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:** 27/09/2021

## Pharmacy context

This is a community pharmacy on the main road of a village. The pharmacy works closely with another Well Pharmacy in the village to provide a range of services. The pharmacy dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It 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. This pharmacy was inspected during the COVID-19 pandemic.

## 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 not all met | 1.1 | Standard not met | The pharmacy does not identify and manage key risks to patient safety. Team members do not follow written processes for all services and activities. This creates significant risk for services including the supply of medicines in multi-compartment compliance packs. |
| **2. Staff** | Standards not all met | 2.1 | Standard not met | The pharmacy does not always have enough team members to safely deliver its services. And the team members it does have are not always suitably experienced and qualified to operate the pharmacy effectively. |
| **3. Premises** | Standards met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Standards not all met | 4.2 | Standard not met | The pharmacy does not always plan and manage all its services safely and effectively. This includes the assembly and supply of multi-compartment compliance packs. |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance **Standards not all met**

### Summary findings

The pharmacy does not always effectively identify and manage all the risks associated with its services. The pharmacy team members do not always follow written processes so there is a risk of mistakes being made. They do not record and review all the mistakes they make. This means team members are missing learning opportunities. The pharmacy keeps the records that it needs to by law although it doesn't always follow standard good practice. And it keeps people's private information safe. Team members know who to contact if they have safeguarding concerns about people.

### Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter, and hand sanitiser available for team members and people using the pharmacy. Most people coming to the pharmacy wore face coverings and team members wore masks. They also washed and sanitised their hands regularly. They cleaned surfaces daily.

The pharmacy had standard operating procedures (SOPs) available electronically. They were not always followed due to staffing challenges. For example, the management of multi-compartment compliance packs and some controlled drug record keeping was not as per the SOPs. And a team member who had started the previous week had not yet read any. The pharmacy kept records of when team members had read and accepted them. The pharmacy superintendent reviewed them every two years or more often and signed them off. An area manager present during part of the inspection accurately explained which activities could not be undertaken in the absence of the pharmacist. And an appendix to the Responsible Pharmacist (RP) SOP explaining activities that could be undertaken when there was no RP signed in was on the dispensary wall. Team members had referred to this over recent months when there had been pharmacist shortages resulting in the pharmacy having to close. The pharmacy followed a process for dispensing, a high-risk activity, 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 had also referred to this during recent challenges.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. But they did not record every error. And they recorded errors that had been identified after people received their medicines. But they did not review these to learn from them and make changes to reduce the chance of similar errors. The pharmacy had a complaints procedure. Recently there had been an increase in the number of complaints from people whose medicines were not ready as expected. And the health board had received some complaints. The pharmacy had not managed to improve its service delivery so far, but the area manager was in the process of staff recruitment and was planning to meet with the surgery team the following week to identify issues and make improvements.

The pharmacy had indemnity insurance, expiring 30 June 2022. It displayed the responsible pharmacist notice and had a responsible pharmacist (RP) log. This showed times over the past few months when there had not been a RP, for example the morning of 21 August. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed

specials records and controlled drugs (CD) registers with running balances maintained. But these had not been audited for about six weeks. It had a CD destruction register for patient returned medicines, but not all items had been recorded.

Pharmacy team members were aware of the need for confidentiality. A new team member had not yet read the SOPs or information governance policies, but she could describe the principles from her previous role. The team segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members stated that they would raise any safeguarding concerns with the local GP teams.

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

### Summary findings

The pharmacy does not always have enough team members to safely deliver its services. And not all team members have the experience that they require. The pharmacy sometimes provides some additional team members to support the team. But the team struggles to manage the workload. The pharmacy does not provide protected learning time.

### Inspector's evidence

At the time of inspection there was a locum pharmacist who had worked in the pharmacy once before, and an untrained team member who had started working in the pharmacy the previous week. During the inspection the area manager who was a dispenser arrived. The team could not manage the workload. The pharmacy also had a part-time trainee dispenser not working that day, who had been in this pharmacy around eight months. An experienced team member had left the previous week. Recent recruitment had resulted in another new-start two weeks previously and another starting the following day. And a relief pharmacy technician had been supporting this pharmacy recently. A locum pharmacist worked nearly full-time in the pharmacy, and a permanent pharmacist was due to start in a few months. The last inspection had taken place about 18 months ago and at that time there was a permanent pharmacist and six dispensers working a variety of hours, with two dispensers at any time, and they could usually manage the workload. And a team member described dispensing volume increasing since then.

The pharmacy was currently unable to provide learning time during the working day for team members. But the area manager had coached the new team member in some processes, and she had been shown how to generate labels from prescriptions. Team members were observed going about their tasks in a chaotic manner because of lack of familiarity with processes in the pharmacy. The new team member was polite and calm when speaking to people using the pharmacy. They were often looking for prescription medicines and neither team member present knew where to look if medicines were not in the most obvious place.

