General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Wemyss Pharmacy, Unit 2 21 Main Road, East Wemyss, KIRKCALDY, Fife, KY1 4RE

Pharmacy reference: 1117359

Type of pharmacy: Community

Date of inspection: 06/04/2022

Pharmacy context

This is a community pharmacy beside other shops in a village. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a medicines' delivery service. And it 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. The inspection was completed during the COVID-19 pandemic.

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

Pharmacy team members follow good working practices. And they show they are managing dispensing risks to keep services safe. The pharmacy documents its mistakes and team members learn from them to improve the safety of services. The pharmacy keeps the records it needs to by law, and it suitably protects people's private information.

Inspector's evidence

The pharmacy had introduced new processes to manage the risks and help prevent the spread of coronavirus. Team members permitted a maximum of two people to enter the pharmacy at the one time. And floor markings helped people to keep a safe two metre distance from each other. The pharmacy provided hand sanitizer for people to use. And pharmacy team members had access to supplies throughout the dispensary. A plastic screen at the medicines counter acted as a protective barrier between team members and members of the public. The pharmacy team wore face masks throughout the day. This helped to protect colleagues from infections.

The pharmacy used documented working instructions to define the pharmacy's processes and procedures. And team members had recorded their signatures to show they had read and understood them. Sampling showed the superintendent pharmacist had last reviewed the procedures in June 2021. This included the 'assembly and dispensing' and the 'near-miss recording' procedures which were valid until May 2023. Pharmacy team members signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant that the pharmacist was able to identify dispensers to help them learn from their dispensing mistakes. Individuals recorded their own errors to help them reflect and to identify the root cause which they also recorded. This helped further to avoid making the same mistakes in the future. The pharmacist reviewed the near-miss errors at the end of the month to identify patterns and trends and to make improvements. They had recently identified a slight increase in the number of errors over the lunch-time period. Team members agreed to take more time with dispensing and to take extra care to minimise the risk of mistakes. They had also separated stock to manage the risk of selection errors. For example, sodium valproate Chrono/sodium valproate CR and imipramine/indapamide.

The pharmacy did not display a notice or provide information to help people complain if they needed to. But it had defined the process in a documented procedure which was valid until August 2023. Team members had evidenced they had read the procedure and knew how to effectively handle complaints. The pharmacist recorded dispensing incidents on a report template. The template included a section to record information about the root cause and the mitigations to improve patient safety. Sampling showed information about the wrong strength of medication being supplied in error. The report showed the superintendent had discussed the error with the team members involved so they could reflect and learn.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurances in place which were valid until 13 May 2022. The pharmacist displayed a responsible pharmacist notice, and it was visible from the waiting area. The RP record was up to date and showed which pharmacist had been on duty when the pharmacy was operating. Team members

maintained the controlled drug registers and kept them up to date. They checked and verified the stock once a month. And they checked methadone balances once a week just before dispensing. People returned controlled drugs they no longer needed for safe disposal. A destructions register showed the pharmacist had signed the records to confirm that destructions had taken place. Team members filed prescriptions so they could be easily retrieved if needed. And records of supplies against private prescriptions and supplies of 'specials’ were up to date. The pharmacy did not display a notice to inform people about how it used and processed their personal information. A policy that was valid until August 2023 provided team members with the knowledge and skills to protect people’s confidential information. For example, they knew to use a shredder to dispose of confidential waste. The pharmacy trained its team members to manage safeguarding concerns. A ‘protecting children and vulnerable adults’ policy was valid until August 2023 and provided a resource for team members to refer to. The pharmacy kept contact details for key agencies. And team members knew to speak to the pharmacist whenever they had cause for concern. This included concerns about failed deliveries or collections of multi-compartment compliance packs. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. This helped to protect children and vulnerable adults.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. They are proactive at learning and making improvements in the workplace. And they complete training to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's workload had increased only slightly since the start of the coronavirus pandemic. And the superintendent pharmacist had not needed to increase the number of team members, and levels had remained the same. The superintendent pharmacist worked at the pharmacy a few times a week. This was to provide cover for the regular pharmacist manager days off. And also to provide extra support as the second pharmacist. This helped the regular pharmacist complete regular tasks, such as controlled drug balance checks. Both the superintendent pharmacist and the pharmacist manager were 'pharmacist independent prescribers' (PIPs). They had not yet started providing the NHS Pharmacy First Plus service. And they were waiting on an extension being completed when they would have improved consultation room facilities. The pharmacy team was well-established and training certificates on the dispensary wall showed each team members qualifications.

The team included one full-time pharmacist with occasional double cover provided by the superintendent pharmacist, two full-time dispensers, one part-time dispenser, one part-time trainee dispenser, one part-time trainee medicines counter assistant, one part-time delivery driver and one trainee medicines counter assistant that worked every Saturday. Team members discussed their annual leave requirements to ensure sufficient cover. And they used a large wall planner to record their leave. This helped them to put contingency arrangements into place and to plan their workload in advance. The pharmacist allocated protected learning time so that trainees were supported. This was calculated at 10% of their regular working hours. They allocated three hours on a Tuesday to the trainee dispenser, and three hours every Monday to the trainee medicines counter assistant.

