General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dears Pharmacy, 4-5 Benarty Square, Ballingry, Lochgelly, KY5 8NR

Pharmacy reference: 9011663

Type of pharmacy: Community

Date of inspection: 04/04/2022

Pharmacy context

The pharmacy is on a parade of shops in a village near a GP surgery. It serves a mixed population with a large number of young families and older people. It mainly dispenses NHS prescriptions. The pharmacy has a travel clinic, providing PCR fit to fly tests and it is a yellow fever centre. It provides a range of services, including needle exchange, blood pressure and glucose checks, smoking cessation and flu vaccinations. And it provides medicines as part of the Pharmacy First service. The pharmacy supplies medications in multi-compartment compliance packs to a large number people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people. The inspection was carried out 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

Overall, the pharmacy identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It protects people's personal information. And team members understand their role in protecting vulnerable people. People can provide feedback about the pharmacy's services. The pharmacy largely keeps its legal records up to date and accurate.

Inspector's evidence

The pharmacist said that the pharmacy had carried out workplace risk assessments in relation to Covid-19. The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs), and reporting and reviewing of dispensing mistakes. Team members had signed to show that they had read, understood, and agreed to follow the SOPs. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes. And near misses were recorded electronically. Team members could use their mobile phones to access the near miss record using a QR code printed on posters in the pharmacy. The pharmacist explained that the near miss record was reviewed regularly for any patterns. The superintendent pharmacist (SI) reviewed the outcomes from all pharmacies within the company. And the outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. The pharmacist said that items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And that the different strengths of amlodipine were now kept on separate shelves as there had been several selection errors involving these medicines. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong type of medicine had been supplied to a person. The person did not use the medicine and it was returned to the pharmacy. The names of the medicines were similar, and this could have contributed to the error. The pharmacist said that he would consider minimising the risk of a similar incident by showing the medicine to the person when handed out.

There was ample workspace in the dispensary, and it was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. Prescriptions were stamped when a clinical check had been carried out by the pharmacist. The dispenser accuracy checker knew that she should only check prescriptions that had been clinically checked by the pharmacist and if she had not been involved with the dispensing processes.

Team members' roles and responsibilities were specified in the SOPs. But the accuracy checking SOP did not specify which medicines should not be checked by an accuracy checker. The trainee medicines counter assistant (MCA) said that the pharmacy would remain closed if the pharmacist had not turned up. And she knew that she should not hand out dispensed items or sell any pharmacy-only medicines if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. All necessary information was recorded when a supply of an unlicensed medicine was made. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked frequently. Any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was largely completed correctly. There were several occasions where the pharmacist had not completed the record when they had finished their shift and there was a different pharmacist working the following day. The pharmacist said that he would ensure that it was completed correctly in the future. The private prescription records were mostly completed correctly, but the prescriber details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The nature of the emergency was not always recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and people using the pharmacy could not see information on the computer screens. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed training about data protection.

The complaints procedure was available for team members to follow if needed. Contact details for the pharmacy were available on business cards in the pharmacy. The pharmacist said that he would initially address any complaints and he would refer them to the pharmacy's head office where needed. The pharmacy's head office contact details were available on the pharmacy's website.

The pharmacist had undertaken some training about her role in protecting vulnerable people. The MCA could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist gave examples of times where the pharmacy had acted appropriately when there had been safeguarding concerns about people using the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they receive some ongoing training to support their learning needs and to maintain their knowledge and skills. Some team members get time set aside in work to complete their training. They can raise any concerns or make suggestions and they have regular meetings. This means that they can help improve the systems in the pharmacy. The team members take professional decisions to ensure people taking medicines are safe. And they discuss adverse incidents and use these to learn and improve.

