General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Thomas McLean and Sons Ltd., 3 Kenilworth Court, Cumbernauld, GLASGOW, Lanarkshire, G67 1BP

Pharmacy reference: 1042395

Type of pharmacy: Community

Date of inspection: 05/12/2019

Pharmacy context

This is a community pharmacy located alongside a medical centre. 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 provides substance misuse services and 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.

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	2.2	Good practice	The pharmacy team members complete regular training. And the pharmacy provides time during the working day to support them to do so.
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. They provide safe services and look after people's welfare. The team members record and discuss mistakes that happen. They use this information to learn and reduce the risk of further errors. But they don't always collect information about the causes of mistakes to help inform the changes they make. So, they may miss opportunities to improve. The pharmacy keeps the records it needs to by law. And it provides regular training to keep confidential information safe. It understands its role in protecting vulnerable people. And team members complete regular training to ensure they are up-to-date with safeguarding requirements. People using the pharmacy can raise concerns. And team members know to follow the company's complaints handling procedure. This means that they listen to people and put things right when they can. The pharmacy encourages people to provide feedback about its services. And they make changes to their processes when they need to.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. The team members had signed to confirm they followed the procedures. And to show they understood their roles and responsibilities. For example, a new medicines counter assistant (MCA) knew to follow the medicines sales protocol. And they knew to refer to the pharmacist when they had concerns about requests such as excessive requests for codeine containing products. The MCA knew to use the WHHAM mnemonic (Who is it for, What are the symptoms, How long have the symptoms been present, Any other medication being used at present and What Medication has been tried already). And this ensured they identified safety concerns that they referred to the pharmacist. The pharmacy employed two accuracy checking technicians (ACTs). And they knew only to check prescriptions that had been approved and annotated by the pharmacists. The pharmacy team signed dispensing labels to show they had completed a dispensing task. And the pharmacist and the accuracy checking technician (ACT) checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The dispensers recorded their own near-misses. And the pre-registration pharmacist had been reviewing the forms see if they could identify patterns and common themes. The pharmacy team discussed the findings. And they had implemented a few additional steps to avoid the same errors happening again. For example, the pharmacy had experienced an increase in the number of people who wanted to wait on their prescriptions being dispensed. And the team members had agreed to monitor the queue and provide realistic waiting times. This had ensured they did not rush dispensing and they avoided making mistakes. The team members had identified a pattern of mistakes during breaks and lunchtime due to reductions in the pharmacy team. And again, the team members agreed not to rush when they were busy. The team members had separated amlodipine 5mg/10mg and amoxicillin 50mg/500mg due to selection errors. The pharmacist managed the incident reporting process. And the pharmacy team members knew when incidents happened and what the cause had been. For example, they knew about an error when atenolol 50mg had been incorrectly supplied against a prescription for 100mg. The pharmacy team had discussed the incident. And they had separated the different strengths and added shelf-edge caution labels to help them manage the risk of the same incident happening again. The pharmacy used a complaints policy to ensure that staff handled complaints in a consistent manner. And it displayed a notice in the waiting area to inform people about the complaints process. The pharmacy encouraged people to provide feedback about its services. And it had mostly

received praise and positive comments.

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 and up to date until 9 January 2020. The pharmacy team kept the electronic controlled drug registers up to date. And the team members checked prescriptions at the end of the day to ensure they had registered controlled drugs. One of the ACTs had been nominated to carry out regular balance checks. And they carried out the checks once a month. 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. 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. But a sample showed that the trimethoprim PGD had gone past its review date of November 2019. And the Health Board was in the process of reviewing and updating the documents.

The pharmacy displayed a notice which informed people about its data protection arrangements. The pharmacy trained the team members on a regular basis to comply with its arrangements. And they knew how to safely process and protect personal information. The team members used a shredder to dispose of confidential waste. And they archived spent records for the standard retention period. The pharmacy used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. And the pharmacists were registered with the scheme. The pharmacy displayed a chaperone notice on the consultation room door. And the it trained the team members to comply with its safeguarding arrangements. The pharmacy provided contact details. And the team members knew who to contact if they had a concern about a child or an adult. The team members recognised the signs and symptoms of abuse and neglect. And knew when to refer to the pharmacist. For example, one of the team members had identified someone who was having difficulty remembering to take their medication. And the pharmacist had intervened and arranged for the person to be supplied with a multi-compartment compliance pack to support them to take their medicines on time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And they identify and discuss their learning needs at regular review meetings to keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training and protected learning time in the work-place. The pharmacy team members support each other in their day-to-day work. And they can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

Inspector's evidence

The pharmacy had experienced a slight growth over the past year. And it was dispensing more NHS prescriptions. The pharmacist carried out reviews to ensure that the pharmacy team continued to have the capacity and capability to provide its services. And the number of team members had increased to meet the extra demands. The pharmacy had appointed a new medicines counter assistant to replace some-one it had trained to work in the dispensary. And it had appointed an extra ACT due to the increased activity.

The pharmacy team members submitted their annual leave requests well in advance. And the pharmacy authorised only one team member at a time to take leave to maintain minimum levels. The pharmacy appointed pharmacy students to provide cover. And they worked at the pharmacy throughout the summer when most people took their main holiday. The pharmacy team members were well-established. And they were experienced and knowledgeable in their roles. The pharmacy kept the team's qualifications on-site. And the following team members were in post; two full-time pharmacists, one full-time pre-registration pharmacist, one full-time and one part-time accredited checking technician (ACT), one part-time and full-time pharmacy technician, one full-time dispenser, one full-time and one part time medicines counter assistant (MCA).

