General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: L E Hartley Chemist, 37 South Trinity Road, EDINBURGH, Midlothian, EH5 3PN

Pharmacy reference: 1042742

Type of pharmacy: Community

Date of inspection: 08/10/2019

Pharmacy context

This is a community pharmacy in a residential area close to a city centre. It dispenses NHS prescriptions including supplying medicines in multi-compartmental 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 a smoking cessation service, blood pressure measurement and seasonal flu vaccination.

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. The pharmacy is looking at all processes to ensure that they are safe. Pharmacy team members record mistakes to learn from them. The pharmacy keeps all the records that it needs to by law. And it keeps people's information safe. Pharmacy team members hep 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. Head office kept the delivery driver's records. The pharmacy superintendent reviewed SOPs every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs and a 'roles and responsibilities' SOP. And each team member had a record sheet clarifying which they were signed up to. 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 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 had a locum folder which contained a variety of information to support locum pharmacists, or other team members not familiar with this pharmacy. This included team details, opening hours, services, daily tasks for week-days and Saturdays, patient group direction (PGD) information, computer tasks e.g. signing in, passwords, wholesalers and restricted supply drugs. The pharmacist always left the folder out for locum pharmacists on her day off. She noted documents and information that she intended to add e.g. MAR chart information and specials' bulletins. All team members used this folder as a refence source.

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 in a similar way to near misses, so there was not a lot of detail. They did not undertake reflection such as significant event analysis. The team did not review these incidents regularly or in a structured way. The pharmacist described dispensing as very accurate. Both dispensers were experienced and had worked in this pharmacy for several years. Team members used shelf-edge labels to highlight similar packaging and shared this information with colleagues. The pharmacist had been in this pharmacy less than a year and was gradually reviewing all processes. She was making improvements where necessary.

The pharmacy had a complaints procedure and welcomed feedback. Team members described several compliments received and could not recall any complaints. They were often complimented on their efficiency, helpfulness and friendliness. This was observed. The pharmacy was taking part in an NHS flu vaccination pilot and people were being asked to complete a survey about this service. This was to help inform the local NHS if this should be a contracted service in the future.

The pharmacy had an indemnity insurance certificate, expiring 31 May 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 most 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. They segregated confidential waste for secure shredding. No person identifiable information was visible to the public. The pharmacy displayed a notice about data processing. 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 but not for this employment. The superintendent pharmacist was addressing this.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained or training staff to safely provide its services. The pharmacy covers staff absence when required. This ensures skilled and qualified staff always provide pharmacy services. The pharmacy gives trainee team members time at work to complete their course work. Team members can share information and raise to keep the pharmacy safe. And they can make suggestions to improve pharmacy services.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager; 2 part-time dispensers (25 and 30 hours per week); one full-time trainee medicines counter/dispensary assistant; one part-time trainee medicines counter assistant (Friday and Saturday only) and a part-time delivery driver (afternoons). The pharmacy displayed their certificates of qualification in a public area. One dispenser was trained to NVQ 3 level. Typically, there were two team members working at most times, and three team members one day per week when the dispensers both worked. At the time of inspection there was the NVQ 3 dispenser, and a dispenser 'borrowed' from another branch to cover absence. She often covered annual leave and absence. The pharmacist had worked in this pharmacy for almost a year, and the two dispensers had been here for several years. Team members were able to manage the workload. Part-time team members had some scope to work flexibly providing contingency for absence.

