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: 11/08/2021

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, the NHS smoking cessation service, the NHS Pharmacy First service and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. This pharmacy was inspected during the COVID-19 pandemic.

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	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, including reducing the risk of infection during the pandemic. The pharmacy team members follow written processes for the pharmacy's services to help ensure they provide them safely. 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. They record some but not all mistakes to learn from them but don't review them regularly to identify common themes. So they could be missing some learning opportunities.

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 it only allowed two people on the premises at any time to enable social distancing. Most people coming to the pharmacy wore face coverings and team members all wore fluid resistant masks. They washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points throughout the day. A team member cleaned the consultation room immediately after use.

The pharmacy had standard operating procedures (SOPs) which were followed. These had been put in place around six months ago by the pharmacy superintendent (SI). Pharmacy team members had read them, and the pharmacy kept records of this. 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 SI and dispensing team members had reviewed the management of multi-compartment compliance packs and the new SOP reflected the improved processes that had been introduced. 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. Over recent weeks there had been a shortage of pharmacists locally. The owner and superintendent pharmacist (SI) described how they had managed this. They had had to close the pharmacy for two and a half days over the course of a few weeks. They had notified local stakeholders including GP practices and the NHS. And they had ensured that vulnerable patients were supplied with their medicines.

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. But sometimes they forgot to record near miss errors. They had not formally or regularly reviewed near misses and errors recently. There had been a few changes of SI over recent months. The current incumbent was holding the position temporarily until a recently appointed SI could take up the role in two weeks. He described continual informal, unstructured review of incidents. This had led to the team rearranging some stock shelves, reviewing stock levels and identifying high risk items with similar looking or sounding names (LASA). The pharmacy had a complaints procedure and welcomed feedback. The team could not recall any complaints and there were positive comments on social media.

The pharmacy displayed an indemnity insurance certificate, expiring 30 April 2022. 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 and controlled drugs (CD) registers with running balances maintained and regularly audited. It had a CD destruction register for patient returned medicines. 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 a SOP and several were undertaking accredited courses which covered this topic. They segregated confidential waste for shredding. And no person identifiable information was visible to the public. There was a safeguarding folder in the dispensary with local procedures and contact details. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. They are trained and competent for their roles and the services they provide. The pharmacy gives them time for training during the working day. Team members can make decisions within their competence to provide safe services to people. And they use their professional judgement to help 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 the following staff: one pharmacy superintendent (SI) working two or three days per week and two regular locum pharmacists working the other days; two full-time dispensers, one who was qualified and experienced and one who was undertaking an accredited course, although she had years of experience and a previous qualification; one part-time medicines counter assistant who was currently undertaking dispensing training; and a 'Kickstart program' trainee working 25 hours per week over four days. The pharmacy displayed their certificates of qualification. Typically, there were at least two, usually three team members and a pharmacist working at most times. For most of the time during the inspection there were three – one was studying his coursework. The pharmacy had reviewed staffing levels since the last inspection, recruiting the full-time qualified dispenser. She was on annual leave at the time of inspection and team members were able to manage the workload. A trainee team member had recently left, so the pharmacy was recruiting for a full-time replacement. A trained medicines counter assistant worked voluntarily two mornings per week carrying out tasks including window dressing and ordering sundries such as dispensing bottles and skillets.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development which was observed. And there was a timetable on the dispensary wall showing weekly training times. Mainly this was accredited coursework. All team members were completing recognised delivery driver training, including the pharmacy owner. They were all involved making medicines' deliveries to people. There was a labelled shelf in the staff area with training material and team members were encouraged to read this when they had time. Team members had access to online training modules which they could choose to do depending on their interests or gaps in knowledge. The SOPs and patient group directions (PGDs) were also available and the SI encouraged everyone to familiarise themselves with these. A recent update to the Pharmacy First service, a recent update letter from the Scottish Government about changes to self-isolation in healthcare settings and the weekly update from the NHS community pharmacy development team were lying out with a note encouraging all team members to read them. Team members did not record what training they had undertaken. The SI was observed to supervise team members and the Kickstart trainee described colleagues as helpful and supportive. He hoped to complete medicines' counter training within his six-month placement. 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. The medicines counter assistant demonstrated an awareness of repeat requests for medicines intended for short term use. And she dealt appropriately with such requests. The experienced trainee dispenser was observed contacting prescribers to address queries and clarify ambiguities on prescriptions. Often, she liaised with the practice pharmacist to resolve issues. She was empowered to make decisions and follow-up issues without referring to the pharmacist. And she informed him of what she was doing and what the outcome was. She also

recorded interventions clearly, including the date and the name of the person she had spoken to.

