General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Market Street Pharmacy, 22 Market Street, HADDINGTON, East Lothian, EH41 3JE

Pharmacy reference: 1090665

Type of pharmacy: Community

Date of inspection: 20/06/2024

Pharmacy context

This is a community pharmacy in the East Lothian town of Haddington. Its main activity is dispensing NHS prescriptions, including serial prescriptions as part of the Medicines: Care and Review service. It dispenses medicines in multi-compartment compliance packs to help people take them at the right time. Team members advise on minor ailments and they deliver the NHS Pharmacy First service.

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

The pharmacy has written procedures relevant to its services to help team members work safely. Pharmacy team members keep the records they need to by law, and they safely keep people's private information. The team is adequately equipped to protect the welfare of vulnerable people. And they record and discuss the mistakes they make to learn from them and reduce the risk of future similar mistakes.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define the pharmacy's working practices. These included procedures related to handling controlled drugs (CDs), the responsible pharmacist (RP) regulations and whistleblowing. Team members described their roles within the pharmacy and the processes they were involved in and accurately explained which activities could not be undertaken in the absence of the responsible pharmacist. SOPs had been recently reviewed by the superintendent pharmacist (SI) and were kept electronically. But the pharmacy did not keep a record to show that team members had read and agreed to follow the updated SOPs. This was discussed with the pharmacy manager who gave assurances that this would be addressed following the inspection. The pharmacy had a business continuity plan to address disruption to services or unexpected closure. Team members described the process for pharmacy closure when there was no responsible pharmacist available. The pharmacy employed a pharmacy technician who worked as an accuracy checker (ACPT). Team members described the process for prescriptions being clinically checked by the pharmacist prior to dispensing and how this was clearly marked on the prescriptions. This enabled the ACPT to complete the accuracy check.

Team members kept records about dispensing mistakes that were identified in the pharmacy, known as near misses. The pharmacist or ACPT asked the team member involved to correct the mistake, so they could reflect on what had happened. The entries on the near miss record highlighted what had gone wrong and documented some simple reasons as to why the mistake had happened. And team members completed more detailed records of errors that had been identified after people received their medicines. The pharmacy team reviewed all near misses and errors each month to learn from them and they introduced strategies to minimise the chances of the same error happening again. For example, they no longer detached people's list of repeat medication from the prescription form during the dispensing process. This prevented forms being mixed-up. The pharmacy had a complaints procedure and trained its team members to manage complaints. The pharmacy manager aimed to resolve any complaints informally in the pharmacy. And they knew to provide the contact details for the SI's office if people wished to escalate any complaints.

The pharmacy had current professional indemnity insurance. The pharmacy displayed the correct responsible pharmacist notice which could be seen from the retail area, and it had an accurate responsible pharmacist record. From the records seen, it had accurate private prescription records with the exception of a small number of entries which did not contain the prescribers' details. It kept complete records for unlicensed medicines. The pharmacy kept digital CD records with running balances. A random check of the quantity of two controlled drugs matched the balance recorded in the register. Stock balances in the register were observed to be checked on a weekly basis against the physical stock in the pharmacy. The pharmacy had an accurate CD destruction register to record CDs

that people had returned to the pharmacy. The pharmacy backed up electronic patient medication records to avoid data being lost.

Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste which was collected for secure destruction by head office. No person-identifiable information was visible to the public. A privacy notice on the wall provided assurance that the pharmacy protected people's personal information. The pharmacy had a documented procedure to help its team members raise any concerns they may have about the safeguarding of vulnerable adults and children. The team engaged in safeguarding learning and they discussed how they would use their knowledge and experience to recognise and raise safeguarding concerns. Team members knew how to access local safeguarding contact details and processes.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the necessary qualifications and skills to safely provide the pharmacy's services. They manage their workload well and support each other as they work. And the pharmacy has suitable procedures in place to help its team manage the workload in the event of unplanned staff absence

