General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, The Fauldhouse Partnership Centre, Lanrigg Road, Fauldhouse, BATHGATE, West Lothian, EH47 9JD

Pharmacy reference: 1105528

Type of pharmacy: Community

Date of inspection: 27/09/2021

Pharmacy context

This is a community pharmacy within a partnership centre in a village. The partnership centre included two GP practices, other healthcare services, community services and sports and fitness facilities. The pharmacy dispenses NHS prescriptions received directly from the GP practices and from people walking into the pharmacy. And it is part of the local NHS palliative care network. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. The pharmacy works closely with another Well pharmacy in the village to provide a range of services. The inspection was carried out during the COVID-19 pandemic.

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	1.1	Standard not met	The pharmacy does not identify and assess key risks to patient safety. Team members do not always follow the standard written procedures for services and tasks, resulting in disorganised workflow. This includes for the dispensing processes and storage of medicines.
		1.2	Standard not met	The pharmacy does not monitor and review the safety and quality of its services even though the team is working under pressure. And team members record few mistakes. They do not use this limited information to review the safety of their services.
		1.6	Standard not met	The pharmacy does not always keep accurate records as it is required to do by law. This includes the Responsible Pharmacist record.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not always have enough suitably qualified and experienced team members who regularly work in the pharmacy. And sometimes team members from other pharmacies support the pharmacy. But they are not always familiar with some of the processes. This means the team struggles to manage the workload.
		2.2	Standard not met	Some team members working in the pharmacy do not have the necessary skills and competence for their roles. The pharmacy has not adequately trained them in some dispensing tasks, such as 'hub and spoke' processes and managed repeat dispensing.
		2.5	Standard not met	Team members raise concerns and provide feedback to improve services. But it is not clear whether this feedback is suitably acted upon by the right people.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy does not provide a suitable professional healthcare environment. Some areas of the premises are cluttered, untidy and disorganised.

Principle	Principle finding	Exception standard reference	Notable practice	Why
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy does not have adequate control of the way it delivers its services. The workflow is disorganised as the pharmacy is behind completing the workload. And this leads to increased pressure on the delivery of services.
		4.3	Standard not met	The pharmacy does not always store and manage its medicines appropriately. This includes separation of medicines in dispensary storage areas, date checking and disposal of returned and obsolete medicines.
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 and manage the risks associated with its services, including dispensing processes and stock management. And team members do not always follow written processes so there is a risk of mistakes. They only record a few of the mistakes they make. And they do not review their mistakes or the way they are working. This means the team members are missing learning opportunities. The pharmacy keeps the records that it should. But some are incomplete and do not meet the requirements of legislation. Team members keep people's private information secure. And they know their role in helping protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) available electronically. But a team member explained that she had not accessed them for around six months so she may not have read and signed any issued over the past few months. Some were not being followed, for example, dealing with prescriptions being dispensed at an off-site 'hub'; and management of controlled drugs including running balance audits. And systems in the pharmacy were chaotic. The only regular team member present described her role including giving examples of tasks she had not been trained to undertake. This included auditing controlled drug running balances. She knew which activities could not be undertaken in the absence of the pharmacist and when there was not a responsible pharmacist signed in. Recently the pharmacy had suffered challenges caused by a lack of pharmacists, so these restrictions had been a reality.

Team members were observed working in a chaotic manner because systems were not embedded. They spent a lot of time trying to find prescriptions and dispensed medicines. Team members continued in this manner and the pharmacy had not taken time to assess the safety and quality of the systems and processes. The team members recorded a few errors they made, known as near miss errors but the information had not been used to assess the current safety of services. And as only a few were recorded it was not possible to identify trends and relate back to their current ways of working. The pharmacy had a complaints procedure. It was receiving complaints currently because of prescription medicines not being ready as expected and this was observed. Team members politely apologised to people and arranged to supply their medicines as soon as they could. Some people misunderstood messages sent from the GP practices about when their prescriptions were ready. Sometimes they assumed this was when their medicines would be ready for collection from the pharmacy, so their expectations were not always met resulting in complaints to the pharmacy. The area manager was to meet the surgery teams soon and this was one topic for discussion.

The pharmacy had an indemnity insurance certificate, expiring 30 June 2022. The pharmacy displayed the responsible pharmacist notice and had a responsible pharmacist log but there were several days with no entries. For example, no entry for 23,24,26 July, and 6,7,9,10,11,17 August. The pharmacy had controlled drugs (CD) registers with running balances maintained but it had not audited these for three months. The dispenser present who was the team leader had not been trained to do this. The area manager had done the most recent audit. The pharmacy had a CD destruction register for patient returned medicines, but team members present were not able to find this on the electronic register, so it was not seen during the inspection. An item had been returned from a GP practice and no record

made. Records of private prescriptions and supplies of unlicensed medicines were not seen.

