General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Blackburn Pharmacy, Unit A, 2 Sycamore Walk, Blackburn, West Lothian, EH47 7LH

Pharmacy reference: 9011341

Type of pharmacy: Community

Date of inspection: 14/08/2023

Pharmacy context

This is a newly opened community pharmacy in the town of Blackburn, West Lothian. Its main services include dispensing of NHS prescriptions, and it dispenses medicines in multi-compartment compliance packs to help people take their medicines properly. Team members advise on minor ailments and medicines use. And they deliver the NHS Pharmacy First and Pharmacy First Plus Services.

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 appropriately manages the risks associated with the services it provides for people. Its complete set of written procedures help the team carry out tasks consistently and safely. Team members record and learn from the mistakes they make when dispensing. And they keep the records they need to by law. Team members have knowledge and experience to help support vulnerable people.

Inspector's evidence

The pharmacy had a set of comprehensive standard operating procedures (SOPs) to help team members manage risks. And they were regularly updated. Team members had read the SOPs relevant to their roles and completed a record of competence signature sheet to confirm their understanding of them. They were observed working within the scope of their roles. And they were aware of the responsible pharmacist (RP) regulations and of what tasks they could and couldn't do in the absence of an RP.

Pharmacy team members recorded mistakes they identified during the dispensing process, known as near misses on a paper near miss record. They explained errors were highlighted to them by the pharmacist, and it was then their responsibility to enter it onto the record. This allowed them to reflect on the mistake. The SI reviewed the near miss record regularly to identify trends and patterns. And they documented this. A recent analysis had showed that some team members did not record all their errors. The pharmacy team had introduced a new process to ensure all near misses were recorded where they each had their own near miss record to improve accountability. The team also recorded details of any errors which were identified after the person had received their medicines, known as dispensing incidents. And these were reviewed by the SI. Following a recent dispensing incident involving the incorrect formulation of a medicine being supplied, the different formulations were segregated on the shelf and caution stickers applied to the shelving area to reduce the risk of the incident happening again. The team aimed to resolve any complaints or concerns informally. But if they were not able to resolve the complaint, they would escalate to the pharmacist manager or SI. A recent complaint involving the pharmacy delivery service had been escalated to the SI who had reviewed the process for deliveries and introduced a text message service to alert people when their delivery was due. This improvement was positively received by people using the service. The SI had recently received an award from the local community for providing continual exemplary service to people using the pharmacy services.

The pharmacy had current professional indemnity insurance. The RP notice displayed contained the correct details of the RP on duty, and it could be seen clearly from the retail area. The RP record was generally in order, but some entries did not include the time the RP had finished, which could cause uncertainty about who was responsible at specific times. The controlled drug (CD) register was held electronically and it appeared to be in order. Running balances were recorded and checked against the physical stock levels of CDs every month. A record of patient returned CDs was maintained in an electronic register and this was up to date. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were recorded to provide an audit trail. Accurate electronic records of private prescriptions were maintained.

An NHS Pharmacy First privacy notice was displayed in the retail area explaning how the pharmacy handled personal information. Team members were aware of the need to keep people's information confidential. The pharmacy kept sensitive information and materials in restricted areas away from unauthorised access. It collected confidential waste in dedicated bags which were collected periodically by a third- party contractor for secure destruction. Pharmacy team members had completed some learning associated with their role in protecting vulnerable people. And they understood their obligations to manage safeguarding concerns. Team members were aware of some vulnerable people who were not able to collect their own medication and knew to contact their representatives if they presented in the pharmacy. The pharmacist was a member of the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has sufficient team members with the right qualifications and knowledge to manage its workload and provide its services. And it reviews its staffing profile following changes in workload to make sure it can operate effectively. Team members complete appropriate training for their roles and keep their skills up to date. They work well together and communicate effectively. And they are comfortable providing feedback and raising concerns should they need to

Inspector's evidence

The superintendent pharmacist who was also an independent prescriber worked at the pharmacy regularly. They were supported by two full-time pharmacists who also worked at a nearby pharmacy owned by the same company. There was a large, experienced pharmacy team that included a full-time trainee pharmacy technician who worked as an accuracy checker. Team members had all completed accredited training or were enrolled on an accredited training course. The SI acted as the supervising pharmacist to the trainee dispenser and trainee pharmacy technician. And they also received support from the other regular pharmacists. The workload had been increasing recently, so the staffing levels had been reviewed and an additional staffing vacancy was currently advertised. Team members were observed working well together and managing the workload. Planned leave requests were managed and part-time staff members supported by working additional hours during periods of planned leave. And there was additional support available from the nearby pharmacy.

Team members enrolled on accredited training courses received regular protected learning time. And they had regular meetings with the SI to review their progress. Team members completed regular training that was relevant to their role such as training relating to seasonal ailments. And they completed regular ongoing training and assessments relating to the sale of herbal medicines . The SI had monthly meetings with the pharmacy team where they discussed safety alerts and any learnings from near misses or dispensing incidents. Team members felt comfortable to raise any concerns with the SI, pharmacist or trainee technician in the first instance. They received an annual formal appraisal with the SI where they had the opportunity to identify individual learning needs. There were no targets set for pharmacy services.

Team members were observed asking appropriate questions when selling medicines over the counter and referring to the pharmacist when necessary. They explained how they would identify repeated requests for medicines subject to misuse, for example codeine containing medicines. And they would refer to the patient medication record to support some sales of medicines. Team members explained that they had received some requests for codeine linctus and that they reported this to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides and are generally appropriately maintained. It has two consultation rooms where the team can have confidential conversations with people.