Inspector's evidence

There was one pharmacist, four trained dispensers (two dispenser checkers), one trainee dispenser and one trainee MCA working during the inspection. One of the dispensers explained that she was waiting to find out if her hospital dispenser course could be transferred to community pharmacy. The pharmacist said that she would be put on an appropriate course if needed. Team members wore smart uniforms, and some had name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The inspector discussed with the pharmacist about the reporting process in the event that a team member tested positive for the coronavirus.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of products containing pseudoephedrine. And she said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. And she used effective questioning techniques to establish whether the medicines were suitable for people. And the WWHAM (who, what, how long, action taken, medicines being taken) questions were displayed near the medicines counter so that team members could refer to them where needed. The trainee MCA referred to the pharmacist when someone wanted a medicine as part of the Pharmacy First service. The pharmacist explained the process and about how the consultation would be carried out. And how he would refer the consultation and outcome.

The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. Several team members had undertaken recent training about the ear micro-suction service. And the pharmacist had completed training about the flu vaccination service. One of the trained dispensers was working towards an NVQ level 3 pharmacy qualification and said that she had one afternoon allocated each week for this training. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He explained that he read pharmacy-related magazines and passed on relevant information to other team members. And he felt able to take professional decisions. He had completed the necessary training for the services offered at the pharmacy. And he had recently completed training about the NHS travel vaccination services. And he had attended a remote meeting about the NHS service before it was implemented.

Team members had appraisals and performance reviews every six months, and these were documented. These were carried out more frequently during probationary periods or for those who were on a pharmacy qualification course. The pharmacist said that he carried out ongoing informal reviews and he would discuss any issues with the team member at the time. Team members felt

comfortable about discussing any issues with the pharmacist or making any suggestions. A newer member of the team said that she felt able to ask any team member if she was unsure about how to do something or where something was in the pharmacy. And she felt supported by the team. The team also had regular reviews of any dispensing mistakes and discussed these openly.

Targets were not set for team members. The pharmacist said that the services were provided for the benefit of the people using the pharmacy. And he did not feel under pressure to carry out the services.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There were two chairs in the shop area. These were positioned close to the medicines counter which meant that there was an increased risk of conversations at the counter being heard. There was a sign to promote social distancing and mask wearing while in the pharmacy.

There were two consultation rooms in the pharmacy. The rooms were suitably equipped, well-screened and accessible to wheelchair users. But they were not kept locked when not in use during the inspection and there were some unsecured medicines in the rooms. The pharmacist said that the rooms would be kept locked in future. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. There was a treatment room with a hatch to the dispensary. This was used by people who needed to speak with the pharmacist in a more private setting. Used plastic cups were discarded into the bin in this room. The pharmacist said that he would consider keeping the bin in the dispensary.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. The pharmacy safely dispenses medicines into different types of compliance packs to help people take their medicines properly.

Inspector's evidence

There was a step up to the pharmacy with a wide entrance. Team members had a clear view of the main entrance and could help people into the premises where needed. A ramp was available and could be used to help people access the pharmacy. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The pharmacy could produce large-print labels for people who needed these. Some medicines dispensed at the pharmacy could be collected from a secure locker in a health and beauty store owned by the company. The pharmacist confirmed that risk assessments for this service had been carried out. People could speak with the pharmacist via the telephone or a video call if they had a query when collecting their medicines. And a small consultation room was available for this. People could also collect their medicines from the locker outside opening hours. People accessing the locker could not access the rest of the store. The pharmacist said that the medicines were stored in a temperature-controlled environment, and records were kept. The pharmacy's delivery driver handed the dispensed items to team members in the store and they then placed the items in the locker. Team members were either trained dispensers, or they had been enrolled on an accredited course. They were trained on how to load the items into the locker system and there were SOPs available for them to refer to if needed.

The pharmacy's needle exchange service was well managed. The pharmacy kept a record of the items supplied and the quantity. Returned sharps bins were placed in a larger bin by the person returning them. This meant that team members did not have to handle the returned bins.

Some team members were trained to carry out consultations as part of the Pharmacy First service. And they were suitably supervised by the pharmacist. They were able to follow the protocol for the service and either offer advice, a referral or suggest a treatment. Team members referred to the pharmacist where needed and records were kept up to date.

