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: 18/05/2022

Pharmacy context

This is a community pharmacy within a partnership centre in the village of Fauldhouse. The partnership centre includes 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 and sells a range of over-the-counter medicines. It offers the NHS smoking cessation service, and HbA1C testing for eligible people as part of a local pilot scheme. 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 met**

Required Action: None

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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 suitably identifies and manages the risks associated with its services, including reducing the infection risk during the recent pandemic. The pharmacy team members follow written processes for the pharmacy's services to help ensure they provide them safely. They record and review their mistakes to learn from them and make changes to avoid the same mistakes happening again. The pharmacy keeps people's private information safe and team members know who to contact if they have concerns about vulnerable people. The pharmacy keeps most records as it should by law.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. Until recently it had a screen up at the medicines' counter, but the team had removed it when it became damaged. Team members wore fluid-resistant face masks, and a few people using the pharmacy wore face coverings. The Scottish Government recommended face coverings to be worn in healthcare settings, but it was no longer mandatory. Team members washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points daily. The pharmacy had hand sanitiser at the premises entrance for people using the pharmacy to use, and some in the dispensary and other areas for team members' use.

The pharmacy had standard operating procedures (SOPs) available electronically which team members followed. They had read them, and the pharmacy kept records of this. Sometimes team members re-read individual SOPs as a reminder of the process to be followed, especially if they or the pharmacist identified that they may not be following a process. Team members described examples. The pharmacy superintendent reviewed the SOPs every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. And each team member had SOPs tailored to their role available to them electronically. Team members described their roles and accurately explained which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. And team members followed a well-defined process for managing prescriptions that were assembled at an off-site hub. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members recorded dispensing errors that were identified in the pharmacy, known as near miss errors. And they recorded errors that had been identified after people received their medicines. They reviewed all near misses and errors each month to learn from them and they introduced strategies to reduce the chance of the same error happening again. The team was in the process of re-arranging medicines on shelves and in drawers to ensure commonly used items were on shelves where they were more visible than they had been in drawers. Team members had identified that sometimes errors occurred when they could not see items clearly in drawers. The pharmacy had a complaints procedure and welcomed feedback. Team members described recent positive feedback from people who were receiving a better service from the pharmacy than at the time of the last inspection. This was reflected in people returning to this pharmacy after a period using a pharmacy in a nearby village.

The pharmacy had an indemnity insurance certificate, expiring 30 June 2022. The pharmacy displayed

the responsible pharmacist (RP) notice and kept a responsible pharmacist record. It showed that a responsible pharmacist was on the premises daily from 9am – 6pm (i.e., the pharmacy opening hours). The record showed two days when the pharmacist had arrived late. A team member explained this was due to unplanned absence. The pharmacy did not open until the RP was on the premises. A team member placed a notice on the door to inform people and told the GP practices. The pharmacy had an electronic private prescription record, but there were no entries in it. A team member explained that the pharmacy seldom received private prescriptions, but they thought there had been one a few months ago. At the time of inspection, the team could not produce any private prescriptions. There was a legal requirement to keep records of private prescriptions, including records of emergency supplies and veterinary prescriptions. Without complete records the pharmacy may be missing opportunities to offer advice about medicines to people. The pharmacy kept paperwork such as invoices and certificates of conformity for unlicensed medicines, but it did not keep records of the people it had supplied with these. This was a legal requirement. And it could mean that if for example there was a recall for one of these medicines, the pharmacy would not know who to contact. The pharmacy had controlled drugs (CD) registers with running balances maintained and regularly audited. Team members recorded unused medicines returned by people into these registers as quarantined but did not keep a separate register recording details of who had returned the medicines or when they had been destroyed. This could cause confusion and did not provide clarity between obsolete medicines and stock fit for the pharmacy to supply to people.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and covered the topic in their accredited courses which they were in the process of undertaking. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members took phone-calls discreetly to avoid conversations being overheard. Team members had also read a SOP and undertaken basic training on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. Team members described examples of the delivery driver sharing concerns regarding people who had not answered their door as expected. The pharmacy team followed-up these concerns by contacting the GP practice. An example was described of a GP changing a person's medicines regime to better suit the situation. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained and competent team members to safely provide its services. It supports team members by providing time for training. Inexperienced team members are well supported and know how to seek guidance if required. Team members make decisions within their competence to help provide safe services to people. They know how to raise concerns if they have any to keep the pharmacy safe.

Inspector's evidence

The pharmacy had a full-time pharmacist manager, one full-time and three part-time trainee dispensers, and a part-time delivery driver. Typically, there were three team members and a pharmacist working at most times. One day per week, when the pharmacy was quiet, there were two team members, and later in the week during busier times there were four team members. The pharmacy had recently successfully recruited, and a team member was starting this week to work across the two pharmacies in the village. At the time of inspection there were three team members and a locum pharmacist. The regular pharmacist was on annual leave which as being covered by two locum pharmacists, which provided some continuity. Most team members including the pharmacist manager had worked in the pharmacy for a few months, starting after the previous inspection when there were not enough team members. Team members were able to manage the workload and supported the locum pharmacist. They described the processes they followed and were confident and competent in dispensing procedures. When new team members had started the pharmacy had registered them on induction training, then accredited courses for dispensing and working on the medicines' counter. The pharmacy provided time for them to undertake the training. And the pharmacist supported team members, coaching them 'on-the-job' on procedures, and ensuring learning was embedded and consolidated. Team members described asking the pharmacist questions related their course work, and the pharmacist giving full responses and confirming team members' understanding. One team member had completed their course work and was ready to sit the final exam. The pharmacy also provided time for team members to read and understand SOPs. They described examples of the pharmacist encouraging them to re-visit SOPs when there was any suggestion that they may not be following them. Recently the health board had provided training to the pharmacist and two team members on how to monitor HbA1C in certain people with diabetes.

