General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Elliot Street, DUNFERMLINE, Fife, KY11 4TF

Pharmacy reference: 1090044

Type of pharmacy: Community

Date of inspection: 09/07/2019

Pharmacy context

This is a community pharmacy beside a GP 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

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

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities/tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed and signed them off every two years. 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. An inexperienced dispenser was clear about the limitations of her role while she was still learning some processes. Dispensing, a high-risk activity, was well managed and organised with coloured baskets used to differentiate between different prescription types and separate people's medicines. The pharmacist marked prescriptions suitable for an accuracy checking technician (ACT) to carry out the final accuracy check. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

The pharmacy had near miss logs and reported dispensing errors. Team members explained that most near miss errors were recorded, but probably not all. The pharmacist reviewed these and the team discussed any learning. They had separated some similar sounding items e.g. procyclidine and prochlorperazine. They were in the process of analysing a recent dispensing error.

The pharmacy had a complaints procedure in place and welcomed feedback. A few months before, the delivery driver had reduced his working hours from five days to three. People had been disappointed that they could not have deliveries on certain days. The pharmacy team members reflected on this and now ensured that people were informed that routine deliveries were only undertaken on certain days. But provisions were in place for urgent deliveries e.g. by using taxis or the delivery service from another branch. Mystery shoppers visited the pharmacy every quarter and provided a report. A recent report showed difficulty in locating prescriptions and team members were not always friendly. The team had discussed this, and team members now tried to acknowledge people in a friendly manner as they entered the pharmacy. The pharmacy had been short staffed at the time of the visit due to sickness and annual leave.

The pharmacy had an indemnity insurance certificate, expiring 30 June 2020.

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 controlled drug (CD) destruction register for patient returned medicines. The pharmacist initialled alterations to records and these were clearly annotated. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Team members were aware of the need for confidentiality. They undertook annual training and had read and signed company policies. They segregated confidential waste for secure destruction, and no person identifiable information was visible to the public. Team members also undertook annual training on safeguarding. They had the local child protection guidelines readily available. The pharmacy had a chaperone policy in place that was displayed to the public. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained or training team members to safely provide its services. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is and makes changes when it can. Team members have access to training material to ensure they have the skills they need. The pharmacy usually gives them time to do this training. Team members can share information, make suggestions and raise concerns to keep the pharmacy safe. The pharmacy team discusses incidents. Team members learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager; one pharmacist mainly running anticoagulation clinics; one full-time accuracy checking technician (ACT); two full-time and two part-time dispensers; one full-time trainee medicines counter assistant and one part-time delivery driver. The pharmacy had appointed a new team member following a recent resignation. The pharmacist manager was offsite for two sessions per week running an anticoagulation clinic and hypertension clinic in the adjoining GP practice. The other pharmacist ran anticoagulation clinics in this pharmacy, other branches and visited people at home. He was seldom in the dispensary. One of the full-time dispensers worked much of her time on the medicines counter and was not involved in all dispensing activities. The trainee medicines counter assistant started work in the pharmacy the day before the inspection and other team members were showing her various processes. She was also reading relevant resources. She had doubled up with another team member on her first day. The pharmacist manager who was only present at the end of the inspection explained that he requested relief dispensers to cover absence when the staff level reduced to 3.5 full-time equivalents. This week was challenging as a full-time team member was on annual leave. He had requested cover, and this was being provided for one day (Friday). The pharmacy was not open at weekends, so Mondays and Fridays were often busy. The pharmacy was planning a review of staff levels over coming months when off-site dispensing was going to be introduced. This was expected to reduce the workload. Team members were observed to manage the workload.

The pharmacy provided protected learning time for all team members to read new SOPs and complete e-expert training modules. Although some team members did this at home in their own time. The pharmacy also provided time for accredited courses. Team members were currently completing modules about a new computer system that was being introduced. The ACT was appointed as the ‘lead user’ and a training day offsite was planned. All team members had completed a module on the requirements of the falsified medicines directive (FMD). They had not had development meetings over the past few years but had recently filled in paperwork with a view to having these. The manager explained that it was challenging to dedicate time to this during the working day. 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.

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 explained that they could raise concerns and offer opinion to the manager or area manager. A team member described an example of a suggestion that had been

adopted – when collection service prescriptions were labelled they were placed into baskets which were labelled by day. This enabled prescriptions to be easily located if required before they had been dispensed. The pharmacist took part in weekly conference calls with the RDM and other managers and shared relevant information with the team. The RDM sent a weekly newsletter which was printed and left in the staff room for all team members to read. This mainly related to targets. The company had a whistleblowing policy. The company set targets for various parameters, but team members stated that these did not have a negative impact on people.