Several people received their medicines using the Medicine Care Review (MCR) service. These prescriptions were highlighted so that team members could easily identify these. And they were kept separate from other prescriptions. The pharmacist said that he would speak with people who may benefit from using this system and refer them to speak with their GP. Medicines and care review service trackers were used for each prescription and people would be contacted if they had not collected their medicines. A repeat prescription processing calendar was used to help team members identify when the prescription processing date was. Team members ensured that the medicines were ready for collection around one week before the person needed them. A treatment summary record was sent to the person's GP once all supplies had been made.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines

such as methotrexate and warfarin. And a record of blood test results was made on their medication record. A note was made on a person's medication record if they were on a higher-risk medicine. And the pharmacist explained that he would discuss any concerns with the person's GP. The pharmacist said that prescriptions for higher-risk medicines were sometimes highlighted, but usually for people who had been prescribed a higher-risk medicine for the first time. This meant that there may be missed opportunities to speak with some people about their medicines. Prescriptions for Schedule 3 and 4 CDs were not kept with the medicines waiting for collection. This could increase the chance of these medicines being supplied when the prescription was no longer valid. The pharmacist said that he would ensure that prescriptions were kept with items until they were collected. The pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant patient information leaflets and warning cards available. The pharmacist said that he would speak with people taking these medicines to ensure that they understood the risks with pregnancy, and he would make a note on their medication record.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months was marked. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked daily. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Situation Background Assessment Recommendations (SBAR) forms were sent to the prescriber to request alternate medicines where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacist said that uncollected prescriptions were checked monthly, and people were often contacted to check if they still needed their medicine. Prescriptions for uncollected items were not available at the pharmacy. The pharmacist said that he would ensure that these were kept with the items until collected in future. This would help team members to know the validity of the prescription when the items were handed out. Uncollected items were returned to dispensing stock where possible.

A small number of people received their medicines in multi-compartment compliance packs. There were several team members involved with the management and dispensing of the packs. The dispenser said that people had assessments carried out by their GP to show that they needed their medicines in the packs. Prescriptions for people receiving the packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. The dispenser said that people usually contacted the pharmacy or ordered the prescriptions from their GP if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Patient information leaflets were routinely supplied. This made it easier for people to have up-to-date information about how to take their medicines safely. Team members wore gloves when handling medicines and tweezers were available. The pharmacy dispensed medicines into 'Pill pouch' boxes to a large number of people to help them take their medicines properly. The management of the prescriptions was similar to that for the multi-compartment compliance packs. But the medicines for the pouches were dispensed using a robot. The robot took a picture of each pouch when it was dispensed. Team members said that there had been fewer mistakes made since using the newer system. And any errors could easily be investigated. The system was also quicker and easier to manage. Prescriptions were clinically checked before being processed. Team members manually added the medicines to the canisters in the robot. The medicines were checked by either the pharmacist or accuracy checker and were numbered in correspondence to

the canisters. The team worked around one or two weeks ahead of when the medicines were needed. If there was an issue with the robot, this could be managed remotely by the support team. If the issue could not be fixed remotely, an engineer would attend the pharmacy within a couple of days. A nearby pharmacy had two robots which could be used to dispense urgent prescriptions, or the team could dispense people's medicines into multi-compartment compliance packs where needed.

CDs were largely kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned, and expired CDs were clearly marked and kept separated from dispensing stock. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures electronically for deliveries where possible and these were recorded in a way so that another person's information was protected. This made it easier for the pharmacy to show that the medicines were safely delivered. When the person was not at home, the items were returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery. The delivery driver would hand undelivered CDs to the pharmacist and inform a team member about any issues with the deliveries.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available and separate measures were used to measure certain higher-risk liquids. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Hand sanitiser, masks and gloves were used to help minimise the spread of infection.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for less than one year. The pharmacist said that it would be replaced in line with the manufacturer’s guidance. The glucose testing machine calibrated regularly. The weighing scales were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. The pharmacist explained that he had a temperature tracker app on his phone, and he received notifications if the temperature was outside the recommended range.

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.