General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Polwarth Pharmacy, 10-14 Polwarth Gardens, EDINBURGH, Midlothian, EH11 1LW

Pharmacy reference: 1042725

Type of pharmacy: Community

Date of inspection: 11/12/2020

Pharmacy context

This is a community pharmacy beside other shops in a residential area of the city. 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. The company director is often at the pharmacy to let team members in and undertake dispensed medicines deliveries.
This pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

Standards not all 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 not all met	1.1	Standard not met	There are unmanaged risks in the pharmacy due to standard operating procedures being old, inadequate, containing incorrect (and sometimes illegal) processes, and team members not following them. And the pharmacy does not keep prescriptions until medicines are supplied.
		1.2	Standard not met	The pharmacy does not adequately record and review mistakes so team members cannot learn from them.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough trained or training team members to safely provide its services.
		2.2	Standard not met	The pharmacy does not provide ongoing training and development to ensure team members have the skills they need for their roles.
		2.5	Standard not met	The pharmacy does not have processes in place for team members to raise concerns if they have any.
3. Premises	Standards not all met	3.4	Standard not met	The pharmacy is not always secure from unauthorised access while it is closed.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	Dispensing services are not always managed safely and effectively due to prescriptions being sent for payment before the medicines are supplied. And the pharmacy does not manage dispensing in compliance packs effectively and safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy team members do not follow written processes so there is a greater risk of mistakes. And they do not review their mistakes so cannot identify learning points. This means team members are missing learning opportunities. The pharmacy keeps all the records that it needs to by law and keeps people's private information safe. Team members know who to contact if they have concerns about vulnerable people. The pharmacy has made suitable changes to help to reduce the risks to people during the pandemic.

Inspector's evidence

The pharmacy had put processes in place to keep people safe from infection during the COVID-19 pandemic. It had a screen up at the medicines' counter and hand sanitiser at the premises entrance. Team members wore face masks and they washed or sanitised their hands regularly and frequently. Some used masks were observed in open buckets in the pharmacy. They had not been placed in bags for disposal. Team members cleaned surfaces and touch points. It was not known if risk assessments had been carried out for team members.

The pharmacy had standard operating procedures (SOPs) which had been implemented in January 2016 (nearly five years ago). Some team members had read and signed some. The locum pharmacist had not signed them, but she explained that it was not appropriate to sign procedures that were not implemented in the pharmacy or were not legal. The SOP for private controlled drug (CD) prescriptions stated that the prescriptions must be filed. That was not in line with legislation which required them to be submitted to the relevant NHS agency (ISD in Scotland). The repeat dispensing SOP referred to a process for filing prescriptions in A5 wallets and completing record cards. That was not followed. Prescriptions were filed for submission to the pricing authority for payment immediately after assembly. This meant prescriptions were not with dispensed medicines at the point of supply, so the pharmacist was unable to give advice. In some cases, the prescription had already been submitted before the supply was made. Several examples of this were observed – i.e. dispensed medicines from previous months still on retrieval shelves and the prescriptions not on the premises. Examples included an item in the fridge dispensed in September, and items dispensed on 8 October with a note on the bag saying, 'due December', and the prescriptions had already been submitted. This could amount to fraud if these medicines were not supplied for any reason. There was sometimes only a pharmacist on the premises and sometimes only a pharmacist and medicines' counter assistant, so some dispensed items were not double checked for accuracy by a second person. The locum pharmacist described her process if she had to self-check. She left the dispensed items in a basket, overnight if possible before carrying out an accuracy check, then she initialled the dispensing label again.

Team members occasionally 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 in a notebook. But reporting was not adequate or frequent enough to provide any learning. Incidents were not reviewed for trends. The pharmacy did not carry our reviews or audits of any processes. Team members present believed that processes followed had been in place for many years. And different locum pharmacists followed a variety of processes for dispensing e.g. some attached prescriptions to bags containing dispensed medicines. This was not the pharmacy's process, but enabled the person supplying the medicine to offer advice, so was a better process for patient care.

The pharmacy had an indemnity insurance certificate, expiring 30 April 2021. The pharmacy displayed the responsible pharmacist notice and accurately kept the following records: responsible pharmacist log although for a long period a previous superintendent pharmacist had recorded the RPSGB membership number not the GPhC registration number, 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. But examples were observed of patient records not matching CD register entries. This was because labels were printed for all instalments at the same time and the record not updated if any were uncollected.

Pharmacy team members were aware of the need for confidentiality. They segregated confidential waste for shredding. No personal information was visible to the public. Team members knew how to raise safeguarding concerns. Information was available on the Community Pharmacy Scotland website.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not have enough qualified and experienced team members to safely provide its services. This means that some medicines are supplied without a second person checking them which increases the risks of mistakes not being spotted. And not all team members have completed or are undertaking relevant courses for their role. The pharmacy does not set aside time or provide resources for them to continue their learning so they may find it difficult to keep their knowledge up to date. Team members cannot raise any concerns they may have within the company.

Inspector's evidence

The pharmacy had the following staff: one part-time trainee dispenser and one part-time medicines counter assistant. A dispenser had been off work for a few weeks. The trainee dispenser had completed a college course which covered the theory but had not completed the practical requirements of the dispensing qualification. She was not registered on an accredited course. She had worked in the pharmacy for around a year. She worked half days with the medicines' counter assistant working the other half. Sometimes there was a short overlap. But this meant that often the pharmacist was working alone in the dispensary. There was no permanent pharmacist – the previous superintendent pharmacist had finished around three weeks before. Several locum pharmacists were providing cover. When the inspector arrived, the locum pharmacist was alone on the premises. The trainee dispenser arrived later, after delivering medicines. Sometimes the company director attended first thing to provide access to the pharmacy for the locum pharmacist. Some days there were no other team members at the start of the day. It was unknown if this was related to contracted hours or lateness. The company director waited until a team member arrived. It was not known what activities she undertook but she was not trained for any pharmacy activities.

