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: 29/01/2024

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 supply over-the-counter medicines.

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

Pharmacy team members follow safe working practices. And they manage dispensing risks to keep services safe. The pharmacy keeps all the records that it should, making sure they are easily accessible. Its team members have an appropriate understanding of their role in helping protect vulnerable people. They manage and protect people's confidential information well.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define the pharmacy's working practices. Team members described their roles within the pharmacy and the processes they were involved in and accurately explained which activities could not be undertaken in the absence of the responsible pharmacist. SOPs had been reviewed in July 2023 by the superintendent pharmacist (SI). Some team members had read and signed to show they would follow them. But not all team members had signed the SOPs related to their job role. The pharmacist manager gave assurances that this would be addressed following the inspection.

Team members kept records about dispensing mistakes that were identified in the pharmacy, known as near misses. And they recorded errors that had been identified after people received their medicines, known as dispensing errors. There were documented procedures to help team members do this effectively. Team members discussed their errors and why they might have happened. And they used this information to make some changes to help prevent the same or similar mistakes from happening again. For example, they had highlighted medicines that looked alike, or sounded alike (LASA) on the shelves to help prevent the wrong medication being selected. Pharmacy team members did not always capture detailed information about why the mistakes had been made to help aid future reflection and learning. And the pharmacy did not analyse the errors for patterns, so it might miss opportunities to reflect, learn, and make improvements to the pharmacy's services.

The pharmacy had current indemnity insurance. It displayed the correct responsible pharmacist notice and had an accurate responsible pharmacist record. From the records seen, it had accurate records for private prescriptions and unlicensed medicines. The pharmacy kept digital controlled drug (CD) records with running balances. A random balance check of two controlled drugs matched the balance recorded in the register. Stock balances were observed to be checked on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy. It backed up electronic patient medication records (PMR) avoid data being lost.

The pharmacy had a documented procedure in place for handling complaints and feedback from people. Pharmacy team members explained how people usually provided verbal feedback. And any complaints were referred to the pharmacist to handle. Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste for shredding. No person-identifiable information was visible to the public. The pharmacy had a documented procedure to help its team members raise any concerns they may have about the safeguarding of vulnerable adults and children and had access to contact details and processes. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. A team member explained the process they would follow if they had concerns about a vulnerable person and would raise concerns to the RP. And they gave an example of how they had raised a concern locally.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely and effectively. Pharmacy team members work well together and can make suggestions to improve safety where appropriate.

Inspector's evidence

The pharmacy employed one full-time pharmacist manager, two full-time trainee dispensers, two part-time delivery drivers and trainee dispenser who only worked on a Saturday morning. A regular locum pharmacist provided cover on the manager's regular day off and was the RP at the time of the inspection.

Team members were seen to be managing the workload. They demonstrated a good rapport with many people who visited the pharmacy and were seen appropriately helping them manage their healthcare needs. Team members had planned learning time during their working day to undertake regular training. A trainee dispenser was observed being supervised in their role and described the training plan that they were working through. Team members had informal appraisals with the pharmacist manager. The SI visited the pharmacy periodically to complete reviews with each team member. And team members felt able to contact the SI by phone when needed.

Team members asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. Pharmacy team members understood the importance of reporting mistakes and were comfortable openly discussing their own mistakes with the rest of the team to improve learning. They felt able to make suggestions and raise concerns to the manager or SI. The pharmacy team discussed incidents and how to reduce risks. The team had occasional team meetings.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a secure and professional environment for people to receive its services. The team keeps them clean and tidy, presenting a suitably professional image. The premises include a private room which the team uses to provide some of its services and for private conversations.

