General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: JE Robertson Pharmacy, 107 Main Street, COATBRIDGE, Lanarkshire, ML5 3EL

Pharmacy reference: 1042226

Type of pharmacy: Community

Date of inspection: 30/10/2019

Pharmacy context

This is a community pharmacy in a shopping precinct in the centre of Coatbridge. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It also offers a smoking cessation service and aesthetic treatments.

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 team members work to professional standards. And this helps them to keep services safe. The pharmacy keeps records of errors when they happen. But, it does not always review them to spot patterns. And the pharmacy team members may not always make the necessary improvements to the way they work. The pharmacy keeps the records it needs to by law. And it provides training to keep confidential information safe. The team members understand their role in protecting vulnerable people. And they contact others to make sure people get the support they need. The pharmacy informs people how to complain or provide feedback. And this helps it puts things right when it is able to.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. And the team members had signed them to show they understood their roles and responsibilities. The pharmacy had displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. The team members signed dispensing labels to show they had completed a dispensing task. And the pharmacists checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The pharmacists recorded the near-misses. But, they did not always provide information about the cause of the error. And they did not carry out regular reviews to identify patterns and trends to manage risks. The team members provided a few examples of stock changes to manage selection errors. Such as attaching a warning label to the shelf where they kept Priadel. And separating atenolol and amitriptyline. The pharmacists managed the incident reporting process. And the pharmacy team knew when incidents happened and what the cause had been. For example, they knew about an error when the wrong multi-compartment compliance pack was handed out. The pharmacy team had reflected on the error. And they agreed to obtain a second check at the time the packs were collected. The pharmacy team did not use a complaints policy to ensure that staff handled complaints in a consistent manner. But, it displayed a notice to inform people about the complaints process and how to give feedback about the service they had received.

The pharmacy maintained the pharmacy records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity insurance in place. And it was valid until August 2020. The pharmacy team kept the controlled drug registers up to date. And they checked and verified the balance of controlled drugs every few months. The pharmacy team recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. The pharmacy provided a delivery service. And the delivery driver made sure that people signed for their medication to confirm receipt. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. And a sample trimethoprim PGD was valid until November 2019.

The pharmacy displayed a notice which informed people about its data protection arrangements. The pharmacy trained the team members to comply with the arrangements. And they knew how to safely process and protect personal information. The team members shredded confidential information. And

they archived spent records for the standard retention period. The protecting vulnerable group (PVG) scheme was used to help protect children and vulnerable adults. And the company had registered the pharmacist with the scheme. The company did not provide safeguarding training. But, the team members knew to refer concerns to the pharmacist. For example, when people using multi-compartment compliance packs were not collecting their prescriptions when they were expected to. The team members contacted family members or carers to check on people. And they referred concerns to the GP to ensure people received the support they needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And it ensures it has the right number of suitably qualified pharmacy team members throughout the week. The pharmacy team members have some access to ongoing training. And they are supported to keep up to date in their roles. The pharmacy team members support each other in their day-to-day work. And they suggest service changes to make sure they have effective working practices.

Inspector's evidence

The pharmacy had experienced a slight growth in the number of NHS prescription items it dispensed over the past year. The pharmacy had improved its skill-mix as a result. And a medicines counter assistant (MCA) was being trained to work in the dispensary and dispense multi-compartment compliance packs. A second pharmacist provided cover three days a week. And he mentored the trainee during protected learning time. The pharmacy team was well-established with most of the team members having worked at the pharmacy for a significant length of time. The pharmacist managed annual leave requests. And authorised annual leave for one team member at a time to maintain minimum levels. The pharmacy kept training qualifications on-site. And the following team members were in post; one full-time pharmacist, one part-time pharmacist, one full-time dispenser, two part-time dispensers, one full-time trainee dispenser, one full-time medicines counter assistant (MCA), one part-time MCA, one Saturday trainee MCA and one part-time delivery driver.

The team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had suggested keeping controlled drug (CD) prescriptions separate. And this had saved time at the end of the day when they entered the relevant prescription information in the CD registers. The pharmacy team members did not always take the opportunity to review each other's near-misses. And this prevented them from learning from mistakes and identifying weaknesses in their systems.