The pharmacists had carried out annual performance reviews in May 2019. And they had met beforehand to discuss the performance review forms that the team members had completed prior to their review meeting. The pharmacists identified common themes that featured in the forms. For example, the team members had documented that they all need to prioritise tasks at busy periods. And this had been discussed to ensure equity across the pharmacy team. The pharmacist and the team members agreed on development objectives. For example, both ACTs had agreed to manage the multi-compartment compliance pack service. And had agreed to liaise with the practice pharmacist at the nearby surgery to ensure that supplies were according to people's prescription needs.

The company provided a range of training resources. And the team members kept training records to demonstrate they were up-to-date and developing in their roles. For example, the team members had recently learned about winter health, sepsis, depression and asthma via an on-line portal. And they had attended off-site smoking cessation training and training to provide supplies of condoms. The company had trained the team members about service developments. And it had provided training about the new e-MAS service. The pharmacists allocated protected learning time. And they supported people to learn.

The pre-registration pharmacist attended a regular Monday meeting with their pharmacist tutor. And this ensured they were taking advantage of the training opportunities available to them and developing the necessary competencies. For example, carrying out supervised consultations and recommending treatments and providing advice via the 'pharmacy first' service. The pharmacist had authorised the pre-registration pharmacist to attend off-site training, such as, smoking cessation and training about the chronic medication service (CMS).

The pharmacists attended bi-monthly managers meetings, so they were up-to-date with company priorities and initiatives. For example, they had discussed the process for managing 'specials'. And the Superintendent had asked them to remind their teams to carry out the necessary checks to ensure that prescriptions were correctly submitted for payment.

The company used performance targets to grow pharmacy services. For example, increasing the number of NHS prescriptions it dispensed. But the team members knew to put safety first. And they did not feel undue pressure to meet the targets that had been set. The team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had introduced a signature audit trail for people to sign when they were collecting their weekly medication. And this had helped the team members to identify when people were requesting their medication early or when they failed to collect their medication on time.

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

The pharmacy had a well-kept waiting area. And it provided seating for people whilst they waited to be attended to. The pharmacy provided a consultation room and separate booth. And people could talk in private with the pharmacy team about their health concerns. The team members had arranged benches for the different dispensing tasks. For example, the pharmacists worked at benches close to the waiting area. And the ACTs each had their own work-station. The pharmacists observed and supervised the medicines counter from the checking bench. And they could make interventions and provide advice when needed. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

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. 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 sources, stores and manages its medicines appropriately. And the pharmacist 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.

Inspector's evidence

The pharmacy had a step free entrance. And it provided unrestricted access for people with mobility difficulties. The pharmacy displayed its opening hours in the window. And it displayed a wide range of healthcare information leaflets and posters at the waiting area and in the consultation room. The pharmacists and the pre-registration pharmacist spoke to people about their medication. And they registered people with the chronic medication service (CMS) when appropriate. The company promoted healthy living on a local radio station. For example, it was providing information about its flu vaccination service. And it was advising people to order repeat medication in time for Christmas. The company had introduced an 'App' for people to order their medicines. And this supported people to make the ordering process more convenient. The pharmacy had changed hands in August 2019. And the new company had introduced new services including extra PGDs for private services such as travel vaccinations.

The team members dispensed a significant number of prescriptions for people who wanted to wait. And this was due to the pharmacy being located close to a medical practice. The dispensing benches were organised. And the pharmacy team used dispensing baskets to keep prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 150 people. And this had increased by around 100 people in the past year. The pharmacy team members used a separate bench to dispense the packs. And they had read and signed the working instructions to show they followed safe working practices. The team members dispensed controlled drugs the day before the supply was due. And this ensured they kept the controlled drug registers up to date. The ACTs managed the dispensing process. And they ordered new prescriptions when they issued the last pack. The team members used supplementary records to ensure service continuity. And to support safe systems of work. The team members isolated packs when they were notified about prescription changes. And they used a change form and kept records of changes in the patient's notes. The team members supplied patient information leaflets. And they annotated descriptions of medicines on the pack.

The pharmacy provided a delivery service. And this also helped them to manage the number of people waiting on their prescriptions. The delivery driver asked people to sign for their prescriptions using an electronic device. And this provided confirmation that had received them. One of the ACTs dispensed methadone doses when the pharmacy opened at 8.30am. And they obtained an accuracy check at the time of dispensing and again at the time of supply to ensure doses were in accordance with prescriptions. The pharmacy used cards to identify people who had arrived to collect their methadone doses. And they placed the cards and the prescription into a dispensing basket which they dispensed

and checked in turn.

The team members kept the pharmacy shelves neat and tidy. And they kept controlled drugs in three well-organised cabinets to manage the risk of dispensing incidents. The pharmacy purchased medicines and medical devices from recognised suppliers. And the team members carried out regular stock management activities, highlighting short dated stock and part-packs during regular checks. The team members monitored and recorded the fridge temperatures. And they demonstrated that the temperatures had remained between two and eight degrees Celsius.

The pharmacy team members acted on drug alerts and recalls. And they recorded the date they checked for affected stock and the outcome. For example, they had acted on an alert concerning ranitidine in November 2019 with no stock recorded. The pharmacy team members had been trained 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 they added flash notes to the PMR to highlight people that were affected. The company had trained the pharmacy team members about the Falsified Medicines Directive (FMD) and what it aimed to achieve. And it had introduced systems to meet the needs of the directive. But it was not scanning packs, and the team members did not know when the system was due to go live.

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 measures for methadone were highlighted, so they were used exclusively for this purpose. 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.