General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 7 Douglas Street, Dunfermline, Fife, KY12 7EB

Pharmacy reference: 9011227

Type of pharmacy: Community

Date of inspection: 24/08/2021

Pharmacy context

This is a community pharmacy beside other shops in a town centre. 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 services including the NHS smoking cessation service.

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 suitably identifies and manages the risks with its services including reducing the infection risk during the 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. They do not make many mistakes. The pharmacy keeps all the records 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 put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter and hand sanitiser for people to use. The retail area was spacious so people using the pharmacy could socially distance. Most people coming to the pharmacy wore face coverings and team members that could, wore masks. The pharmacy manager had carried out a personal risk assessment with each team member to identify any risk that may need to be mitigated in the pharmacy. Those at increased risk worked in areas that were not public facing.

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 every two years or more often as required and signed them off. 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. An example was described of a team member being asked by an area manager to undertake such an activity without a pharmacist to provide service continuity to a person accessing the pharmacy's services. A pharmacy technician described additional responsibilities and tasks that she undertook. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacist stamped and signed prescriptions that she had clinically checked to enable an accuracy checking dispenser to carry out the final accuracy check on some dispensed medicines. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. It had used aspects of this recently when the pharmacy did not have a pharmacist during its normal contracted hours. This included notifying the health board and other services of closures. And making different arrangements to ensure that people received their medicines.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. The company set a target of recording at least five near misses each week in each branch. The pharmacy did not usually meet this target as team members were very experienced and accurate dispensers. They described checking their dispensing before passing to the pharmacist or accuracy checker. And they described the process of recording and correcting errors, so recording was 100%. And they recorded errors that had been identified after people received their medicines. The only recent error had been an item self-checked by a pharmacist when the pharmacy was short-staffed. The pharmacist had apologised, and the person had not been adversely affected. Team members reviewed all near misses and errors each month to learn from them and they introduced strategies to minimise the chances of the same error happening again. Changes that they made following incident reviews included separating co-beneldopa and co-careldopa; and separating and highlighting high

strength medicines. The pharmacy had a complaints procedure and welcomed feedback. The only complaints team members described were about the pharmacy closures at times when there had been no pharmacist available. Mystery shoppers visited the pharmacy regularly, especially following retail promotional changes. The pharmacist usually undertook these changes to enable other team members to continue dispensing. Results from mystery shoppers had been over 90% recently. This also included pharmacy advice and the use of the sale of medicines protocol.

The pharmacy had an indemnity insurance certificate, expiring 30 June 2022. The pharmacy 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. Team members kept very comprehensive and thorough records of all aspects of medicines supplied in multi-compartment compliance packs. And they promptly recorded details of Pharmacy First consultations. Team members signed any alterations to written records, so they were attributable. All records were accurate and up to date. 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 company policies and they segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. They described examples including asking people to return later if they did not appear well enough to take their prescribed medication. And some concerns were shared (with consent) with other agencies, for example people missing several doses of their medication. A delivery driver had called emergency services when he had been concerned about a person. And on other occasions he had shared his concerns with other team members who had contacted the person's GP. The GP responded by making a visit to the person's home. The pharmacy had a chaperone policy in place and displayed a notice telling people this. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme. During the inspection there was a discussion about whether compliance packs should be delivered in bags to prevent people including neighbours knowing that a person received medicines in this way. But team members felt that was not a breach of confidentiality and were concerned that another level of risk could be introduced by placing the pack in a bag e.g. if bag labels became mixed up.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. They are trained and competent for their roles. And the pharmacy gives them time for learning during the working day. Team members make decisions within their competence to provide safe services to people. And they use their professional judgement to help people. They know how to make suggestions and raise concerns if they have any to keep the pharmacy safe.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one part-time pharmacy technician (PT), one full-time and two part-time dispensers and two delivery drivers. One of the part-time dispensers had an accuracy checking qualification and checked multi-compartment compliance packs that she had not labelled or assembled, and that the pharmacist had clinically checked. All team members were qualified for their roles and had several years' experience. They had worked together for a few years and described working well as a team. At the time of inspection, the regular pharmacist, PT and two dispensers were working. They were able to manage the workload. The pharmacist was leaving in two weeks and the team did not know if a replacement had been appointed. Pharmacist cover in the area was currently challenging and there had been several days over the past few weeks when the pharmacy had not been able to open its full NHS contracted hours on the pharmacist's day off. There were times during the week when there were two team members and the pharmacist, and some occasions just one team member and the pharmacist. The team described this as challenging, and the pharmacist sometimes self-checked rather than interrupting a dispenser.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development. The company provided access to 'E-expert' online modules and team members had completed a module on 'point-of-sale' processes recently. The dispensers mostly managing the multi-compartment compliance packs explained the detail of the processes and described how they supported locum pharmacists not familiar with the process. There was an emphasis on coaching and learning. The PT had been a local trainer for the current patient medication record (PMR) system so all team members could use the system effectively. The delivery drivers undertook regular training arranged through the drivers' team. The pharmacy supported other healthcare professionals' training and development. Earlier that day a trainee GP had spent time in the pharmacy learning about processes. And the pharmacist was helping a colleague in a nearby branch by working with him in evenings to help clear his dispensing backlog caused by being short-staffed. 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. The inspector observed several examples of good interactions and consultations with people by various team members. They gave good and correct advice on the management of symptoms, use of medicines purchased, and supported decisions made by other clinicians when discussing medicines and dose regimes with people. Team members were encouraged and empowered to work autonomously and make decisions within their competence. This included contacting GPs and other prescribers and services for clarity on prescriptions or to query changes to medication.