Inspector's evidence

The pharmacy premises were generally clean and maintained to an adequate standard. There was some clutter and obstructions on the floor which could pose a trip hazard to staff. And the rear fire exit was partially blocked but the RP agreed that they would clear it. Team members had ample space to dispense medicines. There were clearly defined areas used for the dispensing process and a separate area to dispense medicines into multi-compartment compliance packs at the side of the dispensary. There was a separate bench used by the RP to complete the final checking process located at the front of the dispensary near the retail counter. The medicines counter could be clearly seen from the checking area which enabled the pharmacist to intervene in a sale when necessary. The pharmacy had enough space to store its medicines. Two good-sized consultation rooms were clearly signposted and able to be locked when not in use. Team members used a hatch between the dispensary and consultation room that was protected by a screen to provide supervision of substance misuse services. There were chairs available in the retail area that provided a suitable waiting area for people receiving clinical services.

There was a clean, well-maintained sink in the dispensary used for medicines preparation and there were other facilities for hand washing. The pharmacy kept the room temperature to an acceptable level. And there was bright lighting throughout.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of services that are well managed and easily accessible for people. It receives its medicines from licensed wholesalers and stores them appropriately. The team carries out checks to help ensure medicines are safe to supply to people. But it does not always maintain a record of the checks so it cannot show whether they are always effective.

Inspector's evidence

The pharmacy had good physical access with a level entrance into the shopping mall and an automatic door into the premises. The pharmacy previously displayed its opening hours and services at the entrance to the pharmacy, but these had recently been removed to allow privacy glass to be installed. And so, people may not know when they can access the pharmacy. The pharmacy had some healthcare information posters for people to read. These included information on Lyme disease.

The dispensary had separate areas for labelling, dispensing, and checking of prescriptions. Team members used dispensing baskets to safely store medicines and prescriptions throughout the dispensing process. This helped manage the risk of medicines becoming mixed-up. The baskets were colour coded to enable team members to identify the type of prescription stored within and to manage workload. Team members signed dispensing labels to maintain an audit trail. The audit trail helped to identify which team member had dispensed and checked the medicine. The pharmacy gave owing slips to people when it could not supply the full quantity of medicines prescribed. The pharmacy offered a delivery service and kept records of completed deliveries.

Team members demonstrated a good awareness of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They explained how they would highlight any prescriptions for valproate for the attention of the RP. They knew to apply dispensing labels to the packs in a way that prevented the written warnings on the packs from being covered up. And they would double check the medicine dispensed with the pharmacist prior to applying the dispensing labels. The pharmacy supplied patient information leaflets and patient cards with every supply. And they always supplied valproate in the original manufacturer's pack.

A large proportion of the pharmacy’s workload involved supplying medicines in multi-compartment compliance packs to help people manage them better. Team members used medication record sheets that contained a copy of each person’s medication and dosage times. They were responsible for managing the ordering of people’s repeat prescriptions and reconciled these against the medication record sheet. They documented any changes to people’s medication on the record sheets and who had initiated the change. This ensured there was a full audit trail should the need arise to deal with any future queries. The packs were annotated with detailed descriptions which allowed people to distinguish between the medicines within them. The pharmacy supplied people with patient information leaflets, so they had access to up-to-date information about their medicines. The compliance packs were signed by the dispenser and RP so there was an audit trail of who had been involved in the dispensing process.

Team members managed the dispensing of serial prescriptions as part of the Medicines: Care and Review (MCR) service. The prescriptions were stored alphabetically, and people telephoned the

pharmacy to advise that they required their next prescription supply. This allowed the team to dispense medicines in advance of people collecting. The NHS Pharmacy first service was popular. This involved supplying medicines for common clinical conditions such as urinary tract infections under a patient group direction (PGD). The pharmacist could access the PGDs electronically and also had paper-based copies. The SI provided the NHS Pharmacy First Plus service where they could prescribe for common clinical conditions. They worked closely with the local GP practice who referred people who were suitable for the service to the pharmacy. A record of the consultation and treatment outcome was documented and shared with the person's GP. A prescription was written by the SI and submitted to the relevant NHS agency every month to enable external auditing of the prescribing service to be maintained.

The pharmacy obtained its stock medicines from licensed wholesalers and stored them on shelves. Team members had a process for checking expiry dates of the pharmacy's medicines. Short-dated stock which was due to expire soon was highlighted and rotated to the front of the shelf, so it was selected first. The team advised that they were up to date with the process and kept a record of checks they had completed. But no records had been completed since January, so it was unclear whether checks had been carried out. The team marked liquid medication packs with the date of opening to ensure they remained suitable to supply. The pharmacy had a medical grade fridge to store medicines that required cold storage which was operating within the correct temperature range. Team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the accepted range of two and eight degrees Celsius. The pharmacy received medicine alerts electronically through email. The team actioned the alerts and kept a printed record of the action taken. They returned items received damaged or faulty to manufacturers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to support the safe delivery of its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources including the British National Formulary (BNF) and the BNF for children. And there was access to internet services. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. There were separate cylinders to be used only for dispensing water which were marked. This helped reduce the risk of contamination. The pharmacy used an automated measuring machine for dispensing of some CD liquids that was calibrated before use and regularly cleaned. And it documented when these tasks were completed on an electronic log.

The pharmacy stored dispensed medicines awaiting collection, in a way that prevented members of the public seeing people's confidential information. The dispensary was screened, and computer screens were positioned to ensure people couldn't see any confidential information. The computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones so team members could move to a quiet area to have private conversations with people.

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.