General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Care Pharmacy, 87 Main Street, Townhill, Dunfermline, KY12 0EN

Pharmacy reference: 9011806

Type of pharmacy: Community

Date of inspection: 16/06/2023

Pharmacy context

This is a community pharmacy in Dunfermline. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs).

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.1	Standard not met	Staff are deployed in such a way that for periods of time there are not enough suitably qualified staff to operate safely and effectively.
		2.2	Standard not met	There is evidence that team members carry out activities for which they are not appropriately qualified or trained.
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 has written procedures to help the pharmacy team manage the risks with some of its services. And pharmacy team members can show they have taken some action to manage risks they have identified. Team members recognise and appropriately respond to safeguarding concerns to protect vulnerable people. But they do not always safeguard people's private information to keep it safe.

Inspector's evidence

The pharmacy used 'standard operating procedures' (SOPs) to define most of the pharmacy's working practices. And the onsite 'superintendent pharmacist' (SI) provided digital copies for team members to refer to. This included 'responsible pharmacist' and 'controlled drug' procedures. The SI had not defined the dispensing process for multi-compartment compliance packs even though the pharmacy dispensed a significant quantity of them for people that needed extra help with their medicines. This meant that team members had no access to a documented procedure to help them manage dispensing risks. The pharmacy's SOPs showed a review date of April 2023, but this had passed and SI had not reviewed and updated them as intended. Team members signed a declaration to confirm they had read and adhered to the SOPs. And records showed a new trainee dispenser had signed the relevant SOPs in January 2023 when they first started.

Team members signed most of the medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. But pharmacists did not always sign to show they had conducted a final accuracy check for multi-compartment compliance packs. This meant there was a risk that some unchecked packs could be issued in error. The pharmacist used the signature audit trails to help team members learn from their dispensing mistakes. And the dispensers were responsible for recording their own near misses to help consolidate their learnings. They had recorded around three or four near miss errors each month. This had helped to inform discussions about safety improvements to manage the risk of common dispensing mistakes. This had included separating medications with different formulations to avoid selection errors, such as prednisolone and mirtazapine.

Team members knew how to handle complaints from people about the pharmacy's service. And they knew to provide the SI's contact telephone number if someone wished to complain. Team members knew to speak to the 'responsible pharmacist' (RP) when they were notified about dispensing mistakes that people reported after they left the pharmacy. But they had no knowledge of the incident reporting procedure to identify and record the root cause analysis and any safety improvements that were introduced to manage dispensing risks. Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place which were valid until 7 February 2024. The pharmacist displayed an RP notice which was visible from the waiting area. And the RP record showed the name and registration details of the pharmacist in charge.

Team members maintained digital 'controlled drug' (CD) registers and kept them up to date. They evidenced they carried out balance checks around once a month. People returned controlled drugs they no longer needed for safe disposal. And team members used a CD destruction register to document items which the pharmacist signed to confirm destructions had taken place. Team members filed

prescriptions so they could easily retrieve them if needed. And they kept records of supplies against private prescriptions and supplies of 'specials’ that were up to date. Team members were aware of data protection requirements and how to protect people's privacy. And they used a shredder to dispose of confidential waste. A privacy notice on the waiting room wall provided assurance that the pharmacy protected people’s personal information. Team members knew to discuss safeguarding concerns with the pharmacist. And the delivery driver provided examples of when they had spoken to the pharmacist and other team members when they had cause for concern. The pharmacy had contact details for local agencies for ease of access.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not ensure that there are enough suitably qualified team members available for it to operate safely and effectively all the time. And it allows them to carry out activities for which they are not appropriately qualified or trained.

Inspector's evidence

The pharmacy had relocated in February 2022 and its prescription workload had been growing steadily ever since. This was mostly due to the increasing number of multi-compartment compliance packs it dispensed. The pharmacy was operating with a full-time trainee pharmacist and a new trainee dispenser who had taken up their post in January 2023. The new team member had read the SOPs that were relevant to their role, and the 'superintendent pharmacist' (SI) had enrolled them on qualification training, so they were eligible to carry out dispensing tasks. The SI usually worked at the pharmacy, but they had been providing cover at another branch due to staffing shortages. A relief pharmacist was providing cover at the time of the inspection.

The pharmacy had recently employed a trainee pharmacist, and the SI was the designated supervisor. They were due to meet the following week to discuss progress and to agree a development plan to make sure they met their training objectives. The pharmacy employed a driver to deliver medications to vulnerable people in their homes. But the SI had not arranged for them to read the relevant SOPs and they had not been enrolled on to the necessary qualification training for delivery drivers. The driver had learned about UK GDPR and safeguarding vulnerable adults and children in the course of their work.

The pharmacy did not provide the trainee dispenser with protected learning time in the workplace to help them with their course work. This was due to the pharmacy operating with a vacant dispenser post due to someone leaving. The SI had been advertising for a replacement dispenser and as an interim measure the pharmacy had been using untrained family members to help with dispensing tasks. This included de-blistering medications for multi-compartment compliance packs. The pharmacy had not adequately trained the trainee dispenser to correctly pre-pack and label medications before placing them on the pharmacy shelves. The pre-packs mostly contained medications from multi-compartment compliance packs that had not been collected. They did not meet labelling legislation which required the medicine’s batch number and expiry date to be included.

