General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dunamis Pharmacy, 27 Elizabeth Drive, Boghall, BATHGATE, West Lothian, EH48 1SJ

Pharmacy reference: 1102323

Type of pharmacy: Community

Date of inspection: 18/09/2024

Pharmacy context

This is a busy community pharmacy located in a residential area in the town of Bathgate, West Lothian. Its main services include dispensing NHS prescriptions, including serial prescriptions and selling over-the-counter medicines. The pharmacy provides medicines in multi-compartment compliance packs for people who need help to take their medicines at the right times. And it provides an NHS injection equipment provision service and a medicines delivery service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.6	Standard not met	The pharmacy does not keep all of its records complete and accurate. This includes incomplete responsible pharmacist records and inaccurate records for some higher-risk medicines requiring safe storage.
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 not all met**

Summary findings

The pharmacy does not always identify risks in its dispensing processes as not all its records are accurate and complete. And it doesn't check its records regularly to identify errors. Team members record and discuss mistakes made during the dispensing process and make changes to prevent a similar mistake happening again. They suitably manage people's confidentiality. And they understand their role in helping to protect vulnerable people.

Inspector's evidence

The pharmacy had a set of paper-based standard operating procedures (SOPs) designed to help support its team members to work safely and effectively. The SOPs covered tasks such as the responsible pharmacist (RP) regulations and the management of controlled drugs (CDs). SOPs were overdue their review date with the sample seen showing review dates of various months between the years of 2022 and 2023. The superintendent pharmacist (SI) explained SOPs were currently under review. And this was clear from the sample of SOPs seen, as they were separated and marked as currently under review. Team members had read the SOPs relevant to their roles and completed a signature sheet to confirm their understanding of the SOP. They described their roles and processes they were involved in within the pharmacy and were observed working to some of the processes described within the SOPs, for example dispensing medicines within multi-compartment compliance packs. But the pharmacy had an automated dispensing machine for original pack dispensing. Team members had been trained to operate the automated dispensing machine, but the pharmacy had not updated its dispensing SOP and so team members did not have an accurate SOP to follow. There was a quick reference guide attached to the automated dispensing machine that included information on how to operate the machine such as, how to input and output stock. Team members were observed to be competent when using the automated dispensing machine.

Team members completed paper-based records about dispensing mistakes identified within the pharmacy, known as near misses. Team members were encouraged to record the near miss at the time a mistake was identified as a method of reflection following a mistake. And they included details such as the date and time the near missed happened, and the type of error that had occurred, for example a quantity error. Mistakes that were identified after a person received their prescription, known as dispensing incidents, were recorded in an incident book then reviewed by the SI and communicated to people’s GP. Team members discussed near misses and dispensing incidents during informal meetings once a week, and they agreed actions they then put in place to prevent the same or a similar mistake from happening again, for example all controlled drugs (CDs) and medicines that required cold storage received a second check prior to a final accuracy check due to a trend identified in dispensing mistakes. The pharmacy had a complaints procedure and team members aimed to resolve any complaints informally. But if they were not able to resolve the complaint, they would escalate to the RP or SI.

The pharmacy had professional indemnity and liability insurance. It displayed the correct RP notice that was visible in the waiting area. But RP records were incomplete. From the records seen there were regular omissions and almost all entries over the last month of when the RP had ceased duties at the end of the day were completely missed. The pharmacy held CD registers electronically, but didn't check the balances regularly. A random balance check on the physical quantity of several CDs found inaccuracies against the balances recorded in the registers and there was a potential duplicate entry

identified in another register. These examples showed that register entries were either incomplete or inaccurate. Team members checked the physical quantity of substance misuse liquid medicine against the balance recorded in the register regularly. And they kept records of this. The pharmacy had records of CDs people had returned for safe disposal. And CDs awaiting destruction were segregated from other stock. SOPs for the management of CDs including the recording of CDs and balance checks were currently under review. From the records seen, private prescription records were mostly complete with minor omissions of the details of the prescriber or the incorrect details of the prescriber. And the pharmacy held certificates of conformity for unlicensed medicines with details of supply included to provide an audit trail.

There was a data notice on display to let people know how their confidential information was stored and protected. And team members were aware of the need to protect people's confidential information. They segregated confidential waste and shredded it in onsite within pharmacy. There was a chaperone and safeguarding policy in place. And team members provided examples of signs that would raise concerns and interventions they had made to protect vulnerable people. The pharmacy had the details for local safeguarding agencies on display in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary knowledge and skills required for the services they provide. The pharmacy supports its team members to develop and gives them time at work to complete learning activities. Team members they feel comfortable raising professional concerns, should they need to.