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 small premises adjoining a GP practice, with access from the surgery and from the street. There was very limited storage space and the dispensary was small for the level of dispensing, but team members managed space well. The sink in the dispensary was not used as this area was required for storage and dispensing, meaning that the sink in the staff room was used for washing measures and obtaining water for reconstitution of antibiotics' solutions. It was tidy and clean. It had a small back shop area providing basic staff facilities. The sinks had hot and cold running water, soap and clean hand towels. The pharmacy had storage space in the attic which was accessed by a folding Ramsay ladder into the dispensary.

People were not able to see dispensing activities. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other people. The pharmacy had a consultation room with a desk, chairs, sink and computer and the door closed providing privacy.

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. The pharmacy team know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a ramp at the entrance and a power assisted door. It was also accessed from the GP practice on the same level. It listed its services and had leaflets on a variety of topics available. 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, usually in mornings when the part-time driver worked. It made urgent afternoon deliveries using a driver from another branch, or sometimes a team member delivering by taxi.

Pharmacy team members followed a logical and methodical workflow for dispensing. One dispenser labelled surgery prescriptions for another to dispense on a separate dedicated dispensing bench. They alternated these tasks to ensure all skills were maintained and there was no boredom or complacency. The team prioritised walk-in prescriptions using different coloured baskets to highlight different prescription types. They placed dispensed medicines for checking onto the pharmacist checking bench for walk-in prescriptions and another area for surgery prescriptions. The pharmacist took these to the checking bench as appropriate to avoid congestion. A separate designated area was used to store dispensed medicines that could be checked by the ACT once they had been marked by the pharmacist as clinically assessed. Once surgery prescriptions were labelled, the team member placed them in a basket labelled with that day of the week. This enabled prescriptions to be easily located if required before they had been dispensed. Team members printed all labels including interactions and other information to assist the pharmacist undertaking the clinical assessment. But they did not always tell the pharmacist if there was a new medication. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when they were due and placed medicines on retrieval shelves. The team did not have a process in place to monitor compliance but there was no evidence of non-compliance with most people collecting these within a few weeks of them being dispensed. Sometimes it was known that people had a stock of medicines at home. Dispensing audit trails were in place in terms of initials on dispensing labels of personnel who had dispensed and checked medicines. Additionally, initials of personnel involved at all stages of dispensing and supply were captured on prescriptions that were accuracy checked by the ACT. She checked most multi-compartmental compliance packs and some surgery prescriptions, usually the ones for delivery. Owings were usually assembled later the same day or the following day. Multi-compartmental compliance packs were managed on a four-weekly cycle with four assembled at a time. Team members assembled these around a week before the first pack was required. When they received prescriptions, they checked that there were no changes from the previous one. The ACT carried out a final accuracy check on dispensed packs where there had been no changes. The pharmacist clinically assessed prescriptions for new patients and when there were any changes, marking prescriptions. The pharmacy supplied patient information leaflets (PILs) with the first pack of each prescription. Team members ensured tablet descriptions were on backing sheets, changing these if necessary to ensure that they

were correct. The pharmacist or ACT checking the packs sealed them. Packs were labelled with patient name and date of supply. They were colour-coded depending on the day of the week they were supplied. The pharmacy stored completed trays in an organised and tidy manner by day of supply. It kept thorough records for all patients including a chronological list of any changes. Methadone instalments were poured daily for the following day by a dispenser and checked by the pharmacist. They were stored in a controlled drug (CD) cupboard. The pharmacy regularly supplied medicines to two GP practices on stock order forms. These were wholesale supplies, but the pharmacy did not have a wholesale dealer's license. The pharmacy provided a needle exchange service and all team members were trained and competent to do this. The new trainee medicines counter assistant had been coached and supervised. (This was observed during the inspection.)

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 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, emergency hormonal contraception, and chloramphenicol ophthalmic products. The pharmacy did not deliver the pharmacy smoking cessation service as the GP practice ran nurse led clinics. People came to the pharmacy with vouchers for supply of nicotine replacement therapy. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. This was variable due to different experience and team members made appropriate referrals to the pharmacist. The pharmacists were prescribers and ran hypertension and anticoagulant clinics in the pharmacy, GP practice and at people's homes. They followed local guidelines and were appropriately trained and competent.

The pharmacy obtained medicines from licensed wholesalers such as NDC and Alliance. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). Team members had undertaken training and were prepared for the implementation of a new computer system that would include scanning medicines in compliance with FMD. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. Members regularly checked expiry dates of medicines and those inspected were found to be in date. They 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. 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. And the pharmacy acts in a positive way.

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 patients accessing services. This included a carbon monoxide monitor maintained by the health board. Team members kept Crown stamped measures by the sink in the staff area, and separate marked ones were used for methadone. They had clean tablet and capsule counters in the dispensary, including a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and back-shop area inaccessible to the public. Team members never left computers unattended and used passwords.

The pharmacist explained that the central heating boiler had broken down, this had been highlighted to the maintenance department and a new boiler was installed in a timely manner.

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.