training team members to provide safe services. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is. And then makes changes if required. This ensures skilled and qualified team members always provide pharmacy services. Team members have access to training material to ensure that they have the skills they need. And the pharmacy gives them time to do this training during the working day. Pharmacy team members make decisions appropriate to their role. And they use their professional judgement to help people. They know how to raise concerns if they have any.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, three full-time and one part-time (29.5 hours per week) dispensers. Two were qualified and very experienced, and two were undertaking the Buttercups joint medicines counter/dispensary course. The pharmacy had three team members and the pharmacist one day per week and two mornings. It had four team members at most other times. And one on Saturdays. The pharmacy had reviewed staff levels over the past few months when team members had retired. It had gained a full-time team member and a part-time team member had increased hours. The pharmacy used rotas to manage staff levels depending on workload. And part-time team members had some scope to work flexibly providing contingency for absence. Team members were able to manage the workload. But, as noted above, the team made more errors when there were fewer team members working.

The pharmacy provided learning time during the working day for all team members to read SOPs each month. They could also access ‘e-expert you’ training modules on a variety of topics. But team members were not currently doing this. The pharmacy provided team members undertaking accredited courses with additional time to complete coursework. It gave them at least an hour per week. One trainee was ahead of where she should be – she was doing some training at home. Trainees described being helped and coached by more experienced colleagues. This included a team member adapting to a learning style.

Team members had annual development meetings with the pharmacy manager to identify their learning needs. Some had these recently and some were still to be held. One team member was hoping to embark on NVQ 3 training so had taken a screening test successfully. 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 awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. A trainee team member described a product that she often had repeat requests for. She was empowered and competent to refuse such requests but explained that she always referred to the pharmacist. Team members were observed to communicate effectively with people. They explained issues experienced obtaining stock, well to a person.

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 or area manager. A team member gave appropriate responses to a scenario posed. The company had a

whistleblowing policy that team members were aware of. A team member was on a company staff forum. So, she was encouraging colleagues in other branches to share topics that they would like brought up at these meetings. The company set targets for various parameters. Team members described how they used these. They tried to dispense prescriptions in five minutes, but all acknowledged that safety and accuracy was the most important aspect of dispensing. Sometimes they felt mistakes were made when rushing to meet this target. They offered services to people who they believed would benefit. People particularly liked the text messaging service. The pharmacy texted them to tell them when their prescription medicines were ready to collect.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy 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 small premises incorporating a retail area, dispensary and basement providing staff facilities and an additional dispensing room. The pharmacy used this room for the management and storage of multi-compartment compliance packs. The premises were clean, hygienic and well maintained. They were tidier and more organised in appearance than at the last inspection. 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, computer and alcohol hand gel. It had a hatch through to the dispensary used for the provision of methadone and buprenorphine consumption. Team members invited people into the consultation room when their medication was ready. The consultation room 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 support people by providing them with information and suitable advice 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. 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 low step and team members helped people 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 vaccination. It could provide large print labels to help people with visual impairment. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

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. One or two team members worked through prescriptions received from the surgeries. As they labelled, the computer automatically ordered stock for items being supplied from the pharmacy. And the computer identified items suitable for assembly at an offsite hub. Team members marked prescriptions to show which items were being assembled at the hub and which in the pharmacy. The pharmacist then clinically checked items for the hub and confirmed this on the computer. Team members sometimes noticed new items or changes in doses and highlighted these to the pharmacist. But they did not always do this. The computer programme was relatively new, and they were not all familiar with all its functions. This meant that occasionally the pharmacist may not have enough information to carry out a clinical check. The pharmacy received dispensed medicines from the hub the following day or the day after that, depending on the time the information was transmitted. The bag labels from hub and locally dispensed items had bar codes. Team members scanned these and bar codes on retrieval shelves using a hand-held device. When people presented at the pharmacy team members entered their name onto the device. It identified which shelves medicines were stored on. It helped ensure multiple bags were supplied. 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. The pharmacy did not supply any medicines on chronic medication service (CMS) serial prescriptions. The pharmacist was registering people but as she was not present no pharmaceutical care issues were described.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time in the dedicated room in the basement. The process was observed to be organised and orderly. Team members used a progress tracker to monitor the process. They assembled packs the week before the first one was due to be supplied. At the last inspection, this was often taking place the day before supply, causing pressure and therefore increasing risk of errors. Team members took packs up to the dispensary for the pharmacist to check and seal. They stored the completed packs in the room in the basement, on labelled shelves depending on week of management and day of supply. And they had a shelf to store assembled packs for people in hospital. This ensured that these were not supplied without changes being made following discharge. They used a colour coding system to help identify the

different weeks. They stored the packs in individual boxes labelled with patient details and day and method of supply. And they labelled packs with date of supply, corresponding to the date on the backing sheet. The backing sheets had some tablet descriptions on them. But some of these did not give enough information to identify tablets. The pharmacy supplied patient information leaflets (PILs) with the first pack of each prescription. Three people were supplied with two weeks' packs at a time to suit carers. But prescriptions stated, 'dispense weekly'. All team members were trained and competent to manage and assemble multi-compartment compliance packs. They took turns to ensure they all maintained skills. A trainee had reviewed the process and made some improvements, particularly to the way packs were stored. The pharmacy kept thorough records of changes, hospital discharges and other interventions. It stored these in different folders corresponding to the week of management.

The pharmacy supplied a variety of other medicines by instalment. The pharmacy had asked people to bring their prescriptions in at least a day before the first supply. A team member set up the instalment dispensing on the patient medication record (PMR) and generated all the labels. And they used a template (PC70) to list all the instalment dates. This helped the team identify when medicines were due for supply and when doses had been missed. If the prescription was for a lot of instalments, a team member dispensed them weekly. But if they were not for many, team members dispensed all at the start. They stored these in labelled baskets, alphabetically on dedicated shelves in the dispensary. This process was very organised and much improved from the previous inspection. All team members could undertake this, but trainees were often supervised by more experienced colleagues.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She 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 and the pharmacist had counselled them appropriately. A team member described some people supplied with valproate in compliance packs who were also supplied with oral contraceptives. The pharmacy displayed information on the subject from the pharmacy superintendent on the dispensary wall. Team members referred to this as required. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, and chlamydia treatment. It also followed private PGDs for flu vaccination. 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 pharmacist (who was not present) delivered the flu vaccination service and was appropriately trained. The trained and experienced dispensers, and the pharmacist delivered the smoking cessation service. Several people enquired about the service but not many committed to it. The trained team members also measured blood pressure occasionally.

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 had the equipment and team members had read a SOP. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. Although there were a few loose tablets in bottles in the

compliance pack room. Team members had removed these from packs following changes. But they had not labelled them fully, so they did not have batch numbers or expiry dates. The pharmacy 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. 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 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. The pharmacy 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 which a team member thought was quite new. But it had no indication of when it required testing or replacement. Team members kept crown stamped measures by the sink in the dispensary, and they used separate marked ones for methadone. The pharmacy had a 'methameasure' pump available for methadone use and team members cleaned it at the end of every day and poured test volumes each morning and lunchtime. The pharmacy team kept clean tablet and capsule counters in the dispensary and washed them after using with cytotoxic tablets. The pharmacy had antiseptic wipes for cleaning hard surfaces and hands.

The pharmacy stored paper records in the dispensary and back-shop areas inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any people in the retail area. 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.