General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 2 Crossroads Place, Rosyth, Dunfermline, Fife, KY11 2LS

Pharmacy reference: 9011214

Type of pharmacy: Community

Date of inspection: 03/11/2021

Pharmacy context

This is a community pharmacy on the main road through a village. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery 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 NHS and private seasonal flu vaccination, the NHS smoking cessation service and it supplies lateral flow Covid-19 test kits. This pharmacy was inspected 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 with its services. This includes introducing a few measures to reduce the infection risk during the Covid-19 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 all the records it needs to by law. And it keeps people's private information safe. Team members know who to contact if they have concerns about people.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had a screen up at the medicines' counter, although this was to one side and not where people using the pharmacy or team members typically stood. The pharmacy allowed three people on the premises at any time. A few people were observed queuing outside during the inspection. Most people coming to the pharmacy wore face coverings and some team members usually wore fluid resistant masks when they were public facing. The dispensary was large enough for social distancing, so team members did not wear masks in the dispensary. This was not in line with Scottish Government guidance. Some team members were exempt. The pharmacist wore a mask when administering flu vaccinations and using the consultation room for other conversations. Team members washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points several times during the day. Team members carried out lateral flow Covid-19 tests at least twice a week. They had completed personal risk assessments at the start of the pandemic to identify any risk that may need to be mitigated in the pharmacy. No such risks had been identified.

The pharmacy had standard operating procedures (SOPs) which were followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them at least every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and were clear about tasks that they could not all carry out. For example, two team members took it in turn to manage and assemble multi-compartment compliance packs. And team members accurately explained which activities could not be undertaken in the absence of the pharmacist. This had been tested successfully recently when there was no pharmacist on a Saturday. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication.

Team members used 'near miss logs' to record 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 to learn from them and they introduced strategies to minimise the chances of the same error happening again. After each incident team members discussed the cause at the time. This was often related to similar packaging, or medicines being stored unusually close together in the 'Top 50' area, for example omeprazole and lansoprazole which were not close alphabetically. Team members had separated some items and highlighted similar packaging to colleagues. There had been a dispensing error a few months previously that had been partly caused by another healthcare professional not following the local NHS guidance for a process.

This had been discussed with NHS colleagues who were addressing it with others to reduce the chance of a similar incident happening in the future. The pharmacy had a complaints procedure and welcomed feedback. No examples were described.

The pharmacy had indemnity insurance, expiring 30 June 2022. It displayed the responsible pharmacist notice and had an accurate responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited. It had a CD destruction register for patient returned medicines.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and company policies. They segregated confidential waste for secure shredding. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to find contact details to raise a concern locally if they had one. Team members described several examples of the delivery driver sharing his concerns for people. The pharmacy acted on these, contacting GPs, or calling ambulances when required. A team member had a current qualification in first aid and had completed ‘first-on-scene’ training in another role.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified, experienced, and team members in training to safely provide its services. They are trained and competent for their roles and the services they provide. The pharmacy gives them time for training during the working day when it can, although this has been challenging during the pandemic. Team members make decisions within their competence to provide safe and effective services to people. And they use their professional judgement to help people. They make suggestions and know how to raise concerns if they have any to keep the pharmacy safe.

Inspector's evidence

The pharmacy had one full-time pharmacist manager, one part-time pharmacy technician, one full-time and one part-time dispensers, and a new part-time trainee medicines counter assistant/dispenser. At the time of inspection, and typically, there were three team members and a pharmacist working at most times. Team members were able to manage the workload. A few months previously the pharmacy had challenges with workload while a team member was absent from work for a few weeks. Recently the same locum pharmacist had covered the regular pharmacist's day off and was covering forthcoming annual leave. This helped with continuity. The part-time dispenser had recently successfully completed an accredited training course. He had undertaken most of his training at home as the pharmacy had not been able to give him protected learning time during the pandemic. But the pharmacist and other team members had been supportive, answering queries, coaching, and demonstrating procedures. He was still carrying out some tasks under supervision. The new trainee had not yet been registered on an accredited course. She had been in the pharmacy for a few weeks and was being given time to read SOPs in a methodical order. And team members were demonstrating processes to her while encouraging her to undertake straightforward tasks under their supervision. Team members had previously had annual development meetings with the pharmacy manager to identify their learning needs. But this had not taken place during the pandemic. Team members described continual learning and sharing of information. The pharmacist and pharmacy technician discussed continuing professional development and revalidation topics. And a dispenser who had some expertise on the pharmacy's computerised processes helped colleagues. 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.

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. An example was demonstrated a few weeks after re-locating to the current premises. Team members were concerned that some sensitive information could be seen by some members of the public. They explained this to the area manager, then re-arranged the dispensary to avoid this. Team members made decisions within their competence, for example providing the NHS Pharmacy First service to different levels depending on skills and knowledge. They also made calls to prescribers for clarity about prescriptions as required. And they reminded prescribers to use 'change forms' which was a standard local NHS process. The pharmacist was aware of these conversations and was confident that team members worked within their competence. Several team members had worked together for a few years so knew each other's strengths. The pharmacy team discussed incidents and how to reduce risks.

