General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Crossgates Pharmacy, 92 Main Street, CROSSGATES, Fife, KY4 8DF

Pharmacy reference: 1075573

Type of pharmacy: Community

Date of inspection: 04/07/2019

Pharmacy context

This is a community pharmacy next to a medical practice. People of all ages use the pharmacy. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartment compliance packs.

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

Pharmacy team members follow processes for all services to ensure that they are safe. They record mistakes to learn from them. And make changes to avoid the same mistake happening again. The pharmacy asks people for feedback. It uses this to make pharmacy services better. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place and followed for all activities/tasks. All team members had read them. The pharmacy superintendent reviewed the SOPs every 2 years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. The pharmacy provided all team members with protected time to read SOPs.

Dispensing, a high-risk activity, was managed in a logical and smooth manner with coloured baskets used to segregate patients' medicines. There was an audit trail in place for dispensed medicines in the form of dispensed and checked by signatures on labels. The pharmacy had a business continuity plan in place to address maintenance issues or disruption to services.

Team members recorded near miss errors using Datix, an electronic tool. The pharmacy team members explained that they believed the pharmacist received feedback from this system to enable him to review trends and patterns, but no documentation was seen. The regular pharmacist was not present. The pharmacy had made errors recently, and root cause analysis for two were observed. The pharmacist had documented strategies put in place to minimise repeat incidents, including attaching shelf edge labels to highlight medicines involved. Team members described sharing information among themselves regarding similar packaging to reduce the chance of the wrong item being dispensed. They had moved amitriptyline to a separate shelf to minimise the chance of this being supplied in error. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. An inexperienced dispenser was clear regarding her limitations.

The pharmacy had a complaints procedure in place and responded to feedback. There had been a history of confusion about when medicines would be ready for collection after ordering prescriptions from the GP practice. The pharmacy now displayed several posters clarifying when prescriptions were ready at the surgery, and when dispensed medicines were ready at the pharmacy. This had helped patients and reduced queries. The pharmacy displayed its indemnity insurance certificate, expiring 30 June 2020.

The pharmacy displayed the responsible pharmacist notice and kept the following records in compliance with relevant legislation: 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; controlled drug (CD) destruction register for patient returned medicines. The pharmacy backed up the electronic patient medication records (PMR) each night to avoid data being lost.

Team members were aware of the need for confidentiality and had all signed company policies. No person identifiable information was visible to the public. Team members segregated confidential waste and shredded it.

Pharmacy had clear information on safeguarding in a folder in the dispensary readily accessible. It also had correspondence from a concern that had been raised a few months previously. Team members were aware of the process to follow to raise concerns. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is and makes short term changes when required. This ensures there are always enough skilled and qualified staff to provide pharmacy services. Team members have access to training material to ensure they have the skills they need. The pharmacy gives them time to do this training. Team members can share information and raise concerns to keep the pharmacy safe.

Inspector's evidence

Staff working in the pharmacy: one full-time pharmacist manager; four part-time dispensers working 25, 24, 27 and 18 hours per week (One dispenser worked full-time between the pharmacy and another in the organisation.); one part-time delivery driver, working three part-days per week. Until recently there had been two part-time drivers, but since one had left, agency drivers were used for the other days. The pharmacy typically had a pharmacist and three team members working at any time. The pharmacist had recently reviewed this and changed work patterns to try and always have three team members working. There was scope for all team members to change their work pattern or work additional hours to cover for absence. At the time of inspection there was a relief pharmacist and three team members, who were able to manage the workload.

The pharmacy team was stable, and most dispensers had several years' experience in this or other pharmacies. The most inexperienced dispenser had around one year's experience.
The pharmacist had been in this pharmacy for around 18 months and had developed a good relationship with the pharmacy team, the local community and the local GP practice.

The pharmacy provided all team members with protected learning time to read SOPs and undertake regular training. They described being up-to-date with the company's e-learning programme. They had not had development meetings for a few years, but these were planned over coming months. Team members described on-the-job sharing of information between themselves and with the pharmacist. They did not have structured meetings but ongoing informal communication. The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist as required.

The pharmacy had a whistleblowing policy, and this was displayed in the back-shop area. Team members described how they could make suggestions and raise concerns locally with the pharmacist or area manager. They described an open environment where they were honest and learned from incidents and each other. They understood the importance of recording mistakes and were comfortable owning up to their own. The pharmacy received communication and updates in different forms from head office, and the pharmacist ensured that all team members read relevant information. This included a monthly newsletter and updates by email several times a day. The pharmacy superintendent sent messages on various topics and a recent one was regarding a dispensing error involving a bag label. Team members had not read this yet as it was very recent but had been printed for them. They explained that they saw these types of updates occasionally.

The pharmacy set targets for various parameters. A team member explained that they were not driven

by these and always put patients first. She further explained that currently most targets were being met. And this was due to there being more staff available than before, and there was better leadership in the pharmacy. People often came to see the pharmacist for advice.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for its services. The pharmacy team members use a private room for some conversations with people. People cannot overhear private conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises with a retail area selling medicines and related products and a narrow dispensary with one dispensing bench used for all dispensing and prescription checking. The back-shop area incorporated basic staff facilities and a small storage area. Space was under pressure but was being well managed. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, consultation 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.

Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. The consultation room had a desk, chairs, sink and computer. It 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 that 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. But some waste medicines are not stored properly.

Inspector's evidence

There was good physical access by means of a level entrance and a wide door. The pharmacy displayed a list of its services and leaflets were available on a range of topics. The pharmacy had a hearing loop in working order which could be used by people with hearing aids. All team members wore badges showing their name and role.

The pharmacy had a logical and smooth dispensing workflow with labels generated at one end of the dispensing bench then dispensed on an adjacent area and checked at the other end. Team members used different coloured baskets to segregate patients' medication and differentiate between different prescription types e.g. collection service or waiting. When prescriptions were received from the GP practice they were labelled as soon as possible which generated an order for stock. Most prescriptions were then dispensed the following day when that stock arrived. Team members described working through these prescriptions, then if time permitted starting on the ones received that day if stock was available. They gave priority to prescriptions for people waiting – due to the proximity to the GP practice there were many walk-in prescriptions.

Dispensing audit trails were in place in terms of initials on dispensing labels of personnel who had dispensed and checked medicines. The pharmacy team used labels to highlight prescriptions including high risk medicines or those requiring special storage. They had pharmacist information forms (PIFs) available to share information with pharmacists but did not use these consistently. They did not have a mechanism in place to always highlight changes or new medications to the pharmacist. This could make it difficult for the pharmacist to undertake a full clinical assessment of prescriptions. Owings were usually assembled later the same day or the following day.

The pharmacy provided a delivery service and people's signatures were obtained on receipt of their medicine. The team present during inspection did not know how items requiring cold storage were managed during transit, but believed journeys were short and these items would not be in the vehicle for long.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Dispensing was undertaken several days before the first pack was due to be supplied. All team members were trained and competent to undertake this. They included tablet descriptions on backing sheets, and patient details, instalment number and date of supply on the pack. The pharmacist checking packs sealed them. They supplied patient information leaflets (PILs) with the first pack of each prescription. Records of any changes were kept. The pharmacy had a list on the wall of the day of the week packs were supplied and whether they were collected or delivered. Methadone instalments were poured by a dispenser and checked by a pharmacist.

Clinical checks were undertaken by a pharmacist and people receiving high risk medicines including valproate, methotrexate, lithium, and warfarin were given appropriate advice and counselling. Written information and record books were provided if required. The valproate pregnancy prevention programme was in place. The pharmacist had undertaken a search but no people in the high-risk group were identified. The locum pharmacist at the time of inspection carried valproate information with him in case he could not find it in pharmacies. The non-steroidal anti-inflammatory drug (NSAID) care bundle had been implemented and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. 'Sick day rules' were also discussed 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, and chloramphenicol ophthalmic products. Some people received medicines on chronic medication service (CMS) prescriptions. The pharmacy dispensed these when people requested them either by phone or coming to the pharmacy. A team member checked the computer system every few days to monitor compliance. This was not an issue, but she explained that people would be contacted if they had not picked their medicine up a week or so past the expected date. The pharmacy continued to register patients for the service, but no examples of pharmaceutical care issues were described – the regular pharmacist was not present. Pharmacy team members were empowered to deliver the minor ailments service (eMAS) within their competence. They had recently started this, previously referring all requests to the pharmacist. They described situations they would manage and those that they would refer to the pharmacist. This was appropriate.

The pharmacist and one dispenser delivered the smoking cessation service but there were currently no people using the service. The pharmacist was an independent prescriber and ran a clinic each week in the adjacent GP practice. He also occasionally responded to common clinical conditions in the pharmacy, writing prescriptions for people and sharing this information with the GP practice.

The pharmacy obtained medicines and medical devices from licensed suppliers such as NDC and Alliance. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). Team members explained that they were currently undertaking training on this and a new computer system which was due to be installed over the next few weeks. It would enable full compliance with the requirements. The pharmacy regularly checked expiry dates of medicines and kept records of this. And items inspected were found to be in date. It stored medicines in original packaging on shelves/in drawers and cupboards. Items requiring cold storage were stored in two fridges with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. One was used for stock and the other for dispensed medicines which were stored in clear bags. Team members checked at the point of supply that the correct item was being supplied. The pharmacy stored patient returned waste medicines in receptacles provided by the NHS contractor. These were stored in the staff toilet area and included schedule three controlled drugs which required to be de-natured before destruction. So, they must not be stored in this receptacle. The pharmacy protected pharmacy (P) medicines from self-selection and supplied these following the sale of medicines protocol.

The pharmacy actioned MHRA drug recalls on receipt and kept records. A team member contacted people who had received medicines subject to a patient level recall. Items received damaged or faulty were returned 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. It kept a carbon monoxide monitor maintained by the health board, in the consultation room where it was used with people accessing the smoking cessation service. The pharmacist had other equipment that he required to deliver other services. Crown stamped measures were kept by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy had clean tablet and capsule counters were also kept in the dispensary, and a separate marked one was used for cytotoxic tablets.

Paper records were stored in a locked filing cabinet in the consultation room and in the dispensary inaccessible to the public. Pharmacy team members never left computers unattended and they used passwords. Screens were not visible to the public.

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.