

# Registered pharmacy inspection report

**Pharmacy Name:** G L M Romanes Ltd, 1 - 3 Market Square, DUNS,  
Berwickshire, TD11 3DB

**Pharmacy reference:** 1092185

**Type of pharmacy:** Community

**Date of inspection:** 08/11/2019

## Pharmacy context

The pharmacy is on a main road in the centre of a small town. It dispenses NHS and private prescriptions and sells over-the-counter medicines. And provides advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartment compliance packs. These help people remember to take their medicines. It provides a delivery service. The pharmacy provides NHS services including the treatment for urinary tract infections. And impetigo and minor ailments. And provides a private flu vaccination service.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	4.1	Good practice	The pharmacy develops and provides services to help the local community. This assists people due to the remote location of the pharmacy. And with distances to travel for services.
		4.2	Good practice	The pharmacy has robust processes in place to help identify and manage the risks associated with providing its services. And it ensures that people receive their medication with the required advice and support.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy has written procedures that the team follows. The team members have a clear understanding of their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. The team members responsibly discuss mistakes they make during dispensing. The pharmacy keeps all the records as required by law, in compliance with standards and procedures. It provides people using the pharmacy with the opportunity to feedback on its services. The pharmacy team members look after people's private information. And they know how to protect the safety of vulnerable people.

### Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which the pharmacy team members had read. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as dispensing of prescriptions, pharmacy practice, patient safety and controlled drug (CD) management. These were last reviewed in 2019. The SOPs had signature sheets and the team had read and signed the sections relevant to their role. The team could advise of their roles and what tasks they could do.

The pharmacy workflow provided different sections for dispensing activities with dedicated benches for assembly and checking, with a separate room for compliance pack preparation. The main dispensing bench had three computer terminals. The team dispensed prescriptions for people waiting and calling back at the front bench. And used the back bench for preparing repeat prescriptions and collections. The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used red baskets for people waiting. This helped plan workload. The pharmacy had a robot unit which the team members filled manually with items. They scanned items in. And they date-checked the stock as they put it in. They routinely date-checked the robot manually and marked short-dated items. They opened the unit and checked individual sections. They explained that they kept the top 80 lines in the robot unit. There were exceptions as they had put some items in the robot following identification at the near miss stage with picking errors e.g. Tegretol and Tegretol retard and tramadol.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The team recorded these on a specific template. Examples included tramadol with capsules dispensed instead of tablets, carbimazole with the quantity 56 and 100 given and diazepam 10mg with 2mg given. The team members had recorded comments such as to check the drug name and focus on the strength. And they had items separated on the shelves. Some actions they had undertaken included putting a drug into the robot or in a drawer to keep similar names or strengths separate. The team discussed any near misses as they occurred, but the pharmacy did not keep any written reviews. And discussion took place that this would be beneficial for ongoing learning and picking up trends and patterns.

The pharmacy had a practice leaflet and a notice displayed in the pharmacy which explained the complaints process. It had a process for dealing with incidents and investigations. The pharmacy also had the NHS Scotland information on dealing with incidents and complaints. The team were aware of the process and advised they would notify the pharmacist of any issues raised. The pharmacy had current indemnity insurance through the National Pharmaceutical Association (NPA) with an expiry date

of 30 April 2020.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records as required. A sample of the CD registers looked at complied with legal requirements. The pharmacy kept a record of CDs which people had returned for disposal and it had a process in place to ensure the team destroyed these promptly. And did not allow a build-up in the CD cabinet. The pharmacy kept records for private prescriptions with emergency supplies and veterinary prescriptions suitably recorded. It kept special records for unlicensed products with the certificates of conformity completed.

The pharmacy displayed information in a notice in the window headed 'Pharmacy Fair Processing' on the confidential data and how it complied with legislation. The team had read General Data Protection Regulation (GDPR) information. And the pharmacy had reviewed its delivery process following the changes in legislation. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. The pharmacy team stored confidential waste in separate containers for offsite shredding.

The team had a safeguarding vulnerable adults and children SOP. The pharmacist had undertaken training through NHS Education for Scotland (NES). And the team had completed training. The pharmacy had a flowchart with information and contact numbers for local safeguarding were available for the team. If a team member had a concern about a child or vulnerable adult, they would discuss this with the pharmacist in the first instance.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough qualified staff to provide safe and effective services. The pharmacy team members are competent and have the skills and qualifications they need for their role. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. And they feel comfortable raising any concerns they have.

### Inspector's evidence

There was one pharmacist, one accuracy checking technician (ACT), one technician, two dispensers and six medicines counter assistants (MCAs) working in the pharmacy. In addition, there was an ACT who was on maternity leave, two technicians and another dispenser. The team worked a variety of hours from 14 to 35 hours a week. One of the dispensers was a registered technician in Ireland and was going through the process to become registered with the General Pharmaceutical Council (GPhC). She explained she had undertaken some conversion course. The MCAs were all trained. One was the shop manager. Some of the team went to other pharmacies in the group to assist when required. The pharmacist advised that it was harder to get pharmacist cover due to many pharmacists taking posts within Health Boards. He had some concerns of the impact over the Winter with illness and bad weather.

Certificates and qualifications were available for the team. The team advised when they were undertaking formal courses they received about two hours a week when required to complete work. This usually occurred at quieter times and when most of the staff were present. The team members undertook ongoing training and had some training records. They had access to training modules. And also had a folder with some leaflets for information. And articles from magazines and suppliers. Recent topics covered included medicines and driving and inhaler training. They had huddles each day to discuss the work and any updates. They discussed near miss errors, but the reviews were not formally documented. They had some training evenings for the pharmacists in the group every six months. And some of the team attended local NHS Education Scotland (NES) training evenings, with the last one being on diabetes.

The team members received yearly performance reviews which gave them the chance to receive feedback and discuss development needs. One member had gone on to do the technicians course and others had undertaken more training in the retail side. The MCA followed the sales of medicines protocol when making over-the-counter (OTC) recommendations and referred to the pharmacist when necessary. The team carried out tasks and managed their workload in a competent manner discussing any issues which arose and dealing with any telephone queries.

The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacists or the superintendent (SI) who worked at the pharmacy. There was a whistleblowing standard operating procedure (SOP) and telephone numbers were available, so the team members could easily and confidentially raise any concerns outside the pharmacy if needed.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean and secure. The premises are well maintained and offer a professional environment for the delivery of the pharmacy's services. The pharmacy has good arrangements for people to have private conversations with the team.

### Inspector's evidence

The pharmacy was clean, tidy and well maintained. It had a large retail area with a range of health-related products, gifts and toiletries. The dispensary was fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines and devices waiting for collection. The dispensary housed a robotic unit for dispensing. The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The benches, shelves and flooring were all clean and the team followed a cleaning rota to ensure they maintained cleaning in all areas. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. And put away orders promptly. The room temperature was comfortable, and the pharmacy was well lit.

The pharmacy had two consultation rooms. There was a sign which stated 'consultation'. And the team directed people for private conversations. One consultation room was glass fronted but not directly visible to people waiting at the counter. So, provided sufficient privacy. The other was also used as an office. The team members left no confidential papers unattended in the office room. And they used the office for consultations when people required more privacy, or for service such as flu vaccinations. There was a member of the team covering the counter and the dispensary members could see people from the dispensary. So, the team were aware of customers in the premises. People could not access the dispensary.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's services are accessible to people. And it displays information about health-related topics. The pharmacy has robust processes and systems in place to help identify and manage the risks associated with providing its services. And it ensures that people receive their medication with the required advice and support. The pharmacy team members dispense medicines into multi-compartment compliance packs to help people remember to take them correctly. It provides services to help the local community. The pharmacy gets its medicines from reputable sources. And it has systems in place to ensure medicines are safe and fit to supply.

### Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There were automatic doors at the entrance for easy access. There was some customer seating. The pharmacy displayed its services in the window and within the pharmacy. The pharmacy had a website. And displayed the General Pharmaceutical Council (GPhC) logo but did not supply any medicines online. The hours of opening were on the door. It had a defined professional area. And displayed a practice leaflet available for people. It had a wide range of leaflets and information on several health-related topics to provide information for people. Information included NHS Scotland booklets and advice sheets on topics such as travel advice. The pharmacist used a malaria and travel inquiry form to provide people with appropriate information. The pharmacy had cards with the 'medicine sick day rules' which advised people which medicines to stop taking if they were unwell. It had a range of British Medical Association (BMA) booklets on a range of topics which people could purchase. The pharmacy kept the pharmacy medicines behind the counter and the team assisted people who wished any of these items. And they provided appropriate advice.

The pharmacy provided the chronic medication service (CMS). And had between 500 to 600 people registered. The pharmacy had provided care plans for these people and about 130 people received serial prescriptions. The pharmacy was taking part in the local Health Board Medicine Reviews. The reviews undertaken, targeted topics such as the 'medicines sick day rules', chronic pain and asthma. For the asthma reviews the pharmacist advised people on their inhaler technique, oral care and often provided a spacer device which people had found beneficial. Other reviews had included blood pressure checks and recommending different times for people to take their medicines. The Health Board had contacted people who had undergone a review for feedback which had provided positive results. The pharmacist provided advice on non-steroidal anti-inflammatory drugs (NSAIDs), to ensure they were taking them correctly and if they required a proton pump inhibitor (PPI). The pharmacist used unscheduled care to synchronise medicines and provided supplies if people ran out. The pharmacist was an independent prescriber. The local stoma nurse prescriber had advised the pharmacist that she was going to be off for a while. And discussed if he could assist. He had decided to up skill and help meet the needs of the local community. He had undertaken a stoma course to enable him to take over the prescribing for these people. He had about 14 people and provided advice on skin care and could arrange for reviews if they required a change in template. He also prescribed for asthma products. The nurse was back at work, but the people had stayed with the pharmacy for the convenience of the service.

The pharmacy had Patient Group Directions (PGDs) in place for chloramphenicol and the Pharmacy First scheme. It provided treatments for impetigo and urinary tract infections (UTIs) through the Pharmacy First scheme. There was little uptake for treatment for impetigo. But several requests for treatment for UTIs and the pharmacy referred people to the surgery when they could not receive the treatment through the PGD. The pharmacy had undertaken about 60 flu vaccinations through a private service. And attended a company to provide flu vaccination to the employees. The pharmacy had between 1500 and 1600 people registered for the electronic Minor Ailments Scheme (eMAS). It generally received between 40 to 50 requests a week from people. And the service was particularly popular on a Saturday. The pharmacy linked with the Borders emergency care service and they worked well together to provide the best outcome for people. This was helpful as it saved people traveling long distances when the pharmacy could assist them appropriately. The pharmacist undertook the smoking cessation service. The pharmacy offered a substance misuse service.

The pharmacy supplied medicines to around 100 people in multi-compartment compliance packs to help them take their medicines. It provided assessments for people for suitability for multi-compartment compliance packs. All people had a profile sheet kept in a pocket file. The team members used trackers to monitor the progress of the packs. And they recorded the dates and who had labelled, dispensed and checked the packs. They worked about a week and a half to two weeks ahead to allow time to complete the process for supply. Each person had a basket which the team kept the stock in. The team members counted the amount of medication required and placed this separately before placing in the packs. This provided an extra quantity check during the filling process. They supplied patient information leaflets (PILs) with each cycle. People signed when they collected packs. And if the pack was not collected as expected someone would check to query why. They delivered about 25 packs.

There was a clear audit trail of the dispensing process. The team completed the 'dispensed by' and 'checked by' boxes which showed who had performed these roles. And a sample of completed prescriptions looked at found compliance with this process. The pharmacist marked prescriptions with 'cc' to indicate the accuracy checking technician (ACT) could check. He also marked if he specifically wanted to speak to any person. The team used appropriate containers to supply medicines. There were some alerts stickers used to apply to prescriptions to raise awareness at the point of supply. The stickers included warfarin and NSAIDs which ensured patients received additional counselling. The team members used CD and fridge stickers on bags and prescriptions to prompt the person handing the medication over that some medication required to be added to complete the supply. The CD stickers recorded the last date for supply, to make sure it was within the 28-day legal limit. The team also put the date for last supply on the prescription. This prevented supplies when the prescription was no longer valid. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. The had undertaken an audit and had one person in the at-risk group. They explained the information they provided to the 'patients in the at-risk' group.

The pharmacy provided a repeat prescription collection service. The pharmacy kept a delivery sheet as an audit trail for the delivery of medicines from the pharmacy to patients. This included a signature of receipt of the delivery. The driver used a separate delivery sheet for controlled drugs. When the pharmacy could not provide the product or quantity prescribed in full, patients received an owing slip. And the pharmacy kept one copy with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers for an alternative if items were unobtainable.

The pharmacy stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. There was some obsolete stock requiring disposal. The pharmacy had a



refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. The team members marked short-dated items and they took these off the shelf prior to the expiry date. They marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use.

The pharmacy used recognised wholesalers such as AAH, Unichem and Eclipse. The pharmacy had a process to receive drug safety alerts and recalls. The team actioned these and kept records of the action taken. The pharmacist advised that some of the pharmacies in the group had implemented the requirements for the Falsified Medicines Directive (FMD). The pharmacy had been accredited by SecurMed. And had scanners and the software in place. The team had started a while ago but there had not been many packs with the codes, so they had stopped. The pharmacist said they would start in 2020. The team used appropriate medicinal waste bins for patient returned medication. The contents of the bins were securely disposed of via the waste management contractor. The pharmacy had appropriate denaturing kits for the destruction of CDs.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people's privacy.

### Inspector's evidence

The pharmacy team members had access to a range of up-to-date reference sources, including the British National Formulary (BNF). They used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs).

The pharmacy had a robotic dispensing unit. This was suitably maintained. The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It had a separate range of measures for measuring methadone. It also had a range of equipment for counting loose tablets and capsules. The team members cleaned triangles after use. Methotrexate was available in blister packs. The team members had access to disposable gloves and alcohol hand washing gel. The equipment such as the carbon monoxide monitor, and blood pressure machine appeared in good working order. The Health Board serviced and replaced the carbon monoxide monitor as required. The pharmacy replaced the blood pressure monitor when required.

The pharmacy stored medication waiting collection on shelves where no confidential details could be observed by people. The team filed prescriptions in boxes in a retrieval system out of view, keeping details private. The computer screens were out of view of the public. The team used cordless phones for private 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.