Inspector's evidence

The pharmacy employed a part-time pharmacist who worked three days per week. And two regular locum pharmacists worked regularly at the pharmacy. A full-time technician had the role of pharmacy manager. There was one full-time and five part-time dispensing assistants, one of whom was a trainee. And four part-time medicine counter assistants. The pharmacy displayed their certificates of qualification. Team members were seen to be managing the workload. Those spoken to during the inspection were experienced in their roles and most of them had been working at the pharmacy for several years. They demonstrated a good rapport with many people who visited the pharmacy and were seen appropriately helping them manage their healthcare needs. The manager planned leave requests so that a maximum of two staff members were off at a time. Part-time staff members supported by working additional hours during periods of leave. And the pharmacy manager could request additional staffing hours from local pharmacies owned by the same company. Team members rotated tasks so that they could be completed effectively during absence periods. And they used a daily rota to help ensure all tasks were completed.

Team members who were enrolled on an accredited training course received protected learning time. And all team members had access to additional learning materials relevant to their roles. They received some learning time at work during quieter periods. The pharmacy manager had regular meetings with all team members where they discussed any learnings from near misses or dispensing incidents and recent drug alerts. And they shared any updates from the pharmacy’s head office, which were displayed on a pharmacy notice board. This ensured that the whole team received relevant notifications and learnings. Pharmacy team members understood the importance of reporting mistakes and were comfortable openly discussing their own mistakes with the rest of the team to improve learning. They felt able to make suggestions and raise concerns to the manager. Each member of the team received informal appraisals with the pharmacy manager where they had the opportunity to raise any individual learning needs. There were no targets set for pharmacy services.

Team members were observed to work on their own initiative, for example to phone the GP practice to ask about missing prescription items. They asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use, for example codeine-containing medicines. And they dealt appropriately with such requests.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides. They are clean, secure, and well maintained. And the pharmacy has a suitable, sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The premises was average-sized and incorporated a retail area, dispensary and staff facilities. It was 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. The pharmacy’s overall appearance was professional. The pharmacy had clearly defined areas for dispensing and the pharmacist used a separate bench to complete their final checks of prescriptions. And there was an additional checking bench on a central island in the dispensary where the ACPT or a second pharmacist could work. The medicines counter was clearly seen from the checking area which enabled the pharmacist to intervene in a sale when necessary. Floor spaces were mostly clear however some larger bags of medicines awaiting collection were stored on the floor of the dispensary. This created a risk of a trip or a fall. The risk was discussed with the team.

People in the retail area were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer. It was generally clean and tidy, and the door closed which provided privacy. It provided a suitable environment for the administration of vaccinations and other services. Team members controlled access to the consultation room and it could be locked to prevent unauthorised access. Temperature and lighting were comfortable throughout the premises. And team members regularly cleaned pharmacy workspaces and staff facilities.

Principle 4 - Services ✔ Standards met

Summary findings

People easily access the pharmacy's services. And the pharmacy manages and delivers these services safely. The pharmacy correctly sources its medicines, and it completes regular checks of them to make sure they are suitable for people to take. The pharmacy team provides appropriate advice to people about their medicines.

Inspector's evidence

The pharmacy had a level entrance and a manual door to access the premises. It displayed its opening hours and some pharmacy services in the windows of the pharmacy. The team also kept a range of healthcare information leaflets for people to read or take away, and posters provided information on local NHS services such as sexual health and counselling. Team members wore badges showing their name and role. They effectively used written communication and online translation services for people accessing the pharmacy who did not use English as their first language.