The locum pharmacist and area manager understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. But this was not embedded in the pharmacy due to the lack of experience of team members. The company set targets for various parameters. One described was for the number of private flu vaccinations to be delivered. A team member explained that all branches were set the same target. But this pharmacy was unlikely to meet it due to lack of demand, and limited capacity for the locum pharmacist (who was a trained vaccinator) to deliver the service. Team members were not able to influence this as the focus was on dispensing. The company also set targets for the Pharmacy First service. This encouraged the pharmacist to record consultations.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises are suitable for the pharmaceutical services it provides. It has suitable facilities for people to have conversations with team members in private. But the pharmacy premises are cluttered and untidy, and some areas are relatively dirty.

### Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary and back shop area including storage space and staff facilities. The premises appeared well maintained but were dirty in places, especially floors. Some areas were untidy and cluttered. Examples included a dispensing bench, the area around the dispensary sink and storage areas. The pharmacist at the time of inspection was keeping the checking bench as clear as he could to reduce the chance of errors. Sinks in the dispensary, staff room and toilet 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, chairs, sink and computer and the door closed providing privacy. Sometimes team members and pharmacists used it as it was large enough to maintain a social distance. But it was cluttered and used for storage of show material and other items including an electric heater. Temperature and lighting throughout the premises felt comfortable.

## Principle 4 - Services **Standards not all met**

### Summary findings

The pharmacy struggles to always deliver its services safely and effectively. And the team does not always follow the pharmacy's written process for services, especially supplying medicines in multi-compartment compliance packs. The pharmacy obtains medicines from reliable sources and mostly stores them properly. People can access the pharmacy's services, although there are sometimes some delays supplying medicines.

### 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 hearing loop in working order for people wearing hearing aids to use. And it could provide large print labels for people with impaired vision. The pharmacy provided a delivery service.

The pharmacy used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. At the time of the inspection the locum pharmacist was dispensing and self-checking as there were no trained team members to assist. He was dispensing the previous day's prescriptions which had been labelled. He was aware of the potential risks associated with dispensing and checking himself. He was taking a mental break between the two processes. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The dispensing workload could be challenging with the limited team. And the GP practices also had challenges which affected the pharmacy's workflow. For example, the time taken to contact the surgery about queries including unsigned prescriptions and urgent instalment prescriptions. And people's expectations were sometimes not met as the texts sent from the surgery were misinterpreted as people thought that their medicines were ready to collect at the pharmacy before they were. The area manager explained that although there had been discussions on this topic before, she was meeting surgery teams the following week and would help to address this.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Some records looked confusing with correction fluid used to make changes so there was not a full history available of medicines supplied. And 'post-it' notes that easily became detached were used to note changes. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. They stored completed packs in named box files on dedicated shelves. But many of these were empty suggesting that this process was very behind where it should be. When asked, the area manager explained that she knew they were behind but not how badly. It was her intention to investigate later that day. She would dispense urgently required medicines. Following the inspection, a relief pharmacist contacted the inspector to explain that they were going to close the pharmacy for two hours to dispense compliance packs. The pharmacy should have supplied eight packs that day, but it had not yet assembled them. The pharmacy supplied a variety of other medicines by instalment. A team member usually dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in individually named baskets on labelled shelves. But due to staffing challenges this process was not always being followed. Team members were sometimes

dispensing the instalment when the person arrived at the pharmacy. The pharmacy had not investigated uncollected instalments or compliance packs. There were compliance packs in a CD cabinet dated for supply ten days previously. No-one in the pharmacy knew the reason and there was no information with them. The pharmacist dispensed some liquid instalments using a pump device when people came to the pharmacy.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. The locum pharmacist was aware of the valproate pregnancy prevention programme and would counsel people appropriately if required. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and chlamydia treatment. It also had private PGDs for flu vaccination. The pharmacist delivered the Pharmacy First service. Over recent years and months the two Well pharmacies in the village had worked closely and shared services to make them as efficient as possible. This resulted in this pharmacy providing opiate replacement therapy and multi-compartment compliance packs. When staffing levels were appropriate this worked well, and the community and GP practices knew which pharmacy delivered the different services. Both branches were currently supplying lateral flow Covid tests.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. The pharmacy mostly stored medicines in original packaging on shelves, in drawers and in cupboards. But there were several bottles containing loose tablets which were not properly labelled. These were not segregated for destruction. The pharmacy stored items requiring cold storage in two fridges and team members usually recorded minimum and maximum temperatures daily. But they had missed some days. Team members sometimes checked expiry dates of medicines and some date expired items were piled on the dispensary floor. The pharmacy protected pharmacy (P) medicines from self-selection. The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment it needs to deliver its services. It looks after the equipment to ensure it works.

### Inspector's evidence

The pharmacy had resources 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 was not currently providing close contact services, so equipment required for these was not in use. For example, carbon monoxide monitor and blood pressure meter. Team members kept crown-stamped measures by the sink in the dispensary, and a separate marked one was used for water. The pharmacy used a 'Methameasure' pump for measuring methadone solution. Team members cleaned it at the end of each day and poured test volumes each morning. The locum pharmacist described his process, testing two different volumes that morning when he set it up. The pharmacy had clean tablet and capsule counters in the dispensary and as methotrexate tablets were supplied in blister packaging, it no longer kept a separate counter kept for these.

The pharmacy stored paper records in the dispensary and rear area inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave 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. |