General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Charlestown Pharmacy, The Surgery, 1A Main Road, Charlestown, DUNFERMLINE, Fife, KY11 3ED

Pharmacy reference: 1106256

Type of pharmacy: Community

Date of inspection: 12/09/2022

Pharmacy context

This is a community pharmacy attached to the GP surgery in the village of Charlestown, Fife. Its main activity is dispensing NHS prescriptions. And it supplies medicines in multi-compartment compliance packs to some people who need help remembering to take their medicines at the right times. The pharmacy offers a medicines delivery service and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And it supplies a range of over-the-counter medicines.

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 has written procedures for its team members to follow to help them safely carry out tasks. They keep the records they need to by law, and they safely keep people's private information. The team is adequately equipped to manage any safeguarding concerns. Team members record and report details of mistakes they make while dispensing and learn from these to reduce the risk of further mistakes.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had hand sanitiser at the medicines' counter and a limit to the number of people allowed in the premises at one time.

The pharmacy had a set of written standard operating procedures (SOPs), and it could show that team members had read and agreed to follow them. The SOPs covered tasks such as dispensing prescription items and selling medicines. Team members described their roles within the pharmacy and the processes they were involved in and accurately explained which activities could not be undertaken in the absence of the pharmacist. Team members had reviewed SOPs within the last year. They were able to describe the process for branch closure when there was no pharmacist available.

Team members kept records of dispensing mistakes that were identified in the pharmacy, known as near misses. And they recorded errors that had been identified after people received their medicines. They reviewed all near misses and errors at regular team meetings to learn from them and they introduced strategies to minimise the chances of the same error happening again. For example, a team member described separating two medicines with names that looked and sounded alike (sertraline and sildenafil) on the shelf. And they gave another example where they highlighted two different preparations of the same drug with similar packaging. The team made these changes after reflecting on incidents involving these medicines.

The pharmacy had current indemnity insurance. The pharmacy displayed the correct responsible pharmacist notice and had an accurate responsible pharmacist record. From the records seen, it had accurate private prescription records including records about emergency supplies and veterinary prescriptions. It kept complete records for unlicensed medicines. The pharmacy kept electronic controlled drug (CD) records with running balances. A random balance check of three controlled drugs matched the balance recorded in the register. Stock balances were observed to be checked on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Team members had restricted access to a password-protected computer terminal linked to the GP practice. And they could use this system to send patient-specific medication queries to the GP team. The electronic messages were logged directly on the person's general practice record. This created an audit trail of communication between the pharmacy and GP practice. Pharmacy team members were aware of the need to protect people's information. They separated confidential waste for secure destruction by an external company. No person-identifiable information was visible to the public. The

pharmacy had a documented procedure to help its team members raise any concerns they may have about the safeguarding of vulnerable adults and children. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. Team members gave examples of hypothetical situations where they would raise concerns to the RP. They were aware of the Ask for ANI (action needed immediately) system to help people suffering domestic abuse access a safe place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the necessary qualifications and skills to provide the pharmacy's services. They manage their workload well and support each other as they work. They feel comfortable raising concerns, giving feedback and suggesting improvements to provide a more effective service. And the pharmacy has adequate procedures in place to help its team manage the workload in the event of unplanned staff absence.

Inspector's evidence

The pharmacy employed a part-time medicines counter assistant and three part-time dispensers. One of the dispensers also held managerial responsibilities. The pharmacy held their certificates of qualification. Pharmacist cover was provided by the Superintendent pharmacist (SI) on two days each week with two regular locums covering the other days. Typically, there were two team members working at most times with a pharmacist.

Team members were seen to be managing the workload well. Team members spoken to during the inspection were experienced in their roles and most of them had been working at the pharmacy for several years. They demonstrated a good rapport with many people who visited the pharmacy and were seen appropriately helping people manage their healthcare needs. The pharmacy reviewed its staffing levels regularly. Part-time team members had some scope to work flexibly providing contingency for absence.

A team member had recently submitted their technician training portfolio and described having support to complete coursework. A trainee medicines counter assistant was observed being supervised in their role and was able to describe the training plan that they were working through. Team members had periodic reviews with the pharmacy manager to identify their learning needs.

Team members were going about their work competently. They asked appropriate questions when supplying over-the-counter medicines 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. 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 SI. The pharmacy team discussed incidents together and how to reduce risks. And the team had occasional team meetings.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises clean, secure, and well maintained. It has a suitable, sound-proofed room where people can have private conversations with team members.

