General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 55a/57a Mayfield Road, EDINBURGH, Midlothian, EH9 3AA

Pharmacy reference: 1042710

Type of pharmacy: Community

Date of inspection: 04/02/2020

Pharmacy context

This is a community pharmacy beside other shops, on a main road close to the city centre. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartment compliance packs and provides substance misuse services. It offers seasonal flu vaccination, the NHS smoking cessation service 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 are safe. Recently they have reviewed these to make sure that they were following them all. 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 by law and has recently improved record keeping. It keeps people's information safe. Pharmacy 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 electronic records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. And this was clarified by the mandatory SOPs that team members accessed on their password protected electronic training platform. SOPs were allocated to ream members by role. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. Trainee team members could describe activities that they were competent in and activities that they were supervised for. 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.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They recorded these electronically on the DATIX system. Head office provided statistics at the end of each month of incidents and the manager reviewed these. Recently errors had occurred with common lines stored on 'top 50' shelves. The manager identified that shelves were cramped. So, he had made an additional shelf available and these were now stored four shelves rather than three. Team members were making less errors with these items now. The non-pharmacist manager started in this pharmacy around three months before. He was systematically reviewing all processes to identify any areas for improvement. He had changed some processes involved in the management of multicompartment compliance packs as the SOP was not always being followed. He explained that team members were now following the SOP, and this was observed. He had also reviewed controlled drug management and improved storage of controlled drug registers. He ensured that running balance checks were undertaken weekly as per the SOP.

The pharmacy had a complaints procedure. The pharmacy had indemnity insurance, 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 a CD destruction register for patient returned medicines. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost. Although CD running balances were currently being audited, the pharmacy had not done this for several months during a challenging period the previous year. It had identified a few discrepancies that could not be resolved despite investigation. These included shortages of methadone solution and oxycodone tablets. The NHS CD accountable officer (AO) had been notified. At that time,

the pharmacy had also been recording branded and generic products in the same register which was not appropriate. The pharmacy had improved record keeping. And team members had not identified any discrepancies since they had resumed regular running balance audits. But some registers were damaged and not 'bound' which was a legal requirement, e.g. MST 15 tablets.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and revisited this annually. 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 pharmacy had a chaperone policy in place and displayed a notice telling people. The pharmacists were PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified or training staff to safely provide its services. The pharmacy reviews staff levels and covers absence if required. 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. Experienced team members show new team members how to carry out activities safely. Team members can share information and raise concerns to keep the pharmacy safe. And they can make suggestions to improve services. They discuss incidents and learn from them to avoid the same things happening again.

Inspector's evidence

The pharmacy had the following staff: three part-time pharmacists (three, two and one day per week); one full-time manager/dispenser; one full-time and one part-time trainee dispensers; one part-time qualified and experienced dispenser and a part-time delivery driver. Typically, there were three team members and a pharmacist working, and this was the case during the inspection. For much of the day one team member worked in the basement managing multi-compartment compliance packs. The non-pharmacist manager started in the pharmacy three months ago. Team members were able to manage the workload. The pharmacy had recently undertaken a review of staffing levels. It was found to be overstaffed following the company staffing formula, but no change was made. The management team acknowledged that there had been challenges over past months with staff shortages. The pharmacy used a rota to ensure team members rotated through all tasks to maintain skills and avoid boredom or complacency. It used these to highlight gaps during absence and relief team members covered these when they were available.

The full-time trainee had started in the pharmacy five months ago. She had completed induction training and the pharmacy had registered her on the Buttercups joint dispensing/medicines counter assistant course. But she had not started this yet as there was some confusion regarding which pharmacy she was working in. The manager was working closely with her and providing ‘on-the-job’ training and coaching. She was assembling multi-compartment compliance packs during the inspection. And she was observed to be competent. The manager explained that the part-time trainee who had started in the pharmacy eight months ago was given two hours per week to complete accredited training. She was not present during the inspection. The pharmacy provided learning time during the working day for all team members to undertake regular training and development. They accessed electronic modules, both mandatory and optional. There was a range of topics available. Team members selected modules that they were interested in, or where they identified gaps in their knowledge. The various individuals 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. Examples were observed of dispensers identifying unusual doses on prescriptions and confirming these with GPs, e.g. an unusual dose of an antihistamine.

