General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pathhead Pharmacy Ltd, 210 Main Street, PATHHEAD, Midlothian, EH37 5PP

Pharmacy reference: 1106443

Type of pharmacy: Community

Date of inspection: 04/03/2020

Pharmacy context

This is a community pharmacy beside a medical centre on the edge of a village, close to a city. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers the NHS smoking cessation service. The superintendent pharmacist works in the pharmacy two days per month.

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 written processes for all services to ensure that they provide them safely. They record mistakes to learn from them. And they review these and make changes to avoid the same mistakes happening again. The pharmacy asks people for feedback. And team members discuss this to make pharmacy services better. The pharmacy keeps all the records that it needs to by law and keeps people's private 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 and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. But some were overdue, and this was being addressed. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. A trainee pharmacy technician was aware of her limitations and took advice from colleagues. She had read the SOP on responsible pharmacist requirements. She was also aware of tasks she could not yet undertake such as dispensing controlled drugs and multi-compartment compliance packs. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. It had a business continuity plan to address maintenance issues or disruption to services. And it had contact details for suppliers and other healthcare professionals.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month and introduced strategies to avoid the same error happening again. The team did not make many errors. The most common error was incorrect quantities. The pharmacist reminded team members to mark packets on all sides after opening. They had also had some errors with inhaler types. The pharmacist had reminded them about different devices. The pharmacy had labelled shelves highlighting propranolol and promethazine which had been involved in incidents elsewhere. The trainee pharmacy technician kept her own near miss/error log to use for her own learning and development. This had highlighted that she was not always aware of different forms of tablet yet e.g. modified release preparations.

The pharmacy had a complaints procedure and welcomed feedback. It had NHS feedback leaflets available on the medicines' counter for people to complete. And it had a box to place them in discreetly. But people never used it. The pharmacy had received a few complaints about not receiving all their medicines together. This happened if the surgery provided prescriptions on different days which was a result of the surgery process. The pharmacy team members now asked people how many items they were expecting. And they had put a notice up reminding people to tell them how many items they were expecting. This had improved this situation although a team member stated that it was still not completely resolved.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. 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 (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP. They segregated confidential waste and shredded it. No person identifiable information was visible to the public. Team members had also read information on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. One team member was very knowledgeable from other work she did. The pharmacist was PVG registered for her work with the NHS, but not the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified or 'in-training' team members to provide safe services. Team members have access to training material to ensure that they have the skills they need. And the pharmacy gives them time to do this training during the working day. Team members can share information and make suggestions to improve ways of working and to keep the pharmacy safe. They know how to raise concerns if they have any.

Inspector's evidence

The pharmacy had the following staff: a pharmacist manager (working three days in the pharmacy and one day in the GP practice), a part-time regular pharmacist, and regular locum pharmacists, one full-time pharmacy technician, one trainee pharmacy technician two days per week, one full-time and one part-time dispenser. Typically, there were three team members and the pharmacist most mornings and either one or two team members in the afternoons. At the time of inspection, the regular pharmacist, the full-time experienced dispenser and the trainee pharmacy technician were working. They were able to manage the workload. But at times this was observed to be challenging during busy spells in the pharmacy. The pharmacist and dispenser were supporting and coaching the trainee team member, but this took them away from other tasks. They were supporting her well with a pleasant manner and giving thorough explanations. Sometimes team members came in to the pharmacy early to catch up on tasks. And some worked through their lunch break when the pharmacy was closed to catch up. The part-time dispenser, who was not present during the inspection, worked mainly on the medicines counter. This relieved pressure on dispensing team members who otherwise had to interrupt dispensing to serve on the counter. The pharmacy manager was reflecting on how to best manage this with the new NHS 'pharmacy first' service due to be implemented over the next few weeks. The trainee pharmacy technician worked two days per week in GP practices and attended college one day per week. The superintendent pharmacist worked two Saturdays per month. Part-time team members had some scope to work flexibly providing contingency for absence. The trainee pharmacy technician had not completed an accredited course on the sale of medicines. The pharmacist supervised her when she was on the medicines counter. The pharmacist was reminded that team members must be registered on an appropriate course within three months of starting their role.

