General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: W M King & Son, 142 Marchmont Road, EDINBURGH, Midlothian, EH9 1AQ

Pharmacy reference: 1042708

Type of pharmacy: Community

Date of inspection: 16/01/2020

Pharmacy context

This is a community pharmacy beside other shops in a residential area close to the city centre. 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 can also provide substance misuse services. And it dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers seasonal flu vaccination.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	Pharmacy team members have regular performance and development reviews. These help them to identify their learning needs. And the pharmacy addresses these needs by providing them with training material. And weekly learning time during the working day.
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 processes for all services to ensure that they are safe. Team members record mistakes to learn from them. They review these and make changes to avoid the same mistakes happening again. The pharmacy asks people for feedback. And team members discuss this to make the pharmacy's services better. The pharmacy keeps all the records that it needs to. And it keeps people's 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. 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. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with baskets used to separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. And it had a locum folder which contained a range of information useful to locum pharmacists who were not familiar with this pharmacy. This included login information for computer systems, phone numbers for a variety of stakeholders, and account details for suppliers. The pharmacy also had comprehensive information regarding the computer software to assist locum pharmacists, phone numbers for all other branches in the company and there was a communication diary to share relevant information.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. Head Office insisted on 100% reporting and team members explained that all incidents were recorded. They did not make many errors – their dispensing volume was low. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. The pharmacy had not had any errors recently and only three near misuses the previous month. Team members had discussed these. And over the past few months since the pharmacy manager had started, they had placed warning labels on shelves highlighting some medicines e.g. warfarin, apixaban (they had separated pack sizes), tablets/capsules, and immediate release/modified release preparations.

The pharmacy had a complaints procedure and displayed a notice encouraging feedback. A team member (medicines counter assistant) described a lot of positive feedback from people. She had recently been awarded 'medicines counter assistant of the year' within the company. She described how she enjoyed helping people, and in response to the feedback did 'more of the same'. She ordered items not usually stocked for people on request. And kept some items in stock specially for some people. The pharmacy stocked some ranges in the retail area that were popular locally and difficult to locate elsewhere. The pharmacy kept specific brands of prescription medicines for some people. Team members noted these preferences on patient medication records (PMR) and kept labels on the items to ensure availability.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed

specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. 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 and regularly re-read it. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. It replaces staff during absence when required. This ensures skilled and qualified staff always provide pharmacy services. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training. Team members can share information and raise concerns to keep the pharmacy safe. Team members make suggestions to improve services. They discuss incidents and learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager who had started in the pharmacy around three months previously; a Saturday only pharmacist; two part-time dispensers working four days and one day respectively; two part-time medicines counter assistants working four days and one day respectively; one Saturday only trainee medicines counter assistant and a part-time delivery driver. Typically, there was a pharmacist, dispenser and medicines counter assistant working. Team members were able to manage the workload. The pharmacy reviewed staffing levels during annual leave and absence. And head office provided cover from other branches, or relief staff.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development. This included online modules, e.g. Nexium; booklets on various topics e.g. incontinence pads and reading SOPs regularly. Team members self-selected topics they wanted to learn about or refresh their knowledge. The SOPs folder was on the desk in the consultation room for easy access. They always read new SOPs on receipt. The pharmacy gave the trainee medicines counter assistant time at work to undertake her training. The pharmacist had completed appropriate online and face-to-face training this year for administering flu vaccination, including emergency first aid. Team members had annual development meetings with the pharmacy manager to identify their learning needs. The pharmacy manager documented these and sent them to head office. A dispenser was currently working to increase her computer skills and develop the chronic medication service. All 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. They gave examples of appropriate action they had taken when they had been concerned about such requests. The pharmacy regularly shared this type of information with two other local pharmacies to keep people safe.

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. They gave examples of making suggestions to the pharmacy manager e.g. relocating stock and keeping certain brands. These were always accepted and adopted. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. Team members read this document and signed to acknowledge this. Topics included similar packaging, and similar names e.g. sulphate/bisulphate. And the superintendent pharmacist included errors or incidents from elsewhere to provide learning for team members. The pharmacy team discussed incidents and how to reduce risks. The company had a whistleblowing policy that team

members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy’s services. 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, small dispensary and staff toilet. The premises were clean, hygienic and well maintained. There were sinks in the dispensary 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, sink and computer which was clean and tidy, and the door closed providing privacy. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The 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 a wide door. 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 had a hearing loop in working order and could provide large print labels. 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, including additional records for controlled drugs. The driver used a cool box to maintain the cold chain and stored controlled drugs in a separate box. Team members described helping people in a variety of ways – opening the door, advice, gathering shopping, recommending appropriate products and services, and promoting special offers that would appeal to known customers. The driver had worked in the pharmacy for many years so knew the people he delivered to well.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to separate people's medicines and prescriptions. The team member labelling always shared any changes such as new items with the pharmacist to enable her to undertake a full clinical assessment. 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 chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when people presented at the pharmacy. The pharmacist explained that she liked to discuss people's medicines with them, including compliance and reasons for any items not wanted. She had reviewed and changed this process recently. The pharmacy had previously dispensed these medicines in advance. The pharmacy was trying to actively register people for this service, but uptake was low. The pharmacist had not identified any pharmaceutical care issues in the few months she had been in this pharmacy. But she identified issues with people receiving medicines in multi-compartment compliance packs. She had liaised with the prescriber and had one item changed to a gastro-resistant formulation, and another drug changed.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time at least a week in advance. It assembled two packs at a time if they contained controlled drugs due to limited storage space. Team members kept thorough records for each person using a colour coded system related to the week the prescription was managed. They recorded when prescriptions were ordered, received and assembled. And kept chronological lists of changes and interventions. A team member re-printed the person's profile following a change. And they documented when the change took effect i.e. if it was mid-cycle or not. Team members printed tablet descriptions on backing sheets and names, instalment number and date of supply on the spines of

packs. They stored completed packs in individual named boxes on designated shelves in the dispensary (for collection) and a cupboard in the consultation room (for delivery).

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 none were identified. 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 referred all requests to the pharmacist for the final decision about treatment. She usually agreed with team members' recommendations. Team members asked people to complete a template to gather personal information and relevant details about symptoms. And they used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment.

The pharmacist had administered several flu vaccinations following the PGDs. She had completed relevant training a few months before vaccination commenced. She described her process which was methodical and professional. She encouraged people to wait in the pharmacy for a short time after the vaccination to ensure they were well. The pharmacy kept NHS and private vaccines in different coloured baskets in the fridge to ensure the correct one was administered. The pharmacist had not administered any NHS vaccinations. The pharmacist also delivered the smoking cessation service. The service was not busy, and the pharmacist had time to do this.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It had some loose tablets in bottles, and they were adequately labelled. Team members marked liquids with the date of opening to ensure they were not supplied after the expiry date. They stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and 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 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 sundries required for flu vaccination. It had emergency adrenaline available. Team members kept crown stamped and ISO marked measures by the sink in the dispensary. They kept a separate marked one for methadone in a different location to measures used for water. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in a cupboard in the consultation room and in the dispensary, inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left them unattended unless they were locked.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.