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. An example was described, and this was being managed appropriately. The pharmacy team

discussed incidents and how to reduce risks. The team had regular weekly meetings. The manager led these meetings and team members discussed a variety of topics. Topics included information from head office and patient safety issues such as near misses or errors. Pharmacy managers (including non-pharmacists) attended managers' meetings and discussed a variety of topics. They had discussed the challenges of covering dispensing team members' absence at a meeting several months previously. The company had addressed this locally by employing relief dispensers. The manager explained this was a useful addition. And a relief dispenser was currently covering absence in this branch. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members offered services to people who would benefit e.g. text messaging service. This alerted people when their medicines were ready and minimised people turning up at the pharmacy to early.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy's services. The pharmacy team members use a private room for some conversations with people. People cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises incorporating a small retail area, dispensary and basement. The basement included Including room used for management of multicompartment client compliance packs, storage space and staff facilities. The premises were clean, hygienic and well maintained. 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, sink and computer which was clean and tidy, and the door closed providing privacy. The door was kept locked to prevent unauthorised access. 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 knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had one step and a power assisted door. Team members could help if required. The pharmacy listed its services and had leaflets available on a variety of topics. Team members could signpost people to other services if requested. They could provide large print labels on dispensed medicines for people with impaired vision. 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. Most prescriptions came to the pharmacy directly from the GP practice. The pharmacy received these around lunchtime. A dispenser scanned them into the computer on receipt. This automatically ordered stock to fill these. The pharmacy received that order the following day. The computer also highlighted which prescriptions were suitable to be dispensed at the company off-site dispensing hub. The hub did not assemble all items, such as some liquids, inhalers, controlled drugs, split packs and compliance packs. So, items for one person could be dispensed in both the pharmacy and the off-site hub. The pharmacist clinically assessed the prescriptions and confirmed this on the computer before they were sent to the hub. If they were sent in the morning, the dispensed medicines were usually received the next day. When stock that had been ordered arrived into the pharmacy the next day, a team member laid it out alphabetically. And a team member assembled prescriptions from that stock. Team members rotated common items on the shelves to ensure that medicines did not go out of date by only using new packets. The computer generated a bar code for the dispensed medicines' bag label. Team members scanned this, and the bar code of the selected retrieval shelf. When the pharmacy received dispensed medicines from the off-site hub, the bar codes on these packs were scanned. This identified if there were already dispensed medicines on the retrieval shelves for that person. And team members placed all items for the same person together. When people came to collect their dispensed medicines, their name was entered onto the computer system using a hand-held device. The device told the team member which shelf the medicines were on. This system was observed to work well. When people received their medicines, they were scanned out using the hand-held device which created an audit trail of date and time. Team members dispensed items for people waiting, at the front of the dispensary close to the pharmacist's checking area.

Team members did not routinely highlight new items to the pharmacist. But if there were interactions with existing medication, the patient medication record automatically highlighted this and generated labels. Dispensers highlighted these to the pharmacist and included these labels with dispensed medicines. The pharmacist clinically assessed the prescription and advised people appropriately. Team members were trying to pay more attention to the details of patient medication records when they were labelling. And they were noting changes and unexpected dates of prescribing and sharing this

information with the pharmacist. A dispenser explained that due to staffing challenges over past months this had not been happening. But as the staff level was better and they were not rushing, they were making more of an effort. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy had very few serial prescriptions, and a lot of managed repeat prescriptions. Team members ensured they were ordered before people expected their medicines and told people when their next supply would be ready. The pharmacy sent text messages to people to let them know when their medicines were ready for collection. Team members were updating people's records to include mobile phone numbers for this reason. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time around a week before the first pack was due for supply. Team members undertook this activity in a dedicated room in the basement where there was little distraction. The pharmacist carried out the final accuracy check in this room. And she sealed packs as she checked them. Team members labelled the spine of packs with patient names and date of supply. They ensured that the date on the backing sheet matched the date on the spine of the pack. They stored packs in individual named boxes per patient. The label on the box highlighted the day of supply and whether packs were collected or delivered. The pharmacy used different colours to highlight the day of supply. The pharmacy had a list of all people receiving multicompartment compliance packs and the day they were supplied on the wall in this room. The pharmacy supplied patient information leaflets with the first pack of each prescription. Team members did not routinely include tablet descriptions on backing sheets. They kept thorough records of changes and other interventions. And they kept notes such as 'only to be supplied by collection' due to a person's individual needs. Each day a team member moved packs due for supply that day to the dispensary. This enabled them to identify anyone who had not collected at the end of the day and take appropriate action.

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 information readily available on the dispensary wall for team members to refer to. 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. It also had information about this on the dispensary wall. 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 assist with delivery of 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.

A pharmacist provided the smoking cessation service, but this was not busy in this pharmacy. She or the manager/dispenser measured blood pressure on request. This was observed during the inspection but was not requested often. All pharmacists that regularly worked in the pharmacy were trained and competent to deliver flu vaccination. Their certificates of competence were filed in the pharmacy. They followed PGDs and had the equipment that they required in the consultation room.

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 stored

medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in three fridges with minimum and maximum temperatures monitored. And team members took appropriate action taken if there was any deviation from accepted limits. They regularly checked expiry dates of medicines and most of those inspected were found to be in date. Two items in a controlled drug cabinet were out of date and not labelled as such. And they were not stored with other date expired items. 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. It 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 team members used it with people accessing its services. This included a carbon monoxide monitor maintained by the health board, and a blood pressure meter which was calibrated as per the manufacturer's guidance. It had a label attached stating that the next testing was due in January 2021. The pharmacy also had items required for flu vaccination, and alcohol gel rub, gloves and sharps boxes. It kept crown stamped 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 stored paper records 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.