

Registered pharmacy inspection report

Pharmacy Name: Well, 66 Bank Street, LOCHGELLY, Fife, KY5 9QN

Pharmacy reference: 1091347

Type of pharmacy: Community

Date of inspection: 10/09/2019

Pharmacy context

This is a community pharmacy on a main road in a small town. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs and provides substance misuse services including needle exchange. It offers additional services including flu vaccination and anti-coagulation clinics.

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 team members follow processes for most services to ensure they are safe. They sometimes record mistakes to learn from them, with more recording recently. The pharmacy keeps most of the records that it needs to by law and usually keeps people's information safe. Team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place 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 training records confirmed which processes each team member undertook. The locum pharmacist had read and recorded SOPs online. He believed he would be contacted when there were updates or replacements. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy mainly managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. But during the inspection some team members chatted about unrelated topics while dispensing. An accuracy checking technician (ACT) checked dispensed medicines if prescriptions were clinically checked and marked by the pharmacist. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members recorded errors reaching people, and used Datix, an electronic tool to record dispensing errors that were identified in the pharmacy. They had recently started using this more regularly after a period of inconsistency. The inspector found some patient safety reports in the SUPER folder. These were in good condition looking like they had been printed and filed but not handled. The documents observed were: February 2019 – six near misses and three errors reaching people, March 2019 – one near miss, and April 2019 – no near misses recorded. This suggested not all incidents were recorded. Team members were required to record all incidents as per the SOP. No other months' documents were observed. The pharmacist identified an error during the inspection. It was an incorrect strength. The dispenser recorded this, explaining that the medicine had been stored in the wrong drawer. He checked the drawer and correctly re-located other packs. Team members reviewed near misses and errors monthly following receipt of an analysis from Datix. They discussed the content 'on-the-job'. A team member explained that the form of co-codamol had been discussed to raise awareness. But not all team members had been involved. Team members were aware of two errors reaching people recently. One had involved the wrong flavour of a liquid medicine, and the other was a wrong strength. Team members were not aware of any analysis taking place following either of these to identify causes and learn from them. Team members did not describe any other audits, but a company compliance audit from eight months ago was observed.

The pharmacy had a complaints procedure and team members stated that they would welcome feedback. They could not describe any examples and explained that they no longer ordered retail items for individuals.

The pharmacy had an indemnity insurance certificate, expiring 30 April 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, but some did not comply with legislation as they did not include prescriber details; unlicensed specials records but some were incomplete; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines but some were not recorded. 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 although some conversations in the dispensary could be heard from the retail area. They had all undertaken annual training on the subject. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also undertaken annual training on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. 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 staff to deliver its services. The pharmacy replaces team members when they leave to ensure there are enough team members to deliver pharmacy services. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training when possible. Team members discuss incidents to learn from them.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist, 1 full-time non-pharmacist manager, one part-time (31 hours per week) accuracy checking technician (ACT), one full-time and two part-time (18 and 26 hours per week) dispensers, and one part-time (22 hours per week) medicines counter assistants and a part-time delivery driver.

All team members were trained for their role except the manager who was new to pharmacy. She had been in this pharmacy for two weeks and had spent two weeks in another branch. She was expecting to commence training on a joint medicines' counter/dispensary assistant course within the accepted timeframe. The pharmacy displayed some certificates of qualification. At the time of inspection there was a pharmacist, ACT, two dispensers, manager and the medicines counter assistant working. A locum pharmacist was working as well as the regular pharmacist as she was running an anti-coagulation clinic. The regular pharmacist had been the manager until a few months ago, but a non-pharmacist manager had been appointed recognising that a pharmacist could not fulfil management duties and run clinical services. The current new manager had been appointed when the previous one had left. Locum pharmacists worked twice a week to cover for clinics.

The pharmacy had been through challenges recently with a few changes to management and recently a new computer system installed. This had led to services being delayed, such as prescriptions being three days behind. At the time of inspection this had improved. The pharmacy's staffing was anticipated to be challenging soon. The un-trained manager was dispensing in anticipation of being registered on an appropriate course. A full-time dispenser was leaving, and recruitment was underway. The regular pharmacist was also leaving over coming months and the team did not know what was planned.

Team members were mostly able to manage the workload. The pharmacists present, and the manager recognised the risk of the manager dispensing when new to the pharmacy and untrained. The locum pharmacist who was familiar with the new computer system was coaching the regular pharmacist and team members. They had all undertaken training, but not had practical experience of the system.

The pharmacy provided protected learning time when it could for all team members to undertake regular training and development. They mostly undertook electronic modules and had password protected training platforms. Team members described this being in 'bits' rather than long enough periods. Some felt this particularly frustrating for training on the new computer system. They had been allocated a half-day training.

Team members described having annual development meetings with development plans in place. But these had not been held for 'a while' and no development plans or objectives were available. The various individuals mostly went about their tasks in a systematic and professional manner. Although some people were kept waiting at the medicines counter for longer than they might expect with no

acknowledgement. Team members 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, although these were not all recorded. They had an open environment in the pharmacy where they could share and discuss these. They stated that they could make suggestions and raise concerns to the manager or area manager but could not provide examples. The area manager sent weekly updates covering pharmacy and business topics, but no examples were seen or described. The superintendent pharmacist sent 'share and learn' documents to the pharmacy for that purpose. But not all team members were aware of these, so did not benefit from them. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters, but these were not used in any particular way.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are safe and clean, and suitable for the pharmacy's services. The pharmacy team members use private rooms for some conversations with people. 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. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, consultation room, 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. The pharmacy had two small consultation rooms. Team members used both for a variety of consultations. Both rooms were clean and tidy, and the doors closed providing privacy. 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 provides additional services to help people in the community including flu vaccination and anticoagulation clinics and home visits. 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. 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 level entrance and a power assisted door. It listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order and could provide large print labels for people with impaired vision. 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. The pharmacist visited people at home that were unable to attend the anticoagulation clinic in the pharmacy.

Pharmacy team members followed a defined workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. There was a GP practice close and most prescriptions were walk-in. A team member collected prescriptions from the surgery first thing each morning. A team member scanned prescriptions on receipt so that the team could check if prescriptions were on the premises when asked. The pharmacy placed them alphabetically into baskets separating those for delivery and those for collection. Sometimes a pharmacist undertook a clinical assessment of prescriptions at this point with little or no reference to the patient medication record (PMR). The regular pharmacist explained that she preferred to label prescriptions so that she could see the patient records while she was clinically checking. She was able to identify new items and check that the frequency of prescribing was appropriate. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. The pharmacy scanned out dispensed medicines so there was an audit trail of supply. It placed dispensed medicines on retrieval shelves where they could remain for up to six weeks. Then a team member sent a letter reminding people to collect their medicine. If people did not collect their medicine after a further week it was returned to stock and prescriptions endorsed appropriately. A team member stated that the pharmacy had never needed to contact prescribers. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when people came to collect them. It did not keep paper records of supply dates but the electronic PMR recorded dispensing. The computer highlighted if the supply was being made earlier than expected. Team members were not yet sure how to monitor compliance using the new computer system. But they were not aware of compliance being a concern. They were not currently registering people for the service due to time challenges, but the new manager had been tasked with increasing registrations. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Team members explained that they tried to work two weeks in advance but some weeks this was not possible if they were busy. They followed a logical process and kept records of changes although they did not record prescribers' names. They included tablet descriptions, date of supply and instalment number on packs. Some people required two packs per week due to the number of tablets and these were well labelled and banded together to ensure the

correct packs were supplied. Team members ensured that the packs contained the same medication each time. The pharmacy only supplied patient information leaflets with the first supply which was not in line with current legislation. Team members carried out needs assessments for people to ensure compliance packs were appropriate for them before the first supply. The pharmacy supplied a variety of other medicines by instalment. Team members assembled weekly instalments in their entirety. And they dispensed daily instalments weekly.

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 pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and the team present at the time did not think there were any people in that group. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information had been given to people supplied with these medicines over-the-counter, or on prescriptions. The pharmacy did not have any written material left to supply, but a team member was aware that the care bundle was being re-launched. Team members also discussed 'sick day rules' 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, smoking cessation, emergency hormonal contraception, and supply of chloramphenicol ophthalmic products. It also 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 regular pharmacist delivered the private flu vaccination service. She described her training which was up-to-date, and she had much experience. She ran anticoagulation clinics from the pharmacy and undertook home visits for people who could not attend the pharmacy. This was a local NHS service and she had been trained to their specifications. She followed a protocol. Although she was an independent prescriber, the pharmacist did not prescribe warfarin but followed an algorithm to change doses. People were referred to her from the GP practice. She confidently described all aspects of the clinic including the record keeping which was done in the surgery once per week. The clinic was observed during the inspection. The pharmacist had been undertaking this for a few years, so the service was well embedded. People liked the informality of the pharmacy setting, the fact that they did not have to have venous blood taken and the immediacy of the results and dose alteration if necessary. The pharmacist also ran an asthma clinic in the GP practice as an independent prescriber. She described several good outcomes for people including the ability to provide spacer devices and/or steroids quickly for flareups. She liaised with other independent prescribers, GPs and nurses in the local surgery for shared learning and advice. The pharmacist had a good relationship with colleagues from other disciplines and was able to refer people from the pharmacy if required. The ACT undertook most blood pressure measurements following a protocol, but there were very few requests for this service. The pharmacy did not actively promote it.

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). Team members had undertaken some training, but not yet used the equipment. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge in one of the consultation rooms with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Team members 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.

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, a blood pressure meter which was replaced every two years, and blood testing equipment calibrated as per guidance. The pharmacist kept antibacterial hand gel in the consultation room and used it during her anti-coagulant clinics. The pharmacy had a 'methameasure' pump available for methadone use and this was cleaned at the end of each day and test volumes poured each morning. It was in one of the consultation rooms and was firmly attached to the fittings. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. And they kept clean tablet and capsule counters in the dispensary. As methotrexate tablets were supplied in blister packaging there was no longer a separate counter kept for these.

The pharmacy stored paper records in the dispensary and back-shop area inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left them unattended unless they were locked. They used a cordless phone to speak to people accessing pharmacy services and healthcare professionals. But sometimes they used it at the front of the dispensary and people in the retail area could hear conversations.

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.