The pharmacy provided learning time during the working day for all team members to undertake training as required. Over the past few months they had completed modules on duty of candour, analgesics and emergency adrenaline. The pharmacy was part of a voluntary network of pharmacies providing an anaphylaxis service. The team had discussed the new 'pharmacy first' service expected to be launched soon. The pharmacy did not use formal development plans, but the pharmacist was encouraging all team members to become competent in all tasks to provide skilled cover during annual leave. For example, the pharmacy technician typically managed the multi-compartment compliance packs with the dispenser labelling. But the pharmacist was encouraging all team members to learn the whole process.

The various individuals 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 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 pharmacy manager. E.g. a dispenser suggested relocating ophthalmic products to a more accessible area. And this was adopted. The dispenser and trainee pharmacy technician gave appropriate responses to scenarios posed. The pharmacy manager explained that she was meeting the pharmacy superintendent and another director the following week. They would discuss various topics related to the management of pharmacy services. The team did not formally meet but shared information during the working day. Team members discussed how they could develop services by promoting them to people that would benefit. They were aware of incidents and events in other pharmacies and reacted to these e.g. separating propranolol and prednisolone tablets. They also talked about similar sounding and looking medicines (lookalike soundalike, LASA). The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy services. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary and back shop area including storage space and staff facilities. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. The pharmacy also had a discreet area beside the medicines counter for specialist services such as substance misuse supervision. 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 support people by providing them with information and suitable advice to help them use their medicines. And they provide extra written information to people taking high-risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. The pharmacy team knows 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 could provide large print labels to help people with impaired vision. It displayed the NHS COVID-19 information and guidance on the door and at the medicines' counter.

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. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. They used labels to highlight expiry date of schedule three controlled drug prescriptions ensure these were not supplied unlawfully.

The pharmacy usually assembled owings later the same day or the following day. Most prescriptions were collected from the GP practice so people wouldn't know there was an owing item. The team member generated all labels for prescriptions and completed the assembly the following day when stock was received. If a person came to the pharmacy to collect their medicine before all stock was available, the owing was set up electronically.

The pharmacy technician who was not present mainly managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. She usually assembled these a week before the first pack was due for supply. But she tried to work ahead of that in advance of holidays. The pharmacy kept patient records alphabetically in two folders. They included profiles, changes and hospital discharges. The team member hand wrote tablet descriptions on to packaging. And she labelled the outside of packs with patient details and date of supply. The pharmacy stored completed packs in individually labelled boxes for each person on dedicated shelves. It supplied patient information leaflets (PILs) with the first pack of each prescription. Some people wished to have two or more packs supplied at the same time despite prescriptions stating 'dispense weekly'. The pharmacist was working with the GP practice to ensure medicines were supplied safely to people. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these weekly and stored instalments in named baskets on dedicated shelves in the dispensary. The pharmacist checked baskets each week to monitor compliance. And she took appropriate action e.g. contacting prescribers depending on the person and if she was concerned.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She 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. It had undertaken a search for

people in the ‘at-risk’ group and the pharmacist had counselled them appropriately. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. It had labels on shelves behind the medicines’ counter as an aide memoire for team members. They also discussed ‘sick day rules’ with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. 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, and chlamydia treatment. Team members discussed all requests for the minor ailments service (eMAS) with the pharmacist.

The pharmacist delivered the smoking cessation service using nicotine replacement therapy and Champix. Some people received treatment from the pharmacy under a shared care arrangement with other healthcare professionals. The pharmacy had some recent successes.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). It had equipment in the pharmacy and the software installed, but it was not working. The team members had been partially trained. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge and team members monitored minimum and maximum temperatures. They took appropriate 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. Team members were observed to check expiry dates as part of their dispensing process. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. The pharmacy was not part of the palliative care network. But due to its location, and proximity to the GP practice, it kept most items on the list. It had information on the wall including a complete list of palliative items and all the pharmacies in the health board area that were part of the network.

The pharmacy actioned MHRA recalls and 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 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 a carbon monoxide monitor maintained by the health board in the consultation room where it was used with people accessing its smoking cessation service. And it kept ISO marked measures by the sink in the dispensary, including separate marked ones for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left 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.