The pharmacist supported team members to learn. And they had arranged for them to be registered with TURAS. This was NHS Education for Scotland's single, unified learning platform.
A dispenser produced a pharmacy procedure for providing the NHS Pharmacy First scheme. It showed a requirement for team members to log on to TURAS and complete learning about the scheme before being deemed competent to participate in it. All team members had signed the procedure to show they had completed the learning. The pharmacist carried out individual performance reviews so that team members could develop. One of the dispensers had asked for more learning opportunities, which had been agreed. And two team members were refreshing their knowledge and skills to work at the medicines counter. The pharmacy team had been proactive at identifying areas for improvement. They had reviewed the working arrangements in place for multi-compartment compliance pack dispensing. And they had decided to make changes so that each dispenser took responsibility for dispensing one of the four-week cycles. This had been beneficial in managing the workload and resolving queries. One of the longest-serving dispensers had led on the review. And they had coached the less-experienced dispensers to follow the company's procedure. They had also reviewed and updated the supplementary records used to help the team manage the dispensing of the packs. Team members kept pharmacy

publications in the room they used for comfort breaks. This provided information for them to refer to if they chose to do so. The pharmacist informed team members about service changes. And they discussed the findings from the near miss reviews. This ensured everyone was involved in agreeing and implementing safety improvements to manage risks.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises adequately support the safe delivery of services. And the pharmacy suitably manages the space for the storage of its medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

Team members had arranged the dispensing benches for different tasks. And they had segregated workstations as much as they could to help maintain a safe distance from each. The dispensing benches were clutter free. And dispensing baskets kept prescription items well-contained. Team members used a series of dedicated shelves for storing multi-compartment compliance packs. And they kept them tidy with packs well-segregated. The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary. A sound-proofed consultation room was available. And it provided a confidential environment for private conversations. Team members cleaned the surfaces in between sessions.

A sink in the dispensary was available for hand washing and the preparation of medicines. The pharmacy was clean and well maintained. Team members cleaned and sanitised the pharmacy on a regular basis. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services. A separate area was used for comfort breaks. This allowed team members to remove their face masks without being at risk of infections.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy gets its medicines from reputable sources and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are not fit for purpose. The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care.

Inspector's evidence

The pharmacy had a step-free entrance and provided unrestricted access for people with mobility difficulties. It advertised its services and opening hours in the window. And it provided information to help keep people safe from coronavirus. This included stating the maximum number of people permitted in the waiting area. The pharmacist provided access to ‘prescription only medicines’ via ‘patient group directions’ (PGDs). They kept ‘hard copies’ of the PGDs in a folder that was easy to access. Sampling showed that the PGD for trimethoprim was valid until April 2022.

Team members kept stock neat and tidy on a series of shelves. And they used controlled drug cabinets that had adequate space to safely segregate stock items. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members carried out a documented expiry date check once a month. Sampling showed that items were well within their expiry date. The pharmacy had two fridges. Team members used one of the fridges for insulin and the other for general stock. Both fridges were organised, and team members monitored and documented the temperatures on a daily basis. They were able to evidence that both fridges were operating within the accepted range of 2 and 8 degrees Celsius. Team members knew about valproate medication and the Pregnancy Prevention Programme. The pharmacist knew to speak to people in the at-risk group about the associated risks. And team members knew to supply patient information leaflets and to provide warning information cards with every supply.

The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people. This had remained at the same level since the last inspection in June 2021. The pharmacy had defined the assembly and dispensing process in a documented procedure for team members to refer to. This included assembling and labelling the original packs before de-blistering. And using different coloured baskets for each of the four-week cycles. The procedure was up to date and was valid until May 2023. Team members used trackers to manage the dispensing process. This helped them to order new prescriptions and ensure they had sufficient time to process subsequent supplies. Supplementary records which contained a list of the person's current medication and dose times were kept up to date. Team members checked prescriptions against the master records for accuracy before they started dispensing packs. They discussed queries with the relevant prescriber and they only made changes to packs on receipt of a new prescription. The pharmacy had defined the ‘medicines care review’ (MCR) dispensing procedures in a documented procedure that was valid until July 2023. Team members kept the serial prescriptions well-organised in two folders. And they used a diary to show when supplies were due. They dispensed prescriptions in advance. This ensured they were ready by the due date. It also helped them manage their workload.

The delivery driver kept a supply of face masks, gloves, and hand sanitizer in the delivery vehicle, and they used them during deliveries. They knew to keep at a safe distance from people to manage the risk of spreading infection. Team members accepted unwanted medicines from people for disposal. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Drug alerts were prioritised, and team members knew to check for affected stock so that it could be removed and quarantined straight away. Team members could show recent emails for drug alerts. But they did not document their findings or what the outcome of the checks had been.

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 access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for methadone. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy used a pump to dispense methadone doses. They calibrated the pump to show it was measuring accurately. The pharmacy had a blood pressure monitor. But team members could not show when it was due to be replaced or calibrated. The pharmacy stored prescriptions for collection out of view of the waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. A portable phone allowed team members to carry out conversations in private if needed. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks.

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.