General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ratho Pharmacy, 64 North Street, Ratho, NEWBRIDGE, Midlothian, EH28 8RR

Pharmacy reference: 1042769

Type of pharmacy: Community

Date of inspection: 23/01/2020

Pharmacy context

This is a community pharmacy set in a row of shops in a village. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service. It also offers 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.

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 has written processes for team members to follow for all services. Team members record mistakes to learn from them. They make changes to reduce the chances of the same mistakes being made again. The pharmacy keeps all the records that it needs to. And it keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) adapted from standard templates. The pharmacy had not amended all of them to reflect processes in this pharmacy. Some of the SOPs included names of team members who no longer worked in the pharmacy. And some referred to English processes e.g. the pharmacy's complaint process. Team members had not read and signed all SOPs. The pharmacist was reviewing these with a view to amending or re-writing some. 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. One dispenser had never undertaken medicines counter training. She therefore could not work on the medicines counter. Some team members were not fully competent with some processes, particularly computer processes. But they were very aware of their limitations and only undertook some tasks under supervision. This meant that the pharmacist undertook many activities herself, while demonstrating them, and coaching colleagues. The pharmacy managed dispensing, a high-risk activity, in a methodical manner. Team members followed a logical process. The pharmacy had a list on the dispensary wall of contact details for suppliers with account numbers, and information and processes for accessing various online systems.

The pharmacist had been appointed as pharmacy manager around three months' previously. She had recently reviewed the previous inspection report and implemented near miss logs. She had not yet reviewed incidents as this process had not been in use long enough. Team members used these to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. The pharmacy had made an error with a dose of a product in a multi-compartment compliance pack. So, the pharmacist had highlighted this item on the person's profile to minimise the chance of this happening again. The pharmacist explained that she was systematically reviewing all the processes in the pharmacy with a view to making improvements where necessary. She had started by meeting with the GP practice staff in order to build and develop relationships.

The pharmacy had an indemnity insurance certificate, expiring 29 Feb 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. There were some historic unresolved controlled drug running balance discrepancies. The pharmacist had identified these when she had started regular running balance audits. She had informed the NHS CD accountable officer (AO). The AO had accepted these could not be resolved and provide an AO log number which was recorded in the CD register.

Pharmacy team members were aware of the need for confidentiality. They took phone calls at the back of the dispensary to avoid people overhearing. And they managed confidential information in the dispensary appropriately when people walked through it to the consultation area. They segregated confidential waste for secure shredding. No person identifiable information was visible to the public . Team members knew how to raise safeguarding concerns. They described how they would contact the GP if appropriate. And they had the local child protection process on the dispensary wall. The team described incidents of concern that they had raised with people's key workers, and other pharmacies. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified or training staff to safely provide its services. It provides time at work to train team members and enable them to read relevant information. This ensures they have the skills they need. Team members discuss incidents. They learn from them to avoid the same thing happening again. They can share information and raise concerns to keep the pharmacy safe.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager who was appointed to the role around three months previously; three part-time dispensers; and one trained medicines counter assistant, four days per week. All dispensers were trained and qualified. But only one was also a qualified medicines counter assistant. One split her time between this and another pharmacy. The pharmacy manager believed she was undertaking her training in the other pharmacy, but this was not the case. And the third dispenser had never undertaken medicines counter training. She focused on dispensing and there was usually a medicines counter assistant working with her. The pharmacist undertook to ensure team members were appropriately trained for their roles. The pharmacy had a staff rota on the wall which clarified staffing each day. The pharmacist spent time talking team members through processes and providing coaching. She was encouraging all team members to become competent in all processes. Team members were able to manage the workload. They had some scope to work flexibly providing contingency for absence.

The pharmacy provided time during the working day for all team members to read information received by the pharmacy e.g. 'training matters'. And team members were focussing on learning pharmacy processes such as medicines administration record (MAR) charts and the management of multi-compartment compliance packs. The pharmacist was supervising team members. 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. The pharmacist shared information with team members to pass on to locum pharmacists. She attended local GP practice meetings, building relationships. And she was planning to start an independent prescribing course soon. The pharmacy superintendent and GPs were supportive of this.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes, although recording was new to them. 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 superintendent pharmacist. The pharmacist described email communication with the superintendent pharmacist. He had been agreeable to her suggestion to make changes in the dispensary. This had improved dispensing workflow. All team members discussed processes 'on the job'. They discussed locum pharmacists with the superintendent pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy's services. The pharmacist uses a discreet area for some conversations with people. Other members of the public 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 facilities. The premises were clean, hygienic and well maintained. There was only a sink in the toilet area. It had hot and cold running water, soap, and clean hand towels. Team members managed this area well, keeping it clean and washing staff cups and dispensing measures thoroughly.