Pharmacy team members present were aware of the need for confidentiality. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members present had awareness of safeguarding. They would speak to the GP practice teams in the first instance if they had concerns.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not have enough regular, suitably qualified and experienced team members to safely provide its services. And team members helping out in an adhoc way do not have the experience of the pharmacy's processes to work effectively. This means the pharmacy struggles to manage the workload. Team members know how to raise concerns. But on occasions feedback does not reassure them services will improve. The team works hard so that people can receive their medicines.

Inspector's evidence

The pharmacy had one dispenser working 28 hours per week, appointed recently as team leader. But there did not seem to be any other permanent team members. The pharmacy was usually staffed with team members from other pharmacies who were not always familiar with processes here. And it was reported that often they were not trained in some of the processes such as hub and spoke dispensing, and managed repeat prescription ordering and dispensing. At the time of inspection there was a locum pharmacist who had not worked in the pharmacy before, and the team leader. During the inspection a dispenser from Glasgow arrived. A team member who had started the previous week in the other branch came to help for 20 minutes over lunchtime. But she was not trained and had not yet read SOPs so was limited in what she could do to help. The area manager had been in the pharmacy earlier that day to offer support. She was a dispenser. Team members were not able to manage the workload. There was no pharmacist continuity with different locums working each day. The team leader described one locum pharmacist who had worked two days some weeks providing a little stability and continuity as they had become familiar with the pharmacy. One day the previous week the pharmacy reported it had closed its doors to people at 4pm to try and catch up. The team leader described the ongoing environment where there was no time to fully complete tasks. And she felt the lack of continuity of pharmacists and team members contributed to this. An example was a pharmacist accepting obsolete stock from a GP practice two weeks previously, and leaving a note on it for the next pharmacist the following day. It was observed during the inspection and had not been dealt with. The surgery would have its own arrangements in place for the destruction of obsolete medicines. The pharmacy did not provide any learning time during the working day for team members to read SOPs or other material to keep their knowledge up to date.

Team members were observed working in a chaotic manner because systems were not embedded. They spent a lot of time trying to find prescriptions and dispensed medicines. And they spent time apologising to people and trying to understand the details of each situation. They were observed to do this in a polite and professional manner.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. But they were often not recording incidents and the pharmacy did not have meetings to discuss these. The team leader had recently emailed a member of senior management expressing her concerns. She felt she had not received a satisfactory response. A team member had suggested to the regional manager that for a short time the pharmacy change its opening hours to 10am – 5pm instead of 9am – 6pm to help address the workload and staff shortage. But this had not been agreed to. It was noted that there was a focus to regularly ensure that the ‘deal of the week’ was implemented in the retail area.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy premises do not adequately provide a suitable professional healthcare environment. Some areas of the pharmacy premises are cluttered, untidy and disorganised. This contributes to chaotic processes and increases the risk of mistakes. The pharmacy has adequate facilities for people to have conversations with team members in private. The pharmacy is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area and dispensary. There was a sink in the dispensary with hot and cold running water. Team members used toilet facilities in the partnership centre.

People were not able to see activities being undertaken in the dispensary. It was cluttered and disorganised with baskets of dispensed medicines for the pharmacist to check, and baskets containing prescriptions not yet dispensed. These were not stored logically due to the general untidiness. The pharmacy had a consultation room which was small. And it was too cluttered with show material to use. Team members addressed this by using a quiet corner of the retail area to have private conversations with people. The area behind the medicines' counter was cluttered and congested with totes containing stock, making it difficult for team members to work behind the counter and reach some products. Temperature and lighting felt comfortable.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always have adequate safeguards in place to ensure it delivers its services safely and effectively. And it doesn't store and manage all its medicines appropriately. It doesn't store and dispose of returned medicines in a timely manner. People can access the pharmacy's services. And the team signposts people when it cannot provide some services.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. And it had a door directly from the partnership centre. It listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to the other village pharmacy for opiate replacement therapy and supply of medicines in multi-compartment compliance packs. And it signposted people to practice nurses to access the smoking cessation service, as it did not have capacity to provide this service currently. It could provide large print labels for people with impaired vision. The pharmacy sometimes closed over lunchtime to help it catch up with the backlog of dispensing. The NHS contract was continuous over lunchtime and a team member did not know if the health board was always notified. She explained that if the pharmacy closed, it was not at the same time as the other local branch to ensure pharmaceutical services were available in the village as much as possible.

Pharmacy team members were not following a logical or methodical workflow for dispensing due to a backlog. They were several days behind with routine dispensing. They tried to generate labels soon after receiving prescriptions from the surgery, but they had not managed to do this for prescriptions received the previous day. This meant that there may not be stock for these prescriptions. Labelling generated an order for stock. After labelling team members placed prescriptions and labels in baskets labelled with the date of receipt. Baskets were observed dated for the three previous working days. Two baskets with the same date were observed in different locations. No-one knew why. This meant that even trained and competent team members could not follow standard processes, resulting in a chaotic situation. 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. But this had slipped recently due to the backlog of routine dispensing. Sometimes the balance had not been dispensed and team members could not find prescriptions when people came to the pharmacy to collect the balance of their medicine. Sometimes this was because prescriptions had not been filed in the correct place. Workflow was interrupted when pharmacy team members had to query prescriptions with the surgery and prioritise the dispensing of prescriptions marked 'urgent'.
The communication between the pharmacy and the GP practices was not consistent. A pharmacy team member checked the NHS email account twice a day. The NHS incontinence service sent orders for people to the pharmacy via email. As with some other services, this had been moved to the other local branch, but currently there was no-one in the other branch with an NHS email address. So, the team in this branch provided these orders to the other branch. This pharmacy provided the NHS palliative care service. But it was difficult to find the time to audit stock meaning that the pharmacy may not have sufficient to fulfil prescriptions. There had been a recent example of this resulting in a complaint. The team member present explained that she had tried to address this by asking the practice nurses to