Team members did this especially after similar packaging was identified, or an error had been made. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters, but team members explained that they only used these to help offer services to people who would benefit from them.

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 reasonably-sized premises incorporating a retail area, spacious dispensary and rear area including storage space and staff facilities. The premises were clean, hygienic, and well maintained. The pharmacy had re-located into these premises around two years previously. It had been fitted out to accommodate the services provided. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available in the dispensary and consultation room.

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. This room was large enough for social distancing which was managed by careful positioning of chairs. The door was kept locked to prevent unauthorised access. The consultation room had a hatch through to the dispensary which the pharmacist used to supervise self-administration of medicines as required. Temperature and lighting felt comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to 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 mostly 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 other services such as travel vaccination. It had a hearing loop in working order for people wearing hearing aids to use. And it could provide large print labels for people with impaired vision. All team members wore badges showing their name and role. The pharmacy provided a delivery service.

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. A lot of the routine dispensing was undertaken at the company's off-site hub. Team members followed the SOP for the management of this. And they had also developed an additional process observed in another branch to simplify the process and provide clarity for prescriptions that had some items dispensed at the hub and some in the pharmacy. This was working well. The pharmacy had experienced some challenges previously with the off-site hub dispensing. There were still some ongoing challenges with items listed as 'error' at the hub and not dispensed. This was sometimes when items were out of stock at the hub. And sometimes it was caused by the team in this pharmacy changing the quantity to be dispensed. They did this to ensure original packs were supplied. In Scotland 10% more or fewer tablets could be supplied of most medicines to enable original pack dispensing. If people came to the pharmacy and their medicine had not been dispensed by the hub, a team member dispensed it immediately and apologised for the delay. This was observed and was well managed. Team members highlighted any issues, concerns, or changes to the pharmacist to enable her to carry out clinical checks. 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 using a documented owings system. A few people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these when they were due so that they were always ready as people expected. There was no evidence of poor compliance. The pharmacy recorded when medicines were supplied and when the next supply was due.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. The pharmacy technician and experienced dispenser undertook this task alternate weeks to ensure they both maintained their skills. And they were coaching and training other team members who only did this under their supervision. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. They were currently working further ahead to compensate for annual leave. They followed a robust process, kept records of changes and other conversations, and stored the completed packs in a logical and safe manner. The pharmacist sealed the packs when carrying out the final accuracy checks. And the team

stored packs containing controlled drugs (CDs) in the CD cabinet. Team members included instalment number, date of supply and tablet descriptions on the backing sheets. But the backing sheets were not attached to the packs. This meant they could easily become detached and there would be no information regarding the person or the medicines on the pack. The team supplied patient information leaflets (PILs) with the first pack of each prescription. The pharmacy supplied a variety 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 alphabetically in individually named baskets on labelled shelves, in different locations depending on the other medicines supplied along with tablets. This helped ensure that people received all their medication as prescribed.
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. The pharmacist had counselled them appropriately and checked that they were on a pregnancy-prevention programme. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, flu vaccination and smoking cessation. It also followed private PGDs for flu vaccination. 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. They referred to the pharmacist as required. And they completed the required records following consultations. Team members described examples of this service enabling effective and timely treatment to people. The pharmacist was delivering private and NHS flu vaccinations, mainly using pre-booked appointments. And some walk-in appointments as resources allowed. This was observed and worked well. Many of these vaccinations were private, with people being encouraged to take up vaccination by their employers locally. The pharmacy provided the NHS smoking cessation service, but this was currently not busy. Once a month the pharmacist ran an anticoagulation clinic in the local GP practice. This was a weekly pharmacist led clinic, with a regular pharmacist providing it all other weeks.

The pharmacy obtained medicines from licensed wholesalers such as HSC, Alliance and AAH. The pharmacy mostly stored medicines in original packaging on shelves, and in cupboards. Some shelves were untidy, and some strips of tablets were not in packaging. Team members described their work in progress to address this. And there were gaps on shelves showing where some re-arrangement was underway. Team members were planning working on a Sunday over coming weeks to complete this task. Team members labelled and segregated obsolete stock in a cupboard to ensure it was not supplied to people. The pharmacy stored items requiring cold storage in three fridges; one was in the consultation room and was only used during the flu season to store vaccines. Team members monitored and recorded minimum and maximum fridge temperatures daily. They were within acceptable 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. Team members look after the equipment that is in regular use, to ensure it works.

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, personal weighing scales and a blood pressure meter. The scales and blood pressure meter had not been calibrated recently but were seldom used with members of the public. The team was not using the carbon monoxide meter during the pandemic to reduce the chance of spreading infection. Team members kept crown-stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy used a 'Methameasure' pump for measuring methadone solution. It had been installed four months previously to help reduce pressure on storage capacity by dispensing when people came to the pharmacy rather than in advance. The pharmacist cleaned it at the end of each day and poured test volumes each morning when it was set up to ensure it was accurate. The pharmacy team kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in a locked cupboard in the consultation room and in the dispensary, so inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. The team had rearranged the dispensary soon after the re-location as there was initially a risk that dispensed medicines could be seen by some members of the public. 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.