General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 2 Main Street, Fauldhouse, BATHGATE, West Lothian, EH47 9JA

Pharmacy reference: 1084903

Type of pharmacy: Community

Date of inspection: 27/02/2020

Pharmacy context

This is a community pharmacy close to another pharmacy and beside other shops in a village. 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 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 the NHS smoking cessation service, 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 provide them safely. They record mistakes to learn from them. And they review these and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to by law and keeps people's private information safe. Team members help 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. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. And team members accessed relevant SOPs on their 'e-expert' training platform. 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.

Team members used electronic near miss logs (DATIX) to record dispensing errors that were identified in the pharmacy. DATIX automatically provided monthly patient safety reports using this data. And the pharmacist reviewed these. She explained that she printed and filed them. But the past few months' documents were not seen. She had identified wrong quantities as an occasional issue. She reminded all team members to ensure they marked open packets on all sides to ensure team members did not mistake them for full packs. The team also recorded errors reaching patients to learn from them. Team members were very experienced and did not make many mistakes. The pharmacy kept a range of important documents in a SUPER folder. This included local information and the company 'share and learn' document. And documented drugs commonly involved in errors e.g. co-codamol, ramipril, metformin, aspirin and omeprazole. And drugs involved in quantity errors e.g. ramipril, amlodipine and simvastatin. But these documents were not recent.

The pharmacy had a complaints procedure that team members were aware of. And it displayed a notice telling people how to feedback centrally. The pharmacy received very little feedback, especially complaints. A few months previously a person had complained about the incorrect quantity of tablets being supplied. This was a prescribing error following a review with a GP. A team member liaised with the GP practice and rectified the quantity.

The pharmacy had an indemnity insurance certificate, expiring 30 June 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. 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 recently.

They segregated confidential waste for secure shredding. No person identifiable information was visible to the public. Team members had also previously read a SOP on safeguarding. They knew how to raise a concern locally by accessing the local health board website. The pharmacy had a chaperone policy in place and displayed a notice telling people. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified or in training tea- members to provide safe 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 know how to raise concerns if they have any.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, a part-time delivery driver and six part-time dispensers (15, 15, 15, 14, 8, and 12 hours per week). One was undertaking the joint medicines counter/dispensing training and the others were qualified. The pharmacy displayed their certificates of qualification. Typically, there were two team members and a pharmacist working at most times. There was only one team member with the pharmacist on Monday mornings and Saturdays. A team member was currently absent. Sometimes relief dispensers were available to cover this. And some team members had scope to work flexibly providing contingency for absence. Team members were able to manage the workload. But sometimes they found it challenging. They had a heavy workload related to the management and assembly of multi-compartment compliance packs. This was time consuming, and they were often interrupted which introduced risk and slowed the process down. The pharmacy was observed to be cluttered and untidy in places. Team members were aware of this but explained it was difficult to get time to address it. And they were often interrupted during all tasks. Interruptions were often to serve on the medicines' counter.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development. But there was no targeted learning as the team did not have development meetings to identify individual learning needs. The pharmacy provided team members undertaking accredited courses with additional time to complete coursework. One team member also undertook some training at home, which was her preference.

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. They responded empathetically to people's requests and spoke in a friendly, knowledgeable and professional way.

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 e.g. staffing levels due to the heavy workload with multi-compartment compliance packs; scales not working; and training on the new computer system. Team members felt the training had been rushed and would have been better delivered as two sessions as it was difficult with them all round one computer. Also, the hand-held terminals did not arrive until the day after the training. They could now access this information on the intranet. The team did not have formal meetings. But team members discussed incidents and shared information while working. The company had a whistleblowing policy that team members were aware of. And they gave appropriate responses to scenarios posed. The company set targets for various parameters. Team members described that they used these to remind people of services that they would benefit from. People found the texting service

very useful.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy services. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary and back shop area including storage space and staff facilities. But there was limited space to assemble multicompartment compliance packs. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff 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. Team members stored prescription medication waiting to be collected in a way that prevented information being seen by any other people. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. 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 support people by providing them with information and advice to help them use their medicines. And they provide extra written information to people taking high risk medicines. The pharmacy obtains medicines from reliable sources and mostly stores them properly. The pharmacy team knows 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 an automatic door. It listed its services and had leaflets available on a variety of topics. It had a notice on the medicines counter explaining what day prescribed medicines would be available to collect after people handed in repeat prescription requests. Four days were required. The pharmacy signposted people to other services such as travel vaccination. It had a hearing loop in working order and could provide large print labels. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines. Team members helped people in a variety of ways including carrying heavy items to their car (this was observed) and using hand written notes.