Inspector's evidence

The pharmacy owner and SI worked full time as the RP and locum pharmacists provided double cover some days of the week. The pharmacy employed a part-time trainee accuracy checking pharmacy technician (ACPT), one full-time dispenser, one part-time dispenser, two full-time trainee dispensers, five part-time trainee dispensers and a deliver driver who worked every day. At the time of inspection, a pharmacy student was also working within the pharmacy who was participating in dispensing activities under the supervision of the RP. The delivery driver had not been enrolled on the appropriate accredited qualification training for their role. Following the inspection, there had been a change of delivery driver within the pharmacy. The SI provided assurances the newly employed driver would be enrolled on the appropriate accredited training for their role. Team members were observed managing the busy workload in a calm manner. One of the part-time trainee dispensers managed specific administrative tasks within the pharmacy, including annual leave requests. These were approved by the SI to ensure staffing levels remained sufficient to manage the workload safely. The SI described occasions where they had accessed locum agencies for dispensing staff during periods of absence. And part-time team members increased their hours for further contingency when required. There was a current vacancy for a dispenser within the pharmacy team.

The pharmacy did not have an official appraisal process. But team members had regular informal discussions to review progress, discuss individual learning needs and relevant updates to services. Relevant information was attached to an information zone on a wall within the dispensary. Recent information discussed included changes to services and the local health board formulary for example, the need for medicines to be prescribed generically under the NHS Pharmacy First service. And also discussed was the process for managing medicines that were out of stock and difficult to procure such as Creon. Protected learning time was provided for team members undertaking accredited qualification training and for specific learning. Team members had received face-to-face training to provide an NHS injection equipment provision service. Team members spoken to at the time of inspection felt well supported throughout their training. They asked the appropriate questions when selling over-the-counter medicines and described how they would handle repeated request for medicines liable to misuse such as codeine-containing medicines, by referring to the RP for supportive discussions.

There was an open and supportive culture within the pharmacy team. Part-time team members had regular conversations to prioritise workload and handover work. Team members were aware of a whistle blowing policy and explained they would feel comfortable raising concerns within the team or with the SI should they need to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and of adequate size to provide services safely. And the pharmacy has suitable arrangements to enable private conversations with a member of the pharmacy team.

Inspector's evidence

The pharmacy premises incorporated a retail area, consultation room, dispensary, and an area for stock holding which had limited floor space due to the stock stored there. There was a separate area used for the completion of other tasks such as the assembly of multi-compartment compliance packs. The retail area was clean with seating for people waiting. It led to a healthcare counter that acted as a barrier to prevent unauthorised access to the dispensary. There was sufficient work bench space but work benches in the dispensary were cluttered with multi-compartment compliance packs awaiting a final accuracy check. The dispensary was laid out in a way that allowed the pharmacist to supervise the activities of team members within the dispensary. And they could easily intervene in a sale of over-the-counter medicines if necessary. Most of the pharmacy's medicines were stored in an automated dispensing machine. Items not suitable for the automated dispensing machine, such as creams and other bulky items were stored on shelves throughout the dispensary. The dispensary had a sink with access to hot and cold water for professional use and handwashing. Staff facilities were hygienic with access to hot and cold water.

The pharmacy had a consultation room that accommodated one of the pharmacy's fridges for medicines requiring cold storage. And provided an area for storage. This did not prevent people from having private conversations with a member of the pharmacy team when requested. Lighting and temperature were kept to an appropriate level throughout.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy services safely and effectively. And they make them easily accessible to people. Team members generally store and manage medicines appropriately and they mostly complete the required checks to demonstrate they are fit for use.

Inspector's evidence

The pharmacy had good physical access by means of a ramp that led to the front door. It advertised its opening hours and the services it provided in the main door and windows. And it advertised information about services available in the local community such as help to stop smoking. The pharmacy had the facilities to provide large print labels to help people with visual impairments take their medicines safely. And team members could access a translator service to communicate with people who did not use English as their first language.

The pharmacy purchased medicines and medical devices from recognised suppliers. And it stored them in the manufacturers original packaging. Team members supplied owing's slips to people when they could not supply the full quantity of a medicine prescribed. And they contacted the prescriber when a manufacturer was unable to supply a medicine, to arrange an alternative treatment. The pharmacy used three well-organised fridges to store its medicines and prescriptions awaiting collection that required cold storage. The fridges were operating within the recommended limits of between 2 and 8 degrees Celsius at the time of inspection. Team members aimed to record the temperatures daily, but records showed several dates within the last month where temperatures had not been recorded. And showed one fridge temperature had exceeded the maximum temperature recommended. Team members had documented their actions following the initial temperature reading, but they did not always record the temperature following the reset to ensure it was operating within the recommended limits.

