General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gordons Chemists, 7 North Street, Armadale, BATHGATE, West Lothian, EH48 3QB

Pharmacy reference: 1099803

Type of pharmacy: Community

Date of inspection: 31/07/2019

Pharmacy context

This is a community pharmacy just off a high street in a small town, close to 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

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 all services to ensure that they are safe. The pharmacy ensures that new team members are familiar with these before they start working. Team members record mistakes to learn from them. They review these and make changes to avoid the same mistake happening again. Team members use feedback from people to make the pharmacy's services better. The pharmacy keeps all the records that it needs to and keeps people's information safe. Team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities/tasks. The area manager had signed them off in 2016, with an expected review date of 2018, which had not yet been undertaken. Pharmacy team members had read them, and the pharmacy kept records of this. The preregistration pharmacist who had started work two days previously, had spent the previous two days reading the SOPs. Staff roles and responsibilities were recorded on individual SOPs. Pharmacy team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. But this never happened. There was always a pharmacist on the premises as there were two pharmacists working Monday to Friday.

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. Pharmacy team members followed two distinct processes to separate higher risk dispensing, with two separate dispensing areas and checking benches. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

The pharmacy kept near miss logs on both checking benches, and recorded dispensing errors reaching patients. Recently the pharmacy had made an error which resulted in a person taking the wrong medicine for several days. Two medicines with similar sounding names, stored on the same shelf had resulted in the wrong one being supplied. A team member had recorded details of the incident and it had been discussed with the whole team. On reflection, the pharmacy team members identified that the shelves had been untidy, and the two items were close together. They had tidied the shelves and separated these items since this incident. Team members did not record a lot of near miss errors, and the pharmacists present during inspection described dispensing as mostly accurate. It was acknowledged that probably not all incidents were recorded. The pharmacy did not undertake formal reviews of these to identify trends and themes.

The pharmacy had a complaints procedure in place and welcomed feedback. Team members explained that they got a lot of positive feedback and gifts and cards of appreciation were observed. Team members also explained that they watched people's body language in the retail area and helped with advice and sales of sensitive items such as incontinence pads and pregnancy tests.

The pharmacy displayed an indemnity insurance certificate, expiring 30 Sep 19. 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 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 had all had training on the topic and read information in the staff handbook. They had not had an update since the general data protection regulations (GDPR) came into place. Team members shredded confidential waste and ensured that there was no person identifiable information visible to the public. They also had awareness of safeguarding and the pharmacists knew that local processes were available on the Community Pharmacy Scotland website. The pharmacists where 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 balances staff numbers to how busy the pharmacy is and makes changes when it can. Team members who are training to gain a qualification have access to training material. This ensures they have the skills and qualifications they need. But qualified team members do not undertake routine training and development. So they may be missing opportunities for learning.

Inspector's evidence

The pharmacy had the following staff: two full-time pharmacists; one full-time preregistration pharmacist; three full-time dispensers, one who was still undertaking training; two part-time dispensers; two full-time and two part-time medicines counter assistants, one who was undertaking training; and a part-time delivery driver. One of the pharmacists was also the pharmacy manager. Recently a pharmacist had left the business, and a new one was starting the following week. At the time of inspection two locum pharmacists were working. They had both worked in the pharmacy before and were familiar with the team and the processes. The preregistration pharmacist had started two days previously. The last preregistration pharmacist had left a few weeks before. One of the dispensers who had many years' experience was known as a 'dispensary technician' in recognition of her experience. She was not a pharmacy technician. Typically, there were two pharmacists, three dispensers and two or three medicines counter assistants working at any time. Team members could manage the workload. The pharmacy used rotas to manage the workload and absence. There was scope for part-time staff members to work additional hours to cover absence. The pharmacy displayed certificates of qualification.

The pharmacy provided protected learning time for new team members to read standard operating procedures, and trainee team members to undertake their accredited training. Although, a trainee medicines counter assistant explained that there was little time during the working day, so she undertook most of her training at home. The pharmacy did not provided time for other routine training or reading. Pharmacists supervised training team members, and they were supported by all team members. Trainees asked all colleagues for advice, and all team members demonstrated activities to others.

Team members had annual appraisals/development meetings with the pharmacy manager with input from the area manager. They described being able to openly discuss any topic or issue. They believed the objective of these meetings was to ensure that they were working to the best of their ability and following processes. They had development plans with objectives related to their role and eperience. The pharmacy had a staff handbook available for all to access which had been written in 2012. It included a whistleblowing policy and described processes in place for team members to raise concerns. Team members described feeling able to raise concerns with the pharmacy manager, or area manager if necessary. The pharmacy did not have regular formal meetings, but team members described constant on-the-job sharing of information. Several team members described the pharmacy team as 'like a family'. They understood the importance of reporting mistakes and sharing any learning with the whole team. The pharmacy sometimes received emails from head office which were relevant to all team members – these were printed and placed in the staff area for all to read.

The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when responding to symptoms over-the-counter and referred to the pharmacist appropriately. They demonstrated awareness of products that should only be used short-term and gave relevant advice to people. The pharmacy did not set targets.

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

The pharmacy premises were reasonably sized, incorporating quite a large retail area selling a selection of medicines and related products, toiletries and household products which were popular with the local community. The premises were clean and hygienic. Sinks in the dispensary, staff room, toilet and consultation room had hot and cold running water, soap, and clean hand towels.

The dispensary was small and cramped, with limited dispensing space. And large bags containing dispensed medicines were stored in boxes on the floor as there was insufficient space on retrieval shelves. The pharmacy had a small back-shop area incorporating basic staff facilities and a small amount of storage space. The pharmacy was planning a refit over coming months, extending into an adjoining building at the rear of the premises to provide more dispensing space.

The pharmacy had a consultation room with a desk, chairs, sink and computer. It was clean but cluttered as it was used for storage. The door closed providing privacy, and all team members used this room. People were not able to see activities being undertaken in the dispensary. 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 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 flat entrance and an automatic door. It displayed a list of the services it provided. It had a few strategies in place to assist people such as a hearing loop in working order, lowered areas on the medicines counter, and it could provide large print labels for people with impaired vision. It also provided a delivery service, and people signed to confirm receipt of their medicines. All team members wore badges showing their name and role.

Pharmacy team members followed a logical and methodical workflow for dispensing. They had two separate areas, one for walk-in dispensing, and the other for all other dispensing such as collection service dispensing and instalment dispensing including multi-compartmental compliance packs and methadone instalments. This worked well ensuring that all prescription types were managed in a timely manner as people expected them. The surgery was very close to the pharmacy resulting in a high volume of walk-in prescriptions, and most people waited for their medicines. A pharmacist worked in each area ensuring that work flow could always be maintained. They covered for each other during lengthy consultations with people. Pharmacists worked three days in each area, so the one working on the Saturday worked at the end of the week then the start of the following week in the non-walk-in area. This provided continuity on Saturdays, with awareness of any issues ongoing with instalments or collection service prescriptions.

Team members shared information with the pharmacist such as new medicines when they observed this during the labelling process. They signed dispensing labels to provide an audit trail of who had dispensed and checked medicines. The pharmacy usually assembled owings later the same day or the following day. A team member removed uncollected dispensed medicines from retrieval shelves after three months. They kept a record of this and altered the electronic endorsement to ensure correct payment. But they did not contact patients or prescribers to address any compliance issues.

The pharmacy managed multi-compartment compliance packs on a 4-weekly cycle with 4 assembled at a time. The pharmacy dispensed these the week before the first instalment was due to be supplied. And where possible, this was done in advance of planned staff absence. Several team members were trained and competent to do this, although one dispenser had ownership of this activity. She followed a robust procedure, keeping records of when prescriptions were ordered, labelled and assembled. The pharmacy also kept comprehensive records of changes to medication and other clinical information.

The pharmacy only supplied patient information leaflets with new medicines, not each time the medicine was supplied. Tablet descriptions were on packaging. The pharmacist undertaking the final accuracy check sealed the packs. Dispensers left tablet packaging with the dispensed medicines to facilitate the accuracy check. Completed packs were stored in individual named boxes clearly marked

with supply information i.e. delivery or collection. People signed to acknowledge receipt when they collected their medicines. The pharmacy supplied a variety of other medicines by instalment. Team members kept records of when medicines were dispensed and collected, including a signature of the person collecting. The pharmacy stored these dispensed medicines in individual named baskets on designated shelves. Prescriptions were filed with the records of dispensing and collecting.

A pharmacist undertook clinical checks 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, smoking cessation, emergency hormonal contraception, chloramphenicol ophthalmic products and chlamydia treatment. The pharmacists had been trained and signed them. The locum pharmacists present during inspection described having read and signed PGDs in different health board areas as they both worked in several areas. The pharmacy did not supply medicines on chronic medication service (CMS) serial prescriptions to lack of engagement with the service from GPs. As the regular pharmacist was not present during inspection there was no evidence or information about the other aspects of CMS. Team members were empowered to deliver the minor ailments service (eMAS) within their competence. They described examples of what they could do and what they would refer. They used the sale of medicines protocol to gather information about symptoms which they recorded and placed in the walk-in prescription queue. Medicines counter assistants described this process and explained that because there were always two pharmacists there was easy access to one to advise people. Medicines counter assistants were trained and competent to measure blood pressure, which they did a few times each week. They provided a written result for patients and always discussed it with the pharmacist so that appropriate advice could be given. They described examples of sending patients immediately to the GP practice, sometimes making appointments on their behalf. The GP practice was responsive when patients stated that the pharmacist suggested they should be seen the same day. Medicines counter assistants also delivered the smoking cessation service, with one team member who enjoyed doing this undertaking most of the consultations. She described several successful outcomes, and the advice that was given to people who were not immediately successful.

The pharmacy obtained medicines from licensed suppliers including Gordons twice a week, and AAH daily. It did not yet comply with the requirements of the falsified medicines directive (FMD). Team members had not had training, and the pharmacy did not have equipment in place. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It kept a lot of stock, and storage space was limited resulting in some shelves being untidy. It stored medicines requiring cold storage in two fridges 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. Examples of appropriate and thorough advice being given were observed.

The pharmacy actioned MHRA recalls and alerts actioned 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 these services. This included a carbon monoxide monitor maintained by the health board, and a blood pressure meter. The pharmacy obtained it in 2016 and it required inspection every two years. Pharmacy team members kept Crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. They had clean tablet and capsule counters, and a separate marked one was used for cytotoxic tablets.

The pharmacy stored paper records in the dispensary. Team members used passwords to access computers, and never left them unattended. They had phone conversations towards the back of the dispensary to ensure they could not be overheard.

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.