Pharmacy team members followed a logical and methodical workflow for dispensing. The dispensary had separate areas for labelling, dispensing, and checking of prescriptions. Team members used baskets to separate people's medicines and prescriptions and prevent them being mixed-up. They signed dispensing labels to maintain an audit trail of who had dispensed and checked medicines. And they attached coloured labels to bags containing people's dispensed medicines to act as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line or a CD that needed handing out at the same time. Team members contacted the prescriber when a manufacturer was unable to supply a medicine. And they used the national Patient Group Direction (PGD) for the urgent supply of repeat medicines to ensure people didn't run out of their medication. The pharmacy offered a delivery service. A team member prepared a list of the day's deliveries and kept this in the dispensary. This was useful if people called the pharmacy asking about their expected delivery. And the delivery driver kept records of completed deliveries, including CDs.

Many people received medicines that had been prescribed using Medicines Care Review (MCR) serial prescriptions. The pharmacy prepared these weekly in advance of people collecting them. Team members only prepared the medicines that were requested by people to avoid waste. They maintained records of when people collected their medication. This meant the pharmacist could then identify any potential issues with people not taking their medication as they should. The pharmacy notified the GP practice for a further prescription when all episodes of the prescription were collected. And they added notes of any care issues identified. This helped make sure people's medicines were reviewed by their GP appropriately. Team members checked regularly for any prescriptions that had not been requested. They then communicated with the GP practice to ensure the prescription remained appropriate.

The pharmacy supplied medicines in multi-compartment compliance packs for people who needed extra support with their medicines. Pharmacy team members managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept a master record for each person which documented the person's current medicines and administration time. Some records had notes of previous changes to medication, creating an audit trail of the changes. The pharmacy sent the majority of its packs to another of the company's pharmacies, known as the hub pharmacy, to assemble using automation. The pharmacy kept the responsibility for the management of the service. This included

ordering prescriptions, checks on the accuracy of the information sent to the hub pharmacy, and the clinical check by the pharmacist. On receipt of the packs into the pharmacy, the pharmacist or ACPT completed a further accuracy check. Team members demonstrated an organised and logical process for tracking the prescriptions through the process. This meant it was easy for team members to check at what stage the dispensing was at. Packs were labelled with a description of what medicines looked like, so people could identify the individual medicines in the pack.

Team members demonstrated a good awareness of the Pregnancy Prevention Programme for people who were prescribed valproate, and of the associated risks. They knew to supply valproate in the original manufacturer's pack and make sure people could access the patient information leaflets and alert cards with every supply. The pharmacy supplied two people with valproate out of the manufacturer's original pack in compliance packs. They had discussed the risks of doing so with the person's GP. But the team had not recorded these interventions on people's medication records to support it in providing continual care. The pharmacy used PGDs to provide a number of services to people. These included for unscheduled care, the Pharmacy First service, smoking cessation and emergency hormonal contraception (EHC). The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They referred to the pharmacist as required.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves and in drawers. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. And team members followed the sale of medicines protocol when selling these. The pharmacy kept CDs in an orderly manner within secure cabinets. Medicines inside the pharmacy's fridge were stored neatly and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. Team members regularly checked the expiry dates of medicines. The team maintained an audit trail to demonstrate completion and they highlighted medicines which were due to expire soon. A random selection of medicines was checked and no out-of-date medicines were found. The pharmacy had disposal bins for expired and patient-returned stock. Team members followed a process for dealing with medicines returned by people promptly and ensured the bins were emptied regularly. The pharmacy team printed a copy of medicine recalls it received by email and signed and dated the sheet with the action taken. Recently actioned recall sheets were seen stored in a file.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

Team members had access to up-to-date reference sources including electronic access to the British National Formulary (BNF) and the BNF for children. And they had access to internet services. This meant the pharmacy team could refer to the most recent guidance and information on medicines. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. And it used separate marked ones for substance-misuse medicines. Dispensed medicines awaiting collection were stored in a way that prevented members of the public seeing people's confidential information. The dispensary was at a higher level than the retail area and computer screens were positioned to ensure people couldn't see any confidential information. The pharmacy had cordless telephones and team members were observed moving to a quieter area of the pharmacy to have private conversations with people.

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.