The pharmacy used an automated dispensing machine to assist team members during the dispensing process. They entered the prescription data on the patient medication record (PMR). When the information was entered medicines required for the prescription and stored inside the machine were selected using barcode technology. The medicines were then delivered to the specific area the team member was working at. Prescription labels were printed and applied to the medicines before a final accuracy check. Team members used coloured baskets to prioritise workload and separate people's prescriptions, so medicines did not become mixed up. And they signed dispensing labels to show who had dispensed and checked each medicine so there was an audit trail of those involved for each stage of the process. They attached coloured stickers to the outside of the bags of dispensed medicines to indicate they contained a fridge line, CD or higher-risk medicine that required further counselling. This included for valproate-containing medicines. Team members were aware of the Pregnancy Prevention Programme and the risks associated with supplying valproate-containing medicines. They supplied valproate out with the manufacturers original packaging to one person in a multi-compartment compliance pack. They had assessed the risk and found this as being the most appropriate way in which the person should receive this medicine.

The pharmacy received Medicines Healthcare and Regulatory Agency (MHRA) patient safety alerts and product recalls via email and actioned these on receipt. They kept paper-based records of action taken

and records seen showed a signature audit trail for future reference. But the inspector highlighted the latest MHRA recall to team members which had not yet been actioned. And they provided assurances they would make this a priority to action. Team members checked the expiry dates of medicines and recorded their actions on a date checking matrix. And they attached coloured stickers to boxes of medicines with a shorter expiry date to indicate they should be used first. Records seen showed date checking was up to date and a sample of 20 medicines showed none had expired. A team member explained how the pharmacy managed the date checking of medicines stored within the automated dispensing machine. Medicines that had an expiry date of longer than six months were entered into the machine using barcode technology to record the batch number and expiry date of the medicine. For medicines that had an expiry date of less than six months, team members entered the details manually and recorded expiry dates on the electronic system. The electronic software produced a list of medicines due to expire stored within the machine and team members described how they output these medicines and dispose of them safely. The pharmacy used an electronic mobile application that allowed people to order their repeat prescription online and receive updates such as alerts to when their prescription was ready for collection.

Some people received serial prescriptions under the Medicines: Care and Review service. Team members prepared prescriptions in advance of people's expected collection dates. They kept records of each supply and expected collection dates, this helped manage workload within the pharmacy and allowed the pharmacist to identify issues with people not taking their medicines as they should. The pharmacy provided a large number of medicines in multi-compartment compliance packs for people who needed help to take their medicines. Team members managed this workload on a four-week cycle, this allowed them time to resolve any queries with people's medication. At the time of inspection, they were behind with the workload and there was a number of multi-compartment compliance packs awaiting a final accuracy check. Team members had secured the packs with a band and included empty boxes of medicines used so the RP could check the expiry dates and ensure medicines were fit to supply. They kept a checklist sheet of the process which included details such as when the prescription was requested from the GP practice, and who it was labelled and dispensed by. They kept records of people's current medicines and administration times on a master sheet. This was checked against prescriptions before dispensing. Team members kept records of any changes to people's medication for example if a medicines strength had been increased or decreased. And they recorded the date the change had been communicated. They attached backing sheets to each pack which included details such as specific mandatory warnings for each medicine, directions for use and a description of what each medicine looked like. And they supplied patient information leaflets (PILs) every month, so people had up to date information relating to their medicines. Some people received their multi-compartment compliance packs as a monthly supply or had designated a safe space for a delivery of a pack to be left for example, in a key safe or a safe place. Team members assessed the risk of supplying medicines this way. And they kept records of this and communicated this to the persons GP.

The pharmacy provided a local NHS injection equipment provision service. This included providing equipment, as well as advice and information that may be of use. Team members were trained to ask the appropriate questions. And they kept non-identifiable patient information by using reference numbers on an online platform. They were supported by local substance misuse colleagues. Team members were trained to provide the NHS Pharmacy First service within their competence and under the supervision of a pharmacist. Team members gathered relevant information before referring to the pharmacist for treatment. The pharmacist provided treatment for common conditions such as skin infections and urinary tract infections under a Patient Group Direction (PGD). The pharmacy kept well-organised paper-based records of treatment provided and referral decisions. And they communicated these to people's GPs to ensure their medical records were kept up to date.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment that it needs to provide its services. And team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had access to internet services to allow team members to access up-to-date electronic resources such as The British National Formulary (BNF) and Stockley's interaction checker, to support them in their roles.

The pharmacy had a set of clean CE-stamped cylinders and tablet counters that were fit for use. It used an automated dispensing pump to dispense substance misuse liquid medicines. The RP calibrated the pump each morning to ensure it measured accurate doses. And it was cleaned regularly to ensure it remained fit for use. The pharmacy used an automated dispensing machine to store most of its medicines in original packs. Team members were trained to use the system and had details for a service line when they needed help to resolve any problems with the automated dispensing machine.

Prescriptions awaiting collection were stored in a retrieval area in the dispensary. And confidential information was not visible from the retail area. Computers were password protected and positioned in a way that prevented unauthorised view. And cordless telephones were in use to allow 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.