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 shared and discussed these. They could make suggestions and raise concerns to the manager or area manager. The pharmacy team discussed incidents and how to reduce risks as incidents occurred. Team members had recently discussed the number of interruptions they experienced when dispensing multi-compartment compliance packs. This sometimes happened at times when there were not many team members working, and they were concerned this could lead to mistakes. They had agreed that sometimes, depending on circumstances, the pharmacist would not disturb them, but she would dispense and self-check. This introduced different risks but on balance, the team decided that at rimes this may be lower risk. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members described these but explained that patient safety was the most important aspect of their work, so would not try and achieve targets if they believed that would compromise patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for the pharmacy's services. It has suitable facilities for people to have conversations with team members in private. And it is secure when closed. The pharmacy team respects and manages people's confidentiality.

Inspector's evidence

The pharmacy re-located to these premises around two years ago. The premises were larger than the previous ones and on one floor. There was a reasonably sized retail area and dispensary. The dispensary had been planned and laid out to provide separate areas that were not public facing to manage and dispense multi-compartment compliance packs. The premises had staff facilities and very limited storage space, and were clean, hygienic and well maintained. Team members cleaned surfaces and touch points frequently throughout the day. 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 retail area and on all dispensing and checking benches.

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 and this was managed by careful positioning of chairs. The door was kept locked to prevent unauthorised access. The consultation room had a hatch to the dispensary. This enabled team members to supervise self-administration of medicines as required and carry out some consultations. Temperature and lighting were 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. 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 low step and an automatic door. Team members helped people if required. The pharmacy listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as travel vaccination. 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. At the time of inspection, the PT was labelling prescriptions received that day. After labelling she segregated them into different baskets depending on whether the medicines were to be delivered, collected or dispensed by the central fulfilment facility. Team members highlighted any changes to repeat medication to the pharmacist. If it was a straightforward issue e.g. a missing item that the pharmacy had ordered, team members contacted prescribers without necessarily notifying the pharmacist. They made records of any interventions. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. When the pharmacist self-checked she signed the label twice, clarifying the two stages. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these the week before they were due for supply. Team members kept thorough records of when medicines were dispensed and supplied.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. Currently they were two weeks ahead to compensate for annual leave. The process was very thorough and methodical. Team members kept records of any interventions and changes. And these were well filed so easy to locate and follow. They used different systems for packs containing certain medication that was added weekly. The systems were very clear to follow, using colour coding and different diaries. Team members wrote tablet descriptions onto packs as they were labelled and dispensed. This ensured they were always accurate regardless of the brand of tablet used. Team members used dedicated dispensing benches for the management, assembly and checking of packs. This contributed to the logical process as there was adequate space. The pharmacist or accuracy checker carrying out the final check sealed the packs. The dispenser left packaging with the packs to aid the accuracy check. Completed packs were labelled with name, address and supply date. They were stored in named box files on shelves depending on day and method of supply. The PT added controlled drugs weekly, then these packs were stored securely. The pharmacy supplied patient information leaflets with the first pack of each prescription. It supplied all

four weeks' packs to some people with the prescribers' consent or instruction. Team members documented this on the PMR. 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. 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, smoking cessation, and emergency hormonal contraception (EHC). 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. A team member was observed delivering this service very professionally and competently, giving relevant advice and recording the consultation. And examples were described of the pharmacist identifying serious symptoms and referring people to other services including hospital. A person had subsequently been diagnosed with a chronic condition and thanked the pharmacist for her action. During the pandemic the pharmacist had delivered some services remotely by phone. This had ensured service delivery while minimising footfall on the premises. Services delivered in this way included smoking cessation, urinary tract infection (UTI) treatment and supply of emergency hormonal contraception (EHC). The pharmacist carried out the consultation remotely and if appropriate, the team prepared medication ready for collection when the person came to the pharmacy. Currently the pharmacy was not delivering many additional services. It was delivering the smoking cessation service to a small number of people. It had delivered flu vaccination in previous seasons but had no plans for the forthcoming season as there was uncertainty about who the pharmacist would be. The pharmacy was supplying lateral flow Covid test kits to people. Team members were actively promoting this in line with Scottish Government guidance and there was good uptake. The pharmacy was part of the local NHS palliative care network and supplied 'just-in-case' boxes to people. The PT was assembling one during the inspection. The prescriber supplied the relevant paperwork as well as prescriptions. The PT and pharmacist described how the service worked. They ensured they always had adequate stock of all the palliative medicines and could supply these boxes at short notice.

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 used space well to segregate stock, dispensed items and obsolete 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. It looks after this equipment 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, and a blood pressure meter which was replaced as per the manufacturer's guidance. The team was not using this equipment during the pandemic to reduce the chance of spreading infection. Team members kept crown-stamped measures by the sink in the dispensary, including separate marked ones for methadone solutions. And they had clean tablet and capsule counters in the dispensary including a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in labelled folders in the dispensary inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented person-identifiable 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.