People were not able to see activities being undertaken in the dispensary unless they were accessing the consultation area. The pharmacy did not have a consultation room but used a small corner of the dispensary which had chairs and screen to separate it from the rest of the dispensary. Before inviting people into this area, team members used the screen to protect confidentiality of medicines stored in this area. They also ensured that computer screens were closed, and prescriptions were not visible to people. This was observed to be managed appropriately. The few months previously the pharmacy had improved and increased dispensing space by removing a partition in the middle of the dispensary. 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

Team members helped people into the pharmacy if required. The pharmacy had steps at the door and there was a handrail to assist people. It listed its services and had leaflets on a range of topics. Pharmacy team members delivered medicines to some people who had difficulty accessing the pharmacy. The pharmacy could provide large print labels on dispensed medicines for people with impaired vision.

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. Team members highlighted any changes or new items on prescriptions to the pharmacist. She undertook clinical assessments and gave examples of confirming changes with the GP practice. 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. The pharmacy did not provide medicines for any people with serial prescriptions. But the pharmacist was working closely with the GP practice and identifying suitable people for this service. The pharmacist sometimes identified pharmaceutical care issues when discussing people's medicines with them. She described examples e.g. identifying medicines prescribed to be taken at the wrong time of day; engaging positively with children, recommending changes to therapy e.g. changing from oral solutions to more palatable formulations, and making GP appointments for them as necessary; and identifying a person prescribed the wrong product. This person described the change positively as 'changing her life'. The pharmacist made suggestions to the GPs when unable to supply items in short supply. She described rapidly developing a positive relationship with the GP practice when suggesting changes and referring people for appointments.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time, around two weeks before the first supply was made. Some people were supplied with four packs at a time when prescriptions stated, 'dispense weekly', but the pharmacist was working with the surgery to address this. The pharmacy kept thorough records of changes and interventions and highlighted any unusual items, doses, or items previously involved in errors or near misses. Team members included tablet descriptions on packs. And people's names and date of supply were on the spines of packs. They stored completed packs on shelves in the dispensary in an orderly manner. They supplied patient information leaflets every six months. This was discussed and the inspector reminded the team that there was a legal obligation to supply these each time medicines were dispensed. The pharmacist had recently reviewed the process. She ordered all prescriptions on Mondays and they were received from the surgery the following day. She clinically assessed prescriptions and labelled them. She was in the process of coaching team members on the administration of these. They were competent to

assemble the packs which they did on an island dispensing bench with adequate space. The pharmacist checked medicines for accuracy before team members placed them in packs. She sealed the packs as she carried out the final accuracy check. She had recently introduced a template to provide an audit trail of who had carried out each stage of the process, and when. Some people received medicines by instalment. Team members dispensed these in their entirety when prescriptions were received. Instalments were placed into individual bags in baskets labelled for each person.

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 there were none. 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 pharmacist explained that this information was now automatically incorporated onto dispensing labels. 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. The pharmacy empowered team members to deliver the minor ailments service (eMAS) 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 pharmacist recorded consultations on the electronic patient medication record (PMR). She also used this facility when making referrals to GPs.

The pharmacist undertook smoking cessation consultations. These were not frequent as uptake in the area was low. She also measured people's blood pressure occasionally. She usually did this manually but had obtained a new calibrated electronic machine recently. The pharmacy had recently started accepting used needles from patients using injections such as insulin and methotrexate. The pharmacist was promoting this service and providing sharps buckets to people who required them.

The pharmacy obtained medicines from licensed wholesalers such as alliance and AAH. It was not compliant 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 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 protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. And they had access to NES consultation skills guidance.

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. The pharmacist checked if any patients were on medicines subject recalls as soon as they were received. The pharmacy 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 had a carbon monoxide monitor maintained by the health board, and a blood pressure meter which was new. Team members kept crown stamped measures by the sink in the toilet area, and a separate marked one was used for methadone. They kept clean tablet and capsule counters in the dispensary and had 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 personal information being seen by members of the public. Team members screened this area off when people were invited into the area. They 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.