The pharmacy did not use individual performance reviews to identify areas for development. But, the pharmacist kept the pharmacy team members up-to-date with service changes at the time, so they were competent in their roles. The pharmacy had provided some training over the past year. And it had developed the team member's knowledge about Viagra, CBD oil and the Pharmacy First service. The pharmacy didn't use numerical targets to grow services. But, team members knew to focus on people that would be suitable for the chronic medication service (CMS).

Principle 3 - Premises ✔ Standards met

Summary findings

The premises is secure, clean and hygienic. It has a consultation room that is professional in appearance. And it is an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

A well-kept waiting area presented a professional image to the public. And the pharmacy provided seating and healthcare information leaflets for self-selection. The pharmacy had allocated areas and benches for the different dispensing tasks. And the team members dispensed multi-compartment compliance packs in a separate upstairs room. The pharmacist supervised the medicines counter from the checking bench. And could make interventions when needed. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy provided a consultation room and integrated hatch, and it was professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from licenced wholesalers. But it doesn't always provide assurance that medicines are stored at the temperature they need to be. The pharmacy keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know what services are available to them.

Inspector's evidence

The pharmacy had step-free access. And an automatic door provided unrestricted access for people with mobility difficulties. The pharmacy displayed its opening hours in the window and inside the pharmacy. And it displayed healthcare information leaflets in the waiting area and in the consultation room. The dispensing benches were organised. And the pharmacy team used dispensing baskets to keep prescriptions and medicines contained throughout the dispensing process.

A pharmacist independent prescriber provided an aesthetics clinic in a separate upstairs room. The room was equipped with a fridge and cupboards to store aesthetic products and a yellow bin for clinical waste. But, the fridge temperature records were not kept on-site. And there was a lack of assurance to show that products had remained in the accepted range of 2 and 8 degrees Celsius. The pharmacist displayed separate indemnity insurance arrangement which expired in August 2020. And he displayed a certificate of membership with the Aesthetic Complications Expert Group (ACE) which provided training and guidelines. The pharmacist issued private prescriptions. And these were kept alongside the pharmacy's private prescription records.

The pharmacy collected prescriptions from the local GP practices. And it provided a delivery service to housebound and vulnerable people. The delivery driver asked people to sign to confirm receipt of their medication. And the records were returned and retained in the pharmacy. The team members had been trained to speak to people about their medicines. And they used a questionnaire to identify people that would be suitable for the chronic medication service (CMS).

The pharmacy dispensed multi-compartment compliance packs for between 140 and 170 people. The pharmacy team members had read and signed working instructions to confirm they followed safe and effective practices. And they dispensed the packs in a separate room to minimise interruptions and distractions. The team members selected stock and placed it in a yellow basket. And the pharmacist carried out pre-checks before they assembled the packs. The team members isolated packs when they were notified about prescription changes. And only made changes once they had received the new prescription. The team members supplied patient information leaflets. And they annotated descriptions of medicines inside the pack. The team members obtained an accuracy check at the time they issued packs. And this managed the risk of hand-out errors. The pharmacists dispensed and supplied methadone doses to around 20 people. And the doses were dispensed either the day before, or on the morning they were due to be supervised. The pharmacist attached an extra label to the sugar-free methadone stock container. And this ensured team members were able to diferentiate it from the sugar-containing liquid.

The team members kept the pharmacy shelves neat and tidy. And kept controlled drugs in three well-organised cabinets. The pharmacy team carried out regular stock management activities. And highlighted short dated stock and part-packs during regular checks. The team members monitored the fridge temperatures. But, they did not always record the temperatures to show that stock had remained between two and eight degrees Celsius. The pharmacy used two fridges; one for general stock and the other for insulin products. The pharmacy accepted returned medicines from the public. And it disposed of them in yellow containers that the health board collected.

The pharmacy team acted on drug alerts and recalls. And they recorded the date they checked for affected stock and the outcome. For example, they had checked for ranitidine in October 2019 with no stock found. The pharmacy had implemented the Falsified Medicines Directive (FMD). And the team members had been routinely scanning packs up until a few days before when they were unable to access the system. The pharmacist was in discussion with the service provider to resolve the issue. The team members had learned about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards and when to issue them. The pharmacist monitored prescriptions for valproate. And added flash notes to the PMR to confirm that people had been provided with safety messages.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used crown-stamped measuring equipment. And the measure for methadone was highlighted and kept separate. The pharmacy kept cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team. The pharmacy team members used a portable phone. And they took calls in private when necessary.

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.