The pharmacy provided protected learning time for team members who were undertaking accredited training. But it did not provide structured ongoing training or development, or regular protected time for all team members. The pharmacist supervised trainees. There were no trainees working at the time of inspection. Team members tried to read training and promotional material that was received in the post but did not keep records of this. The pharmacist had completed face-to face flu vaccination training the previous year. And she had recently undertaken an online refresher course, as required by the patient group direction (PGD). Team members had discussed how they could promote the service to people. Team members who had been on leave at the time the 'hub and spoke' model was introduced had received training on it when they returned. They had seen the dispensing robot in operation which helped their understanding of the process. All team members were expecting development meetings over coming months. The pharmacist had worked in this pharmacy for less than a year, and the two dispensers had been on maternity leave over the past year. Pharmacists had discussed the topic at a recent meeting and had requested a standard template. This was expected to be implemented. 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. Team members demonstrated effective communication with people, often checking people's understanding. This was delivered in a friendly and professional manner.

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. The pharmacy tried to have weekly meetings and all team members were encouraged to contribute. They described examples of giving feedback to the pharmacist about procedures they would

like changed, e.g. the way paperclips had been used, covering prescription detail. This had seemed trivial but making the small change had improved safety. They also discussed topics such as reading SOPs, correct storage of CD keys, and team members' moods that had an impact on the whole team. The company arranged quarterly meetings for pharmacists who could raise any issues or concerns. The pharmacist had requested regular development meetings, which had been supported by peers, and was due to be implemented. They discussed and shared a variety of topics including managing medicines shortages and implementation of flu vaccination. The company had a whistleblowing policy that team members were aware of. Team members gave appropriate responses to scenarios posed. And an example of raising a serious concern was described. It had been resolved.

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. Other people cannot hear these conversations.

Inspector's evidence

These were small premises incorporating a retail area, dispensary, staff toilet facilities and a basement. The pharmacy stored shop fittings, sundries such as bags and some bulky retail stock in the basement. The premises were clean, hygienic and well maintained. The pharmacy had retained many traditional fittings and medication containers. Some of these still contained original contents. The superintendent was making efforts to have the contents destroyed safely. The pharmacy displayed these items on high shelves that could not be easily accessed by people. 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 and chairs, which was clean the door closed providing privacy. But it was cluttered with cardboard. The pharmacist explained that this was uplifted daily, and there was very limited storage space on the premises. The room had two doors and people entered from the retail area. All team members used the consultation room with people. And the pharmacist supervised self-administration in the room. The pharmacist kept anaphylaxis information in the consultation room, including a poster on the wall. And her certificates of vaccination training were on the wall. The pharmacy had limited staff facilities, so team members sometimes ate lunch in the consultation room. They ensured it was cleaned after use. And they vacated it if it was required for consultations. The pharmacy's ambient 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 advice to help them use their medicines. They provide extra written advice to people with some medicines. The pharmacy gets medicines from reliable sources and stores them appropriately. It works with prescribers when medicines are not available to ensure people receive their treatment.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and team members helped people if required with the door. It listed its services and had leaflets available on a variety of topics. The pharmacy was included in a NHS pilot to offer flu vaccination to people who met certain criteria. It signposted people who did not meet the criteria to their GP practice. It could provide large print labels for people with impaired vision. The pharmacy provided a delivery service and people signed to acknowledge receipt of controlled drugs only. The delivery driver ticked name and address labels on his delivery sheet as he delivered medicines to people.

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. They used dedicated areas to dispense, then placed medicines, for people who were waiting, straight onto the pharmacist's checking bench. And they stacked baskets for other dispensed medicines in a separate area to avoid congestion on the checking bench. Team members highlighted any changes or new items to the pharmacist as they were labelling. And the pharmacist looked at the patient medication record (PMR) to enable an informed clinical check. Team members prioritised prescriptions for people waiting, or urgent supplies made under the urgent supply patient group direction (PGD). Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. They 'scanned out' dispensed medicines as they were supplied and recorded who had collected them. This provided an audit trail of when medicines were supplied. The pharmacy usually assembled owings later the same day or the following day. A few people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when people requested them. They were all compliant and requested their medicines as expected. The pharmacy was registering people for this service. The pharmacist sometimes identified pharmaceutical care issues when discussing people's medicines with them. These included dexterity issues so some people were then assessed for multi-compartmental compliance packs. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time at a nearby offsite 'hub'. A team member entered prescription data onto a computer in this pharmacy, which was checked by a pharmacist before sending to the hub. The pharmacy kept records of personnel carrying out these tasks. The information was sent to the hub two weeks before the first supply was due. And the assembled packs were received one week before. The pharmacy kept records of packs' progress. The team at the hub signed backing sheets to provide an audit trail of who had dispensed and checked. And team members included tablet descriptions and photographs of tablets on backing sheets. They ensured date of supply and instalment numbers were on all packs. The pharmacy supplied patient information leaflets (PILs) with new medicines. Current legislation required PILs to be supplied for each prescription. It stored completed packs on dedicated shelves in the dispensary. The pharmacy kept records of changes and hospital discharges. It had a system in place to record details of people in