Inspector's evidence

The pharmacy comprised of a small retail area leading into a large dispensary with back shop area including storage space and staff facilities. Its overall appearance was professional. It had sufficient space to store medicines and adequate bench space to carry out the various processes and procedures. The premises were generally clean and hygienic. There was a sink in the rear staff area of the pharmacy which was also used to measure liquid medicines. It was kept clean so was suitable for professional use. And it had hot and cold running water, soap, and clean hand towels. The was evidence of isolated damp patches at the top of the wall in the rear area of the dispensary. And team members described water ingress through the roof following recent extreme weather. They had reported these issues to the SI. No medicines were stored in the affected areas.

People were not able to see activities being undertaken in the dispensary. The pharmacy had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions. Team members kept a record of daily cleaning activities. The pharmacy had a consultation room with a desk and a chair, and the door closed which provided privacy. And it provided a confidential environment for the administration of vaccinations and other services. An integrated hatch in the consultation room provided access for those that used supervised consumption services. When not in use, the door was kept locked to prevent unauthorised access. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages its services well to help people look after their health. It correctly sources its medicines, and completes checks of them to make sure they are suitable to supply to people. And it takes the right action when it receives an alert about the safety of a medicine.

Inspector's evidence

Steps at the front entrance created some difficulty for some people to access the pharmacy. For example, people who used wheelchairs, or had prams. Team members monitored the entrance so they could see people at the door while they waited outside. And the owners were waiting for a contractor to install a concrete ramp to the entrance. The pharmacy advertised some of its services and its opening hours in the main window. And it provided a medicines' delivery service. A team member prepared the day's deliveries and details were uploaded onto an online delivery platform. This allowed team members to view the day's scheduled deliveries. This was useful if people called the pharmacy asking about their expected delivery. Delivery drivers used an electronic device to plan and record deliveries and people signed to acknowledge receipt of certain medicines such as CDs.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to separate people's medicines and prescriptions. And they attached coloured labels to bags containing people's dispensed medicines to act as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line or a CD that needed handing out at the same time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked medicines. Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these on a weekly basis in an eight-week cycle. Team members maintained records of when people collected their medication. This meant the pharmacist could then identify any potential issues with people not taking their medication as they should.

The pharmacy supplied medicines in multi-compartment compliance packs to people who needed extra support taking their medicines. Pharmacy team members managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept master backing sheets for each person for each week of assembly. These master sheets documented the person's current medicines and administration time. Records contained notes of previous changes to medication, creating an audit trail of the changes. Packs were labelled so people had written instructions about how to take their medicines. But labels did not include descriptions of what the medicines looked like. And team members only provided people with patient information leaflets about their medicines when they started receiving their medication in packs, or when requested. So people may not be able to identify the medication contained in the packs, or have all the information they need about their medicines. Shelving to store the packs was kept neat and tidy. The pharmacy supervised the consumption of some medicines. And team members dispensed doses in advance, so they were available for people to collect.

Team members removed some tablets from original packaging to first place them into sealed white plastic containers, then to be used for multi-compartment compliance packs. Team members labelled all containers with drug name, batch number and expiry date. They did not record the date the medication was removed from its original packaging and who carried out and checked these tasks. The

pharmacy did not have data to confirm how long medicines could be safely removed from manufacturers' packaging.

Team members had some knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. And they dispensed valproate in the original pack. But they could not show if any interventions with the pharmacist to discuss the ongoing use of valproate had been recorded on the patient medication record (PMR). The pharmacy had patient group directions (PGDs) for unscheduled care, the Pharmacy First service, smoking cessation and emergency hormonal contraception (EHC). Pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They referred to the pharmacist as required.

The pharmacy obtained medicines from recognised suppliers. It stored medicines neatly on shelves. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. And team members followed the sale of medicines protocol when selling these. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. They attached stickers to highlight short-dated stock and maintained a list of these products to ensure they were removed from the shelves before they expired. The pharmacy had disposal bins for expired and patient-returned stock. The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records about what it had done.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people’s private information.

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 access to a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines.

Team members kept clean crown-stamped measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. The pharmacy team kept clean tablet and capsule counters in the dispensary. 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.

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.