General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Superdrug Pharmacy, 10 Falkland Gate, The Kingdom Centre, GLENROTHES, Fife, KY7 5NS

Pharmacy reference: 1084697

Type of pharmacy: Community

Date of inspection: 14/05/2019

Pharmacy context

This is a community pharmacy in a shopping centre. 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 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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	There are not enough pharmacy team members to deliver all the pharmacy's services within their working hours. And trainees are not given time and support to complete their courses.
3. Premises	Standards not all met	3.1	Standard not met	The area that the pharmacy makes prescriptions up in is not suitable. It is too small and team members have to use 'pull-out' steps to assemble prescriptions.
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 processes for all services to ensure that they are safe. But there are not enough team members. And they are working in a small area. Team members record some but not all mistakes to learn from them. They review these and make changes to avoid the same mistake happening again. But they cannot make changes for every mistake because they do not record them all. The pharmacy keeps all the records that it needs to. And keeps people's information safe.

Inspector's evidence

Standard operating procedures (SOPs) were in place and followed for all activities/tasks. They had been read by relevant staff members and electronic records kept. They were reviewed every two years and were signed off by the pharmacy superintendent. Staff roles and responsibilities were recorded on individual SOPs.

The team members described dispensing as high risk. Dispensing volume and footfall had increased over the past year due to a change of situation in another pharmacy nearby. Staffing had not increased, and the dispensary was observed to very cramped and small for the volume of dispensing. Team members described the process they followed to reduce pressure and risk e.g. a dispenser moving on to another computer to allow a colleague access for a particular activity. Fridays were described as particularly high risk as the pharmacy was busier. There was a high level of walk-in prescriptions on Fridays, increasing dispensing and interruptions to serve on the medicines counter. Team members described starting tasks again following interruptions. This reduced the risk of error but slowed the dispensing process down. The team members co-operated and communicated well. The Friday of the previous week had been so busy with walk-in prescriptions that the collection service ones could not be dispensed as usual. Team members often worked up to an hour past their finishing time, to complete tasks to reduce risk the following day. There was an audit trail in place for dispensed medicines in the form of dispensed and checked by signatures on labels.

Business continuity planning was in place to address maintenance issues or disruption to services. Phone numbers for a variety of issues and internal departments were available and kept in a communications diary.

Electronic near miss and error reporting was in place, but not used consistently. Observation was made of a near miss being identified and recorded during the inspection. A trainee dispenser had selected the wrong item when checking availability. The dispenser labelling had not noticed the incorrect strength. The electronic recording system provided monthly summary reports. The previous two months, one and two near misses had been recorded respectively. These were reviewed, with statements such as 'take more care'. There was insufficient data for meaningful review. Team members described separating medicines in similar packs and sharing this with colleagues. Pharmacy audits were carried out periodically. A recent one had been rated 'green'. An action plan had been put in place, with actions such as a reminder to team members that patient returned medicines must be destroyed within four weeks.

Staff members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. Although absence was not generally used, despite an

assumption that only the dispensary and medicines counter were registered as a pharmacy. All team members could undertake all tasks.

There was a complaints procedure in place and examples were described of responding to feedback from people. A team member had a habit of not being concise when explaining things to people – colleagues and members of the public had highlighted this, so he was making great effort to provide explanations in a succinct manner. People had provided feedback about the in-store radio promoting online ordering with items delivered to people's homes. The service was not available in Scotland so team members explained this to people and drew attention to the small print on leaflets explaining this. Pharmacy had indemnity insurance, expiring 01/20.

The following records were maintained in compliance with relevant legislation: Responsible Pharmacist notice displayed; Responsible pharmacist log- Pharmacists did not record absence at lunchtime as they believed the whole premises was registered as a pharmacy. But GSL medicines were stored out with the shuttered area, suggesting that the whole premises were not registered. Private prescription records including records of emergency supplies and veterinary prescriptions. Unlicensed specials records; Controlled drugs registers, with most running balances maintained and regularly audited. Evidence of methadone running balances being audited was not seen; Controlled drug (CD) destruction register for patient returned medicines. The electronic patient medication record (PMR) were backed up each evening.

Pharmacists annotated alterations in the controlled drug records using their signature and registration number. Pharmacy team members were aware of the need for confidentiality. They had read and signed documentation. No person identifiable information was visible to the public. Confidential waste was segregated for secure destruction.

Team members undertook annual training on safeguarding. They were aware of the process to be followed if they needed to raise a concern. The pharmacist was PVG registered. A team member described an example of a person receiving three prescriptions for an item subject to abuse within a 15-day period. The pharmacy had highlighted this to the prescriber, and this medicine had been taken off automatic repeat.

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

Summary findings

The pharmacy does not have enough staff members to deliver all services. Team members have access to training material to ensure that they have the skills they need. But the pharmacy does not give them time to do this training. This could affect how well they care for people and the advice they give.