hospital and ensure their packs were not delivered during that time. Team members had discussed an issue that had occurred sometime previously, then devised and recorded a new system to avoid repetition. The team in this pharmacy made changes to trays if they were required, rather than the hub. The hub did not include controlled drugs in packs, so team members added these prior to supply. Most people had their packs delivered, and the pharmacy had a list on the wall of people's delivery days. This helped locum pharmacists, or team members from other branches working.

The pharmacy supplied medicines following the urgent supply PGD. The pharmacist assessed the situation, and sometimes phoned the GP practice to ensure that there was not another prescription coming from there. This was observed for an inhaler, ensuring the person did not receive too many inhalers which would be inappropriate clinically.

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. 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 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, supply of chloramphenicol ophthalmic products and chlamydia treatment. It also followed private PGDs for seasonal flu vaccination. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence and under supervision. Team members described situations when they referred requests to the pharmacist e.g. skin complaints, or if the person had already tried something which had not helped. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment.

The pharmacy offered flu vaccination. And the pharmacist had completed all the required training and was following PGDs. She kept the PGD and all associated paperwork in a folder for reference. The pharmacy promoted the service through posters and labels on dispensed medicines' bags. People could make appointments or 'walk-in'. The pharmacy was taking part in an NHS pilot, delivering flu vaccination to people who may find it difficult to attend the GP practice. People eligible were in the 'at-risk' groups and aged between 18 and 64. They also had to meet other criteria. A small number of pharmacies and GP practices were taking part in the pilot. The pharmacist had reminded the GP practice that it could refer eligible people to the pharmacy.

The pharmacist delivered the smoking cessation service as other team members were not trained. Most people were receiving 'shared care', whereby the pharmacy was only involved with the supply of medicines, and not the counselling aspect of the service. The pharmacist also measured blood pressure when requested.

The pharmacy obtained medicines from licensed wholesalers such as Alliance, AAH, Phoenix, Eclipse, Ethigen, and Aver. It did not comply with the requirements of the Falsified Medicines Directive (FMD) yet. The scanning process had caused difficulties with ordering stock due to the software set-up. Also, the superintendent pharmacist had identified several incorrect codes. So, he was working with the software provider to address the issues before implementing in pharmacies. The pharmacist was aware of the requirements and had discussed this with the superintendent pharmacist. The pharmacy stored

medicines in original packaging on shelves, in drawers and in cupboards. It 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 was experiencing challenges with several medicines in short supply. The pharmacist explained that if she anticipated a shortage, the pharmacy ordered more to minimise the impact on people. If it was unable to supply a medicine, the pharmacist usually contacted the prescriber and suggested a suitable alternative which was available. The pharmacy had a good relationship with the local GP practice and this worked well, limiting inconvenience for people. 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 delivery of its services. Team members protect people's information when using equipment.

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. The pharmacist knew this was at least a year old but did not know when it required calibration or replacement. The pharmacy also kept an anaphylaxis kit, sundries for vaccination and sharps' bins in the consultation room. Team members 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.

The pharmacy stored paper records in the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored 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.