General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M Farren Pharmacy, 45-47 Main Street, MUIRKIRK, Ayrshire, KA18 3QR

Pharmacy reference: 1041873

Type of pharmacy: Community

Date of inspection: 22/11/2022

Pharmacy context

A traditional community pharmacy in the small village of Muirkirk. The pharmacy provides a range of services including dispensing prescriptions and selling over-the-counter medicines. It provides a selection of other services including a prescription collection service and a medicines' delivery service. It also provides a flu vaccination service and the NHS Pharmacy First service. And it supplies medicines for its substance misuse 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 has written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's private information properly. The pharmacy adequately identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The responsible pharmacist (RP) highlighted and discussed mistakes as they happened. He did this to help the team to reflect and learn from them. And to prevent it from making the same mistake again. The pharmacy team recorded its mistakes in a 'near miss' log. And the RP then sent the records to head office for review. But the near miss records did not contain much detail. And they did not show what the team member had learned. And what they would do differently in future to prevent a similar mistake. The RP recognised that near miss records should provide enough detail to allow him to monitor the team's improvement. And he recognised the importance of monitoring and reviewing near misses and errors so the team could learn as much as possible from them. Team members described how they had separated medicines which look alike and sound alike (LASA) to reduce the chance of selecting the wrong one. And they described their process of double checking each item as part of their dispensing process. This was in addition to the pharmacist's final accuracy check. The pharmacy had put measures in place to help reduce the transfer of infections. It had put screens up at its medicines' counter. And it had hand sanitiser at different locations in the pharmacy for people and the team to use. The team had a cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly.

The pharmacy had a set of standard operating procedures (SOPs) to follow. And staff had read them. The SOPs had last been reviewed over two years ago. And they were due to be updated. Team members appeared to understand their roles and responsibilities. The medicines counter assistant (MCA) was seen consulting the RP when she needed his advice and expertise. And the dispensing assistant (DA) could describe the procedure she followed when dispensing medicines into multi-compartment compliance packs. She knew how to check for any items missing from prescriptions. And she had a system for tracking the process. She tracked the process from when prescriptions were due to be ordered up to the point that the packs were collected or delivered to people. She was seen to do this and to alert the RP when she needed to. The RP had placed his RP notice on display showing his name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services. Team members described the pharmacy as having a low number of complaints. And they generally dealt with any concerns as they arose. They also provided people with a number for head office if they were asked. But in general, the team sought feedback by listening to what people had to say. Most of the people who used the pharmacy's services lived locally. And it was clear that the pharmacy team had a good relationship with them. It had received thank you cards from people who were grateful for the team's help and support with providing their medicines. But, if necessary, the pharmacy team could provide people with details of the local NHS complaints procedure for the local health board. And they could find these details

online. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy kept its records in the way it was meant to, including its unlicensed specials records, private prescription records, RP records and controlled drugs (CD) registers. It maintained and audited its CD running balances. And during the inspection, a check of a product in stock matched the running balance in the pharmacy's CD register. The pharmacy kept a CD destruction register for patient returned CD medicines. This was up to date as team members completed the record as soon as they received any. The pharmacy also had the appropriate records for supplies made under the NHS Pharmacy First service, the NHS 'Medicines Care Review' (MCR) service and serial prescriptions. It did not have records for emergency supplies as it didn't make any. Instead, the pharmacy supplied emergency medicines by using the NHS Unscheduled Care patient group direction (PGD). And it recorded these supplies using the necessary form (UCF). And notified the patient's GP. The team knew that it was important to ensure that all the pharmacy's essential records were complete and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed appropriate training. Confidential paper waste was discarded into separate waste containers. And currently, while the pharmacy's shredder was broken, it sent its confidential paper waste to head office for shredding. People's personal information, including their prescription details, were kept out of people's view. The RP had completed appropriate safeguarding training. Other team members had a good understanding of their safeguarding responsibilities and knew to report any concerns to social services, the police or a person's GP as appropriate. The team could access details for the relevant authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has an appropriate range of skills and experience to support its services. And it manages its workload safely and effectively. Its team members support one another well. And they keep their knowledge up to date. Team members receive sufficient feedback to help them carry out their tasks satisfactorily.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours and found the regular RP on duty. The rest of the team consisted of two DAs and an MCA. Most of the pharmacy's team members had worked at the pharmacy for several years and were known to people in the local community. They worked regularly together. And they formed a close-knit team. Team members had a clear understanding of what their tasks were. And when they should do them. And they were seen supporting one another to complete them. Including attending to people at the counter or helping each other to locate a prescription. Overall, the working atmosphere was calm, efficient and organised. Staff were up to date with the daily workload of prescriptions. This included prescriptions for multi-compartment compliance packs. And they attended to people coming into the pharmacy promptly.

Although the pharmacy's team members did not have formal reviews about their work performance. They discussed issues as they arose while they worked. And they could also have a one-to-one with the regular RP when they wanted or needed one. The regular RP also kept the team up to date with any changes affecting their work or any new work priorities. And team members were encouraged to keep up to date by reading training material. On new products for example. Staff could raise concerns and discuss issues with the regular RP, locum RPs or the superintendent (SP). The RP felt that he could also discuss any concerns with the SP. Pharmacists could make their own professional decisions in the interest of people and were not under pressure to meet business or professional targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. The pharmacy is tidy and organised. And it is sufficiently clean and secure.