Inspector's evidence

Staff numbers working in the pharmacy were: One full-time equivalent pharmacist. The regular pharmacist had left six months previously and not been replaced. This role was being filled with a variety of locum pharmacists. Pharmacy team members described the lack of continuity as challenging; two part-time dispensers working 26.5 and 16 hours respectively; one part-time pharmacy technician, 20 hours per week. She had been off for the previous five weeks.; two part-time trainee dispensary/medicines counter assistants, working 11 hours, and eight hours Saturday only. There was some scope for these team members to work additional hours through the week to cover for the pharmacy technician's absence, but not all hours. Typically, the pharmacy was staffed with the pharmacist and one or two team members. There were usually two team members over lunch times and on Fridays which were busy. On the day of inspection there was a pharmacist and trainee assistant only working late afternoon. This meant that the pharmacist was alone in the dispensary while the trainee assistant worked mainly on the medicines counter under supervision. Team members were struggling to manage the workload. They were emotional about the situation and passionate about trying to get through all tasks and activities. A dispenser attempted to manage the workload using staff rotas which she completed at home in her own time. She always ensured that the locum pharmacists got a break during their shift, but other staff members typically did not. Both part-time dispensers gave examples of staying 45 minutes late at the pharmacy to complete tasks in addition to working without breaks. Because the dispensers were working hard and long hours, most activities were being completed. But they were behind with date checking. And they undertook training, and any reading at home. They were not updating an information board which was a useful tool to share information in the dispensary. The dispenser had raised concerns with the temporary area manager regarding the staffing levels. Agreement had been given to employ an additional eight hours this week, so the Saturday only assistant was working.

The pharmacy did not give the trainee assistants time at work to undertake their accredited courses. They were doing this at home and consequently was going very slowly as they did not have a regular pharmacist to mentor and encourage.

Team members accessed standard operating procedures and training modules electronically. They explained that they prioritised this activity. They had not had development meetings recently and did not have development plans in place. Individual learning needs were not identified. The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when selling medicines and were aware of frequent purchases and items of abuse.

There was an openness between team members who shared information with each other. They understood the importance of discussing and recording mistakes. They used to have meetings to discuss these topics, but these had not taken place for some months. The pharmacy receives a

summary of near misses and errors recorded in electronic form. Team members reviewed this and discussed that when there was time. The pharmacy received weekly information from the pharmacy superintendent's office providing information on various topics such as training to be undertaken, product information and information on serious incidents. All team members read this and discussed topics if appropriate. They knew how to contact the superintendent pharmacist and the controlled drug accountable officer to raise concerns or share information regarding mistakes as necessary. Appropriate responses were given to scenarios posed. Targets were set for various parameters. These did not affect people using pharmacy services.

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

Summary findings

The pharmacy is safe and clean. The area that the pharmacy makes up prescriptions is too small. And sometimes prescriptions are made up on areas not designed for that purpose, such as on 'pull-out' steps. The pharmacy team members use a private room for some conversations with people. People cannot overhear private conversations. The pharmacy protects people's information. The pharmacy is secure when locked.

Inspector's evidence

The pharmacy was located at the rear of a larger store. There were shutters protected from unauthorised access when the rest of the store was open e.g. on Sundays. GSL medicines were stored out with this area. Team members present during inspection did not know whether the whole premises or just this area was registered as a pharmacy. This should be checked.

The dispensary was too small and cramped for the activities undertaken. Baskets of dispensed medicines waiting to be checked were stored on the floor as there was nowhere else for them. The confidential waste bag and general waste bucket were causing an obstruction in the dispensary. The phone, which was not cordless was in a corner of a dispensing bench with the dispenser labelling on one side, and another dispenser trying to assemble multicompartment medicine packs on the other side. When the pharmacist moved into the corner to use the phone team members were too close together. Team members were observed to make best use of the available space and move out of each other's way as they could. The pull-out steps on the storage drawer system were used to dispense on at times when the third dispenser was dispensing walk-in prescriptions.

There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. (The staff facilities were not observed during inspection.) The area inspected was observed to be clean and hygienic.

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.

There was a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. The door was kept locked to prevent unauthorised access. Team members used the consultation room for supervision of medicines to be consumed on the premises.

The premises were alarmed, had CCTV, and security mirrors. Shutters protected the dispensary and medicines counter when the pharmacy was closed and the rest of the shop open. (General sales medicines were accessible.) 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. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

There was good physical access by means of a flat entrance and an open entrance to the shopping centre. Services provided were displayed in-store. A hearing loop in working order was available although seldom used. Large print labels could be provided for people with impaired vision. All staff members wore badges showing their name and role.

Dispensing work flow observed to be logical and smooth although very difficult under cramped conditions. There were two labellers adjacent to each other on a dispensing bench. One was located close to a corner of the dispensary where the phone was, so it was not the favoured machine. Team members found it difficult to use the phone while somebody was using that labeller due to the cramped nature of the dispensary. The phone was not cordless so could not be used elsewhere. One dispenser labelled prescriptions, placing each patient's prescriptions and labels in separate baskets. The other dispenser used the only available dispensing bench space to dispense these, one patient at a time. The trainee medicines counter/dispensary assistant who was working on the medicines counter brought 'walk-in' prescriptions into the pharmacy, checked availability and placed medicines and prescriptions into an appropriately coloured basket for labelling. The dispenser who was labelling interrupted the process at a suitable point, to label walk-in prescriptions. There was a designated checking bench. The collection service prescriptions were dispensed later by any staff member, often having to use the 'pull-out' steps on the stock drawers' system, as there was no available dispensing bench. At the time of inspection several baskets of dispensed medicines were observed to be on the floor waiting to be checked as there was no available bench space. The dispensary was very cramped. Dispensing audit trails were in place in terms of initials on dispensing labels of personnel who had dispensed and checked medicines.