highlight the most commonly used items. When she could, the team member checked availability of these items.

Some repeat prescription dispensing was undertaken at an off-site hub. But due to lack of time and the inexperienced team, some team members did not follow the correct process for reconciling these dispensed medicines with prescriptions. So, some medicines were supplied to people without the prescription. And prescriptions were not properly filed or sent for processing as they should be. This resulted in the system not being reliable. And there was not always an audit trail to show what stage prescriptions were at. Several examples were described of the electronic system saying medicines had been supplied, but people saying they had not received their medicine. Team members spent considerable time trying to resolve these issues. During the inspection examples were observed of the pharmacist asking the surgery to re-print prescriptions, then dispensing them again. These re-prints were not signed but the pharmacist felt comfortable making the supply as she could see on the computer that there had been a signed and valid prescription that could not be located now. The risk in this situation was that the person received the medicines twice. And looking into this and addressing by re-dispensing took time, therefore interfering with the routine workflow. The team member present described this as common practice. One example observed was of a person becoming very angry because he had been told over a week ago by the surgery that his prescription was at the pharmacy. It could not be found. The pharmacist dealt very calmly and professionally with this difficult situation. The company had hand-held devices that the teams used to scan dispensed medicines out. But many locum pharmacists had not been trained to use these, which largely contributed to this problem. A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. They or a team member supplied written information and record books if required. The pharmacy supplied a variety of medicines by instalment. A team member dispensed the instalment ‘at the last minute’, often when the person came to the pharmacy or shortly before. Most team members did not use PC70 forms. These were not required for non-controlled-drug items but were an invaluable way of recording when medicines were supplied. The SOP was not being followed, with different pharmacists following different processes. The pharmacy stored prescriptions in individually named baskets on labelled shelves.

The pharmacy had patient group directions (PGDs) in place for the NHS services including unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and chlamydia treatment. But some locum pharmacists were not trained or signed up to them all meaning that there was inconsistency with which services could be provided. But this was not a big issue as the pharmacy was mainly focussing on dispensing prescribed medicines. The pharmacy supplied lateral flow tests to people and delivered the Pharmacy First service when it could. But these were not always documented as some team members were not trained, and they struggled to find time for administrative tasks. Over recent years and months the two Well pharmacies in the village had worked closely and shared services to make them as efficient as possible. This resulted in this pharmacy not providing opiate replacement therapy or multi-compartment compliance packs. They were supplied from the other branch a very short distance away. When staffing levels were appropriate this worked well, and the community and GP practices knew which pharmacy delivered the different services. The pharmacy was not offering flu vaccination this season due to the unstable staffing situation. But the online booking system had not been paused, and the pharmacy had received stock. The area manager was aware and addressing this. Similarly, the pharmacy was not offering the NHS smoking cessation service and was signposting people to the nurse-led service in the GP practices.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. The pharmacy stored most medicines in original packaging on shelves, in drawers and in cupboards. But open packs used by pharmacists to help with their accuracy checking were not returned to drawers and shelves but

placed into baskets then totes. This meant that they would not be easy to find if needed for dispensing. And multiple packs of the same medication could be open. The controlled drug cupboard was untidy and congested. Stock, patient returned items, date expired items and dispensed items due for supply were stored together, presenting a risk of inadvertent supply of the wrong medicine or an obsolete item. The pharmacy kept the non-CD palliative medicines segregated in a drawer. But it was untidy which could contribute to selection errors. Team members had previously checked expiry dates of medicines regularly but had not done this for at least six months. Several items were observed out of date on shelves, in drawers and among other items in the CD cabinet. The pharmacy had a large quantity of an item that had been ordered in error. These items were in a tote on the floor and had been there too long to apply to return them. There was a large quantity of patient-returned medicines, mostly in bags, stacked up in a corner of the dispensary. These were taking a lot of space. And team members had not had time to check the contents of the bags, or to place them in the appropriate receptacles for disposal. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. The temperatures recorded were within the standard accepted range. The pharmacy protected pharmacy (P) medicines from self-selection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to deliver its services. And team members look after this equipment to ensure it is safe for use.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used. And it had crown-stamped measures and clean tablet and capsule counters in the dispensary. The pharmacy stored paper records in the dispensary inaccessible to the public. And it stored prescription medication waiting to be collected in a way that prevented people's information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave them unattended unless they were locked.

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.