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. Much of the pharmacy's dispensing was carried out at an offsite hub. When team members scanned prescriptions for labelling, the computer system identified those items suitable for dispensing at the hub. Team members marked prescriptions so that they all knew which had to be dispensed locally. This also informed the pharmacist of items that she needed to clinically check, then she annotated the electronic system. The off-site dispensing took three days, so if people were in a hurry for their medicines they were assembled in the pharmacy. Team members could recall items that had already been sent to the hub if people came to the pharmacy looking for the dispensed items early. This was observed. The medicines' bag labels had barcodes which were used to identify people's medicines and supplies safely. Team members scanned labels using a hand-held device then scanned a barcode on the shelf that medicines were being placed on. When people came to collect their medicines, team members entered their name into the hand-held device which identified which shelf the medicines were stored on. Dispensed medicines returned from the off-site hub also had barcodes and were placed on shelves in a similar way. Sometimes some items for the same person had been dispensed in the pharmacy and others at the hub. The hand-held device identified both, and this ensured that all items were supplied at the same time. The system was observed to work effectively. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines that were assembled in the pharmacy. Team members had told most people that some of their medicine was assembled at a central location.

The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. It kept a workload tracker to monitor progress and ensure packs were ready as

expected. Team members were currently working on packs due for supply the following week. But they explained that often they were assembling for supply the following day. They kept records of changes, hospital discharges, method of supply and other relevant information. The pharmacy stored records in four folders depending on the week of management, and another folder for people that were currently in hospital. Records were untidy with several amendments following changes. Team members explained that they had not had time to reprint these. They included tablet descriptions on packaging and supplied patient information leaflets with the first pack of each prescription. The pharmacy stored completed packs in clear bags in individual boxes labelled with the person's name, whether medicines were delivered or collected, and the week number that the packs were managed in. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these in entirety and stored them in labelled bags in individual baskets per person in the back-shop area. The pharmacist poured methadone instalments three times a week and a dispenser checked them. They were stored in baskets by day 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. She or a team member supplied written information and record books if required. The pharmacist knew about the valproate pregnancy prevention programme. But she knew the pharmacy did not supply valproate to anyone in 'high-risk' group, so she had not shared information with other team members. She described how she would council people if required. Team members knew about the non-steroidal anti-inflammatory drug (NSAID) care bundle and they gave written and verbal information to people supplied with these medicines over-the-counter, or on prescriptions. 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 relief pharmacist followed private PGDs for flu vaccination. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. 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 less experienced team members made more referrals to the pharmacist.

A locum pharmacist who was appropriately trained and worked one day per week delivered the flu vaccination service. The pharmacy manager delivered the smoking cessation service on Saturdays. She mostly provided nicotine replacement therapy.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). It had the equipment in the pharmacy, but team members had not been trained. As noted above the pharmacy scanned dispensed medicines using bar codes on bag labels and storage shelves. This improved accuracy when supplying. And helped ensure that multiple bags were supplied if appropriate. The pharmacy stored most medicines in original packaging on shelves and in cupboards. But it had several bottles of loose tablets that were not fully labelled. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored. Team members took appropriate action if there was any deviation from accepted limits. They 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.

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 the delivery of its services. The pharmacy looks after this equipment to ensure it works. The pharmacy team members raise concerns when equipment is not fit for purpose.

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 which was calibrated as per the manufacturer's guidance and labelled with the date of the next test. It had personal weighing scales, but they had a notice on them saying that they were not working. The pharmacist explained this had been reported to head office. The pharmacy also had height measure that was not working. It had a label from November 2017 (over two tears previously) saying 'fail'. The pharmacist explained that this had also been reported. But it was never used and needed to be removed. Team members kept crown stamped measures by the sink in the dispensary and used a separate marked one for water for antibiotics. The pharmacy team kept clean tablet and capsule counters in the dispensary. It did not have separate counter for cytotoxics as methotrexate tablets were supplied in blister packaging.

The pharmacy stored paper records in the dispensary and back-shop area inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any people in the retail area. 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.