Inspector's evidence

The pharmacy was on the main street in the centre of the village. It was in an old building with a traditional appearance. And inside, it had a small network of rooms. The pharmacy had a retail space which was sufficient to stock its general sales medicines, beauty products, baby products, general gift items and items related to healthcare. The pharmacy kept its pharmacy medicines behind the medicines counter. And alongside the medicines counter it had a consultation room. An open doorway from the counter led to a short corridor which connected directly to a prescription storage area and the dispensary. Further along, the corridor led to a back room, staff facilities and a general storage area. The back room was used for storage and for dispensing multi-compartment compliance packs. But the main dispensary was used for most of the pharmacy's dispensing activities. These included the dispensing of repeat prescriptions, medicines care review (MCR) prescriptions and instalment prescriptions.

The main dispensary had work surfaces on three sides. And it had storage shelves and drawers. In general, team members tidied up as they worked. They did this to make sure they had enough space to work safely. The pharmacy's consultation was sufficiently soundproof to ensure that private conversations held inside it could not be heard by other people. The pharmacist used the room for private conversations with people and when providing certain services. This included its service for treating a urinary tract infection under PGD. People could access the consultation room from the retail area. The team cleaned the pharmacy daily to ensure that contact surfaces were clean. Stock on shelves was tidy and organised. And work surfaces were free from unnecessary clutter. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. And it supports people with suitable advice and healthcare information. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy generally stores its medicines properly. But it does not ensure it properly packages all the medicines it supplies.

Inspector's evidence

The pharmacy promoted its services and its opening times on its windows and doors. It had step-free access. And the team kept the retail area free of clutter and unnecessary obstacles. The pharmacy had a delivery service for people who could not visit the pharmacy to collect their prescriptions. And it could also order people's repeat prescriptions for them. The pharmacy team used baskets to hold individual prescriptions and their corresponding medicines together to help avoid errors. The RP gave people advice on a range of matters. And he gave appropriate advice to people taking higher-risk medicines. The pharmacy had a small number of people taking sodium valproate medicines. But no-one was in the at-risk group. The RP knew to counsel any at-risk people when supplying the medicine to ensure that they were on a pregnancy prevention programme. And to ensure that they were aware of the risks associated with the medicine. The pharmacy had the appropriate patient cards and information leaflets which they gave with each supply.

The pharmacy supplied medicines in multi-compartment compliance packs for people living at home. The pharmacy's labelling directions on compliance packs gave the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines and with regular repeat medicines. And it labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. The pharmacy organised its compliance pack service in accordance with a rolling four-week cycle. It reordered people's prescriptions on week two. And it ordered their medicines on week three. This gave the team time to chase up any missing prescriptions and arrange for alternatives when items were unavailable. It then dispensed them, so they were ready for delivery or collection on week four, when people were on their last pack of the previous cycle. And ready for their next one.

The pharmacy offered the NHS 'Pharmacy First' service. Where people could obtain medicines for a range of minor ailments and conditions. Team members had been trained to supply medicines for a select range of conditions such as antihistamines for hay fever. And lactulose for constipation. They followed the local health board protocol and supplied medicines from a specified list. Team members knew when to refer to the pharmacist when someone presented with a condition which they had not been trained to treat such as a urinary tract infection (UTI) or a skin infection. The pharmacy had a range of patient group directions (PGDs) in place. This provided a way for pharmacists to provide prescription medicines. PGDs in place included antibiotics for impetigo or a UTI.

A small number of people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The team knew how to process serial prescriptions. And it had a system for monitoring and tracking supplies so that it knew when people were due to get their medicines. The system also allowed the team to monitor compliance and address any issues. The RP used the pharmacy care record to identify

people for review. These were often people on regular repeat prescriptions. He used the NHS medicines care review (MCR) process to identify any care issues, referring people back to their GP where further medical intervention was required. The pharmacy supplied a variety of medicines by instalment. A trained team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the labelled medicines together in individual baskets to keep the instalments together.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines, appropriately and in their original containers. But the inspector found a pack of venlafaxine 75mg tablets which contained strips of tablets from two different batches. And the strips had two different expiry dates. The pharmacy also had a bottle of loose tablets which had been removed from their original pack. Although the pack had been labelled it did not contain all the manufacturer's information. And so, it could be missed if it was part of a medicines recall. The inspector discussed this with the RP, and it was agreed that team members should review their understanding of the correct procedures to follow when putting medicines back into stock after dispensing.

The pharmacy supplied some daily doses and weekly instalments of tablets in labelled transparent plastic bags rather than a tablet carton. The RP and inspector discussed the importance of ensuring that the packaging used should adequately protect the contents.

In general, stock on the shelves was tidy and organised. The pharmacy date-checked its stocks regularly. And the team kept records to help it manage the process effectively. Short-dated stock was identified and highlighted. And the sample of stock checked by the inspector was in date. The team put its out-of-date and patient returned medicines into dedicated waste containers. And it stored its fridge items appropriately. It monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. But the team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. And they had access to personal protective equipment (PPE), in the form of sanitiser, face masks and gloves. The pharmacy had several computer terminals which had been placed at individual workstations around the pharmacy. Computers were password protected. And prescriptions were stored out of people's view. The pharmacy had cordless telephones to enable team members to go to a quieter location to hold 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.