Team members acted on suggestions for improvements. For example, they had changed the way they stored dispensed items in the CD cabinet following feedback from a locum pharmacist. And they had introduced individual dispensing baskets to safely segregate dispensed doses for each person to manage the risk of dispensing mistakes. Team members understood their obligations to raise whistleblowing concerns if necessary. And they knew to refer concerns to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises support the safe delivery of its services. And it effectively 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

The pharmacy provided a modern, purpose-built environment from which to safely provide services. It had sufficient space to store medicines and adequate bench space to carry out the various processes and procedures. Team members used a large separate rear area to assemble and store multi-compartment compliance packs.

A sound-proofed consultation room provided a confidential environment. And people could speak freely with the pharmacist and the other team members during private consultations. An integrated hatch in the consultation room provided access for those that used supervised consumption services. And team members cleaned and sanitised the dispensary and the consultation room when they had time to do so. This ensured it remained hygienic for its services.

Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate room provided adequate space for team members to take comfort breaks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are mostly accessible. And it manages its services to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. But stock medicines are not always appropriately packaged or labelled. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has some arrangements to identify and remove medicines that are no longer fit for purpose. But it is not always able to show how it acts on drug alerts or recalls.

Inspector's evidence

A stepped entrance provided access to the pharmacy, but some people with mobility difficulties found it difficult to access the pharmacy's services. The pharmacy did not have a portable ramp, or other such arrangements and team members monitored the entrance so they could see people at the door while they waited outside. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were safe to supply. They checked expiry dates at least every six months and attached stickers to highlight short-dated stock. And an audit trail helped team members keep track of when checks were next due. The pharmacy used a fridge to keep medicines at the manufacturers' recommended temperature. And team members monitored and recorded the temperature to provide assurance it was operating within the accepted range of two and eight degrees Celsius. Team members kept stock neat and tidy on a series of shelves. And they used a secure controlled drug (CD) cabinet for some of its items. Medicines were well-organised and items awaiting destruction were kept segregated from other stock.

The pharmacy had medical waste bins which helped the team to manage and dispose of pharmaceutical waste. Team members could recall acting on drug alerts, but they were unable to produce an audit trail of previous alerts to evidence the action they had taken. This meant there was a risk of some items being missed and not being removed from stock in time. Several pre-packed medicines were seen on the shelves, but they did not meet labelling legislation which required the medicine's batch number and expiry date to be included. The pharmacy did not have a documented procedure for pre-packing and there was no requirement for team members to obtain accuracy checks from the pharmacist. This meant there was a risk of mistakes going undetected and people receiving the wrong medication. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so as not to cover-up the warning messages. The pharmacy supplied patient information leaflets and information cards. And they had spare information cards in the event they needed to supply split packs. The pharmacy used dispensing baskets to safely hold medicines and prescriptions during the dispensing process. And this helped manage the risk of items becoming mixed-up.

The pharmacy supervised the consumption of some medicines. And team members dispensed doses in advance, so they were available for people to collect. They obtained a clinical and accuracy check at the time of dispensing. And the pharmacist carried out a final accuracy check at the time they made the supply. Team members stored the doses in individual baskets to safely segregate items to manage the

risk of dispensing mistakes. The pharmacy supplied medicines in multi-compartment compliance packs to help people with their medication. And they used a separate rear area to assemble and store the packs. Trackers helped team members to plan the dispensing of the packs. And this ensured that people received their medications at the right time. They also used supplementary records that provided a list of each person's current medication and dose times which they kept up to date. And they checked new prescriptions against the records for accuracy. Team members did not provide descriptions of medicines and they did not supply patient information leaflets for people to refer to. Some people collected the packs either themselves or by a representative. And team members monitored the collections to confirm they had been collected on time. This helped them to identify when they needed to contact the relevant authorities to raise concerns. The pharmacy had recently purchased a robot for the dispensing of multi-compartment compliance packs. The robot was not in use and had not been used previously for the dispensing of packs. The ‘superintendent pharmacist’ (SI) was considering its use which included dispensing packs for three other branches. De-blistered medicines in large, labelled containers had been pre-packed around six months previously in readiness for the robot’s operations but some had expired in May 2023 and were still on the shelves. The pharmacy dispensed serial prescriptions for people that had registered with the ‘medicines: care and review’ service (MCR). The pharmacy had a system for managing dispensing. And they retrieved prescriptions once a week so they could order items and dispense them in advance. Most people collected their medication when it was due. And team members knew to refer people who arrived either too early or too late so the pharmacist could check compliance.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. But it does not always use 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 a separate measure for methadone. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could carry out conversations in private if needed, using portable telephone handsets. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the sink was clean and suitable for dispensing purposes.

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.