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 pharmacist and owner. This included telling the owner when equipment was no longer working well. An example was the printer and computer system which were then replaced. Team members described feeling able to discuss any concerns with the owner. And they discussed any issues amongst themselves and with the SI. The grievance SOP which team members had read and signed had an appendix including contact details of the owner and SI. Team members used a communication book to share information, and as a reminder of tasks to be completed.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

These were average-sized premises incorporating a reasonably sized retail area, dispensary and a basement including storage space and staff facilities. The team had recently tidied the basement which had been very cluttered at the last inspection. There was now a large volume of items for disposal waiting to be uplifted. The SI had archived old records which were required by law to be kept for different periods of time. These were filed and dated and stored in an orderly manner on shelves in the basement. 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, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser in the retail area and dispensary. Temperature and lighting were comfortable.

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. It was clean and tidy, large enough for social distancing and the door closed providing privacy. The team had tidied this room and removed obsolete and unnecessary items, so it had a more professional appearance than at the last inspection.

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 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 stores them properly. 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 power assisted door. It listed its services and had leaflets available on a variety of topics. But not all services were currently available. Some due to the pandemic and some due to changes in regular pharmacists and the SI over recent months. The new SI who would be the full-time pharmacist was due to start in two weeks. She had a lot of experience delivering a variety of NHS and private services. The pharmacy was waiting for her to start and review services. It 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 often undertaken by the owner although all team members carried out deliveries sometimes and they were all trained, or completing an appropriate course.

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. The dispensers shared information such as changes and new items with the pharmacist to enable him to carry out an effective clinical check. 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. And team members texted people to let them know when their medicines were ready. The team had reviewed the dispensing process and improvements introduced included retaining prescriptions until all supplies had been made. And the team had improved storage of dispensed medicines, introducing an effective filing system. Team members checked the retrieval shelves regularly to identify any uncollected medicines and help with people's compliance. They contacted people after about three weeks to remind them their medicines were waiting. And they kept records of this. When appropriate, team members notified prescribers when they were concerned about uncollected medicines.

A few people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. This service was in early stages and the pharmacy had not yet decided on the best process to follow. Team members expected this service to increase over coming months as practice pharmacists moved people on to serial prescriptions.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. The team had reviewed and greatly improved this service since the last inspection. Team members assembled four weeks' packs at a time, at least one week before the first pack was due to be supplied. They kept comprehensive records of changes and other relevant information. These included dates and personnel involved in the pharmacy and the GP practice. Changes and deletions were made accurately and neatly enabling all team members to follow and understand them. Team members attached backing sheets usually with one staple, which could

cause sheets to become detached. Then people using the packs might not know what they contained. They clearly labelled packs with name, address and date of supply. And completed packs were stored in individually labelled boxes per person. The pharmacy supplied patient information leaflets with the first pack of each prescription. The pharmacy supplied a variety of other medicines by instalment. A team member usually dispensed these prescriptions in their entirety when the pharmacy received them. This was variable depending on the instalment frequency, but team members always assembled several instalments in advance and stored these on designated shelves in individual baskets per person. They labelled the bags with date of supply.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. 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 patient group directions (PGDs) in place for unscheduled care and the Pharmacy First service. The pharmacist was in the process of working through two recently introduced PGDs for supply of medicines under the Pharmacy First service. 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. The medicines counter assistant described this process and demonstrated using the template that was in place to capture people's information. She described promoting the service and explaining it to people. During the pandemic the pharmacist had delivered some services remotely by phone, but people were now usually coming to the pharmacy. The team used the consultation room to provide services including smoking cessation, supply of emergency hormonal contraception and treatment of urinary tract infections.

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. And team members used space well to segregate stock, dispensed items and obsolete items. They had recently reviewed stock holding and had labelled shelves with the number of packets of all items to stock. This helped to ensure medicines were available for people, reducing balances. And it helped to reduce the amount of stock not required, minimising waste with medicines going out of date. The team was constantly reviewing this and changing the shelf labels as required. 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 NHS controlled drug authorised witness had recently attended the pharmacy to witness destruction of obsolete controlled drugs. 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 electronic records. The team contacted people affected if required. They returned items received damaged or faulty as soon as possible to suppliers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment needs to deliver its services. Team members look after this equipment to ensure it works and the pharmacy replaces it as needed. They raise concerns when equipment is not fir for purpose. And the pharmacy acts in a positive and appropriate way.

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. Team members mostly accessed resources including the BNF online. The patient medication record and other software had recently been updated providing an effective system that team members found easy to use. It included controlled drug registers, private prescription records and incident reporting. The system was also used to support prescription ordering and send text messages to people informing them when their medicine was ready to collect. People using the pharmacy found tis helpful. And team members used the system to help manage workload and track prescription journeys. The pharmacy also had a new printer after team members highlighted to the owner that the old one was not working well.

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, although team members were not using it during the pandemic. It had other equipment and sundries required for services such as vaccination. But these services were not being offered due to the pandemic and changes in pharmacists over the past few months. The pharmacy had clean crown-stamped measures and clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in a locked filing cabinet in the consultation room, in the basement 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 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.