Team members were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. A team member described an example of referring a person to their GP. Team members were encouraged to make decisions within their competence to help people. A team member described making calls to the GP practices or the other pharmacy to address straightforward queries. Usually, team members told the pharmacist what they were doing but only asked for advice if the query was out with their competence.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the manager or area

manager. Team members gave appropriate responses to scenarios posed. They knew how to contact the area manager and were aware of the company whistle blowing policy. The company set targets for various parameters. Team members described how they used these, only offering services to people when they believed they would be of benefit. One example described was the text messaging service. The process was working well in the pharmacy and people who were signed up to this were notified when their medicines were ready to collect, saving wasted journeys to the pharmacy. Team members explained that people had to be able to trust the system, so it was important to follow the process carefully, which they did.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and suitable for the pharmacy services provided. The pharmacy has suitable facilities for people to have conversations with team members in private.

Inspector's evidence

These were average-sized premises incorporating a retail area and dispensary. The pharmacy premises were located within a building providing a variety of services. The pharmacy had an external door, and access through to the main building, although this was not currently in use. 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 observed to be tidy and clear of ‘clutter’, which was a great improvement from the last inspection. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. Temperature and lighting throughout the premises felt comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people access its services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with suitable information and advice to help them use their medicines. And they provide extra written information to people taking higher-risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. Pharmacy team members 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 an automatic door. 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 services and supply of medicines in multi-compartment compliance packs. The pharmacy could provide large print labels for people with impaired vision. Team members wore badges showing their name and role. The pharmacy was currently closing over lunchtime to enable team members to have a break. And sometimes at busy times, team members used this time to catch up with dispensing. The two village pharmacies worked closely and did not close at the same time. This was approved by the health board. The pharmacy provided a delivery service.

Some repeat prescription dispensing was undertaken at an off-site hub. A team member discussed this with people to ensure they were aware that their medicines were not dispensed in the pharmacy. And people could opt out at any time if they would prefer their medicines to be dispensed locally. The pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. They prioritised 'walk-in' prescriptions and highlighted to the pharmacist when these medicines were ready to be checked and supplied to people. The pharmacy received prescriptions directly from the surgery twice a day. A team member worked on these as soon as possible, producing labels for medicines to be dispensed in the pharmacy, and starting the process for items to be dispensed by the off-site hub. The team member undertaking this process printed labels highlighting any drug interactions and new items. This enabled the pharmacist to carry out clinical checks. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacist sent prescription information electronically to the off-site hub once they had completed the clinical check. The pharmacy received the dispensed items the following day for data sent in the morning, and the day after for data sent in the afternoon. This was reliable, so enabled team members to give people realistic expectation of when they could collect their medicines. Some items including bulky items or those requiring cold storage were dispensed in the pharmacy rather than the of-site hub. When dispensed medicines were received from the hub, a team member scanned the bar codes on bag labels which highlighted if there were any additional locally dispensed items. Team members then placed these items together to ensure that the pharmacy supplied all items to people. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

The pharmacy supplied a variety of medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. They

were stored alphabetically in individually named baskets on labelled shelves. But some people had not collected their medicines. A team member explained the reasons, but the pharmacy had nothing documented. So, if that team member was not working, others may not know the situation, resulting in inappropriate action or medicines supply. The pharmacy did not supply medicines from 'Medicines Care Review' (MCR) serial prescriptions because the GP practices did not issue these.

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 had put the guidance from the valproate pregnancy prevention programme in place. And the pharmacist had counselled people appropriately and checked that they were on a pregnancy-prevention programme. Team members described how they would counsel people in response to scenarios posed.

The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), bridging contraception and chlamydia treatment. The locum pharmacist working at the time of the inspection was trained and signed up to deliver all PGDs in this health board area. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. The pharmacy kept the formulary beside the medicines' counter for team members to refer to. They documented consultations and referred to the pharmacist as required. The pharmacist always handed out dispensed medicines and gave people advice on how to use the medicines. The pharmacist delivered the smoking cessation service as other team members were not yet trained do provide it. Recently the pharmacy had started to offer HbA1C tests to eligible people with diabetes. Team members described the criteria for eligibility. The pharmacist and two team members were trained to provide this service which was a local NHS pilot.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. And team members mostly used space well to segregate stock, dispensed items, and obsolete items. The pharmacy kept the non-controlled drug palliative care medicines segregated in a drawer. This enabled team members to monitor stock levels and ensure the pharmacy always had adequate stock of these items. The pharmacy stored items requiring cold storage in two fridges and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action 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 Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety 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 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.

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, although the team was not using it currently as part of the pharmacy's infection control measures. And it had equipment to measure HbA1C in some people with diabetes. The health board provided the equipment, and it was maintained as per the manufacturer's guidance. Team members kept 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.