Inspector's evidence

These were small premises incorporating a small retail area and dispensary with space to operate safely but with limited storage space. Staff facilities were accessed in the adjoining general practice premises. The premises were clean, hygienic, and well maintained. There was a sink in the dispensary with hot and cold running water, soap, and clean hand towels. Its overall appearance was professional. The pharmacy had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions. People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk and chairs. The door closed which provided privacy. Temperature and lighting were comfortable throughout the premises. A team member described plans to alter the premises within the next six months to incorporate a larger dispensary area and modified consultation room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people. And it manages its services well to help people look after their health. The pharmacy correctly sources its medicines, and it completes regular checks of them to make sure they are in date and suitable to supply. And the pharmacy team provides advice to people when supplying medicines to them.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance. Team members assisted those who needed help opening the door. For example, people who used wheelchairs, or had prams. And the central pharmacy counters were low in height for those using wheelchairs. The pharmacy advertised its opening hours in the main window. And it could provide large-print labels for people with impaired vision. The pharmacy provided a delivery service on one day each week and people signed to acknowledge receipt of their medicines.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to separate people's medicines and prescriptions. And they used various stickers to attach to bags containing people's dispensed medicines to act as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a CD that needed handing out at the same time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. A team member prepared deliveries due each week and kept these together on a designated dispensary shelf. Prescription forms were retained until confirmation of delivery had been received. This ensured that team members were aware of the day's scheduled deliveries and was useful if people called the pharmacy asking about their expected delivery.

Most prescriptions were issued using 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy prepared these in advance on a four-weekly cycle. Prescriptions due to be collected on the same week were stored together on colour-coded shelves. The shelves were checked at the end of each week and any prescriptions that had not been collected after four weeks were removed from the shelf.
The pharmacy also notified the GP practice about these. The pharmacist often identified pharmaceutical care issues when discussing people's medicines with them. These included higher-risk medicines such as warfarin or methotrexate. When all episodes of the serial prescription were collected, the pharmacy notified the GP practice that a further prescription was required. This allowed time for the GP to review people before generating a new serial prescription. The pharmacy team then checked the new prescription on receipt to make sure all items had been received. They made a note on the patient medication record if a prescription item was changed or cancelled.

The pharmacy supplied medicines in multi-compartment compliance packs to people who needed extra support with their medicines. Pharmacy team members managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept master backing sheets for each person for each week of assembly. These master sheets documented the person's current medicines and administration time. Records of changes to medication were observed and the pharmacy retained written communication from the person's GP practice. This created a clear audit trail of any medication changes. Packs were labelled so people had written instructions about how to take their medicines. Pharmacy team members included descriptions of what the medicines looked like, so they could be

identified in the pack. Shelving to store the packs was kept neat and tidy. The pharmacy had a reference source with information about how stable most medicines were when removed from their original packaging. So, they knew which medicines were suitable to go in the compliance pack.

The pharmacy supplied a small number of other 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 in separate baskets on labelled shelves.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving higher-risk medicines including methotrexate, lithium, and warfarin. People were supplied with written information and record books if required. The pharmacy team were aware of the guidance for the valproate Pregnancy Prevention Programme. The pharmacy did not currently supply valproate to anyone in this group.

The pharmacy had patient group directions (PGDs) for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and impetigo treatment. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. The GP practice would regularly refer people for a consultation at the pharmacy as part of their triage service. Team members used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. The pharmacist was able to provide monitoring of people's blood pressure. They also passed the information to the practice if requested as part of ongoing monitoring of the persons treatment.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves, in drawers and in cupboards. And team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. Team members regularly checked expiry dates of medicines. They described the process for highlighting stock that would expire within six months. These items were highlighted with a red label on the packaging and the medicine's details added to a spreadsheet. The team checked the spreadsheet at the start of each month to ensure the team removed stock due to expire from the shelves. A selection of medicines inspected on the day were found to be in date. The pharmacy had disposal bins for expired and patient-returned stock.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records about what it had done on an electronic system. 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 provide safe services and it uses its facilities to suitably protect people's private information.

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 access to a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines.

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 blood pressure meter which was calibrated as per the manufacturer's guidance. Team members kept ISO-stamped measures by the sink in the dispensary. The pharmacy team kept clean tablet and capsule counters in the dispensary. People waiting at the counter could not read confidential information on computer screens. The pharmacy stored paper records in the dispensary inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented people's information being seen by anyone 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.