The pharmacy did not provide resources or protected time for team members' learning or development. Team members were observed going about their tasks in a professional manner, but there were no defined systems to follow. When asked about processes the dispenser explained it depended which pharmacist was working. No examples of interventions or sales of pharmacy medicines were observed.

The locum pharmacist understood the importance of reporting mistakes and was planning to report the issue with the private CD prescriptions (noted above) to the CD accountable officer. There was no established channel of communication for team members to raise concerns or share information.

Principle 3 - Premises **Standards not all met**

Summary findings

Sometimes the pharmacy is not sufficiently secure from unauthorised access while it is closed. It is safe and clean, and suitable for the services provided. It has put measures in place to minimise the spread of infection during the pandemic. The pharmacy has suitable facilities for people to have conversations with team members in private.

Inspector's evidence

As noted above, the pharmacy had installed a Perspex screen to offer some protection from infection between team members and members of the public.

These were average-sized premises incorporating a reasonably sized retail area, dispensary and basement including storage space and staff facilities. The premises were clean, hygienic and well maintained. Team members cleaned surfaces and touch points more often than before the pandemic. There were sinks in the dispensary, consultation room/office and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available in the retail area.

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 and the door closed providing privacy. This room was reasonably sized and was also used as an office. It was observed to be untidy and cluttered with items such as a screen like a shower screen and a large table lamp stored on its floor. It was not established if it was currently in use.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not have adequate procedures for its team members to follow. And it does not keep satisfactory records. This means that the pharmacy may not be providing some of its services safely, especially those where medicines are supplied in instalments. The pharmacy helps people to use its services, using different approaches during the COVID-19 pandemic. The pharmacy obtains medicines from reliable sources and stores them properly.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and a power assisted door. It listed its services and had leaflets available on a variety of topics. The pharmacy had a hearing loop in working order for people wearing hearing aids to use. And it could provide large print labels for people with impaired vision. The pharmacy provided a delivery service, which was undertaken by the director and team members.

Pharmacy team members used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. They 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.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. But this was observed to be chaotic with poor and disorganised record keeping. Prescriptions for individual patients had been written on different dates, and some were for 28 days and some 56. An example had some prescriptions written on 20 October and some on 5 November. Some were for 28 days and some for 56 days. The pharmacy had not recorded start dates on any of these or documented how many instalments had been supplied from each. There was information recorded on a 'post-it' note, three other pieces of paper stapled to the person's record, and correction fluid used to remove previous items from the record. This made it extremely challenging to ascertain what was current and what was not, posing a real risk of the person being supplied with the wrong medication. Team members recorded changes requested by prescribers but in different ways as this example demonstrates. There was no defined process to follow. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied, but sometimes this was done under pressure as prescriptions were sometimes requested late due to the disorganisation. And some prescriptions were submitted to the pricing authority for payment before the medicines were supplied. So, records of what was supplied from individual prescriptions was not kept with the prescriptions as was usually seen in pharmacies. Team members wrote tablet descriptions onto the packs and people's names on the spine. They did not always write the starting date on to the pack, and the labels had the date of printing on them which was sometimes several weeks before supply e.g. packs waiting to be supplied on 11 December were dated 9 November. This would be confusing for other healthcare professionals to make a judgement about compliance or what medication the person was taking e.g. on admission to hospital. The locum pharmacist had found that one person's prescriptions had finished, and new ones had not been ordered. She contacted the GP to

clarify what medication was required then made the supply under the unscheduled care patient group direction.

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 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 followed private PGDs for flu vaccination. The pharmacist delivered the Pharmacy First service using the sale of medicines protocol and the formulary to respond to symptoms. Other team members were able to undertake some aspects of the service but there was only one computer, so they were unable to complete the recording. During the pandemic pharmacists had delivered some services remotely by phone. This had ensured service delivery while minimising footfall on the premises. Services delivered in this way included smoking cessation, urinary tract infection (UTI) treatment and supply of emergency hormonal contraception (EHC). The pharmacist carried out the consultation remotely and if appropriate, the team prepared medication ready for collection when the person came to the pharmacy. Some people consumed their medication under supervision in the pharmacy. They poured their medicine from the bottle into a cup then handed the bottle back to the pharmacist. The pharmacy re-used these bottles, posing a risk due to potential contamination. The locum pharmacist at the time of inspection destroyed bottles that were stored in the CD cabinet for re-use.

The pharmacy had provided a flu vaccination service, but team members present during the inspection did not know the details of this. The service had been available on some days depending on which pharmacist was working. Used syringes/needles were observed in open receptacles intended for obsolete medicines in the basement.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. But an example was seen of loose tablets in bottles with inadequate labelling. And team members used space well to segregate stock, dispensed items and obsolete items. But there were date-expired prescriptions and dispensed medicines in the CD cabinet. 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 most of the equipment it needs for the delivery of its services. But it does not have a big enough variety of sizes of measures for liquid medicines. Team members look after 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 crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. But it only had two sizes – 25ml and 100ml. This made it challenging and possibly inaccurate when measuring larger volumes, such as when carrying out weekly audits of liquid medicines. The pharmacy team kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in the dispensary and office/consultation room 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.