Owings were usually assembled later the same day, or the following day and a documented system was in place. Dispensers shared information such as new medicines or any changes with the pharmacist. But they described challenges as there was a lack of continuity and pharmacists did not know patients.

There was a delivery service and signatures were obtained on receipt. A dispenser selected multi-compartmental compliance devices to be delivered and these to the driver. Items requiring cold storage were removed from the fridge immediately before the driver left the pharmacy, and these were delivered first.

Multi-compartmental compliance packs were managed on a four-weekly cycle with four assembled at a time. After a dispenser had gathered the stock, this was checked by the pharmacist who initialled the packaging to denote this. The dispenser then placed tablets into trays, and the final accuracy check was undertaken by the pharmacist. The dispenser also signed the labels. Tablet descriptions were handwritten on to packaging which ensured they were always accurate. Patient information leaflets (PILs) were provided with the first supply of each prescription. Several patients received a lot of tablets

split over two packs. This was managed in an effective manner ensuring that medicines and labels were always arranged in the same way to assist patients. Trays were clearly marked T1 and T2 and stapled together. Completed trays had patient details and date of supply on the outside of the packaging. Robust records of changes were kept in chronological order in patient folders. As changes were actioned, team members updated the dose regime template. It was used to assist in the dispensing process to ensure tablets were placed in correct positions in packs. All team members were competent to undertake this task. There were robust processes in place to ensure that prescriptions were ordered, and devices assembled with adequate time. During the inspection, a dispenser took around an hour to complete one patient's packs due to their complexity and the number of interruptions she received. There was a large volume of collection service prescriptions still to be dispensed. Team members explained that they could not embark on assembly of multi-compartmental compliance devices when there was only one person working.

Methadone instalments were poured by a dispenser and checked by a pharmacist when people presented at the pharmacy, using a 'methameasure' pump device. When prescriptions were received the pharmacist or pharmacy technician put data onto the computer. Sometimes the dispenser did this and the pharmacist checked. Photographic identification was used. Although some people did not have photographs on the device as the camera was broken. The pharmacy had notified head office, but it had not been repaired or replaced so far. People were asked for their date of birth.
There were a variety of other medicines supplied by instalment and these were managed in a methodical and robust manner.

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 available. The valproate pregnancy prevention programme was in place. The non-steroidal anti-inflammatory drug (NSAID) care bundle had been implemented and 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.

NHS services followed the service specifications and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception and chloramphenicol ophthalmic products. These were current, and pharmacists had been trained and signed them.

There were several patients receiving medicines on chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when patients phoned or came into the pharmacy. The pharmacy did not actively monitor compliance due to staffing resources. But team members did not think there were any compliance issues. They were registering patients as required but not using the questionnaire to identify pharmaceutical care issues as there was no regular pharmacist. Pharmacy team members were empowered to deliver the minor ailments service (eMAS) within their competence. The pharmacy had offered flu vaccination during the season, but this had been very challenging as not all locum pharmacists were able to deliver the service.

Invoices were observed from licensed suppliers such as Alliance.
The pharmacy did not meet the requirements of the Falsified Medicines Directive (FMD). Medicines inspected were found to be in date. Medicines were stored in original packaging on shelves/in drawers. Items requiring cold storage were stored in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits.Controlled drugs were stored appropriately with space was well used to segregate stock, dispensed items and obsolete items.

Pharmacy (P) medicines were protected from self-selection. Sale of P medicines was as per sale of medicines protocol and effective questioning observed. MHRA recalls and alerts were actioned on receipt and records kept. Patients were contacted following patient level recalls. 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. But damaged equipment is not always replaced or repaired in a timely manner.

Inspector's evidence

Texts available in the pharmacy included current editions of the British National Formulary (BNF) and BNF for Children. There was internet access allowing online resources to be used. A carbon monoxide monitor maintained by the health board, and a blood pressure meter were available in the consultation room and used with people accessing these services. They were used infrequently as there was little time for additional services and no permanent pharmacist. Crown stamped measures were kept by the sink in the dispensary, and separate marked ones were used for methadone.
There was a 'Methameasure' pump available for methadone use and this was cleaned each evening and calibrated each morning. The camera on this device was broken, and this had been reported to head office some weeks previously. This meant that photographs of new people using the service could not be taken. Photographs were used to help identify people to ensure they received the correct medication.

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 the dispensary inaccessible to the public.

Computers were never left unattended and were password protected. Screens were not visible to the public. Care was taken to ensure phone conversations could not be overheard.

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.