General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M. Farren Ltd., 133 Main Street, Lennoxtown, GLASGOW, Lanarkshire, G66 7DB

Pharmacy reference: 1042413

Type of pharmacy: Community

Date of inspection: 22/11/2019

Pharmacy context

The pharmacy is in the centre of Lennoxtown. 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.

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 information about errors when they happen. And this helps the pharmacy team members to make safety improvements. The pharmacy keeps the records it needs to by law. And the team members 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 complaint or provide feedback. And this helps it puts things right when it can.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. The pharmacy team members had signed to confirm they followed the procedures. And 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 pharmacist and the accuracy checking technician (ACT) checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The team members recorded their own errors. But, they did not provide a reason why they thought they might have happened. The pharmacist carried out a monthly review. And the pharmacy team discussed the findings at a monthly team meeting. The regular pharmacist had been providing support at another branch. And the pharmacy team had not been discussing the near-miss review as frequently as they had been over the past few months. A team member produced the September near-miss report form which was displayed on the notice board. And it highlighted ‘wrong label’ as a recent trend due to team members not noticing dose changes when they should have. The team members provided other examples of dispensing risks. And the changes they had made to stop them happening. This included, separating gabapentin/pregabalin and rivaroxaban/rivastigmine.

The pharmacist managed the incident reporting process. And the team members knew when incidents happened and what the cause might have been. For example, they knew about a mix-up with aciclovir 400mg and 800mg medication. And that the error had occurred on one of their busiest days. The pharmacy used a complaints policy to ensure that staff handled complaints in a consistent manner. And a leaflet informed people about the complaints process and how to provide feedback if they wished. The pharmacist had contacted the surgery when people complained that their prescription items were not all ready at once. And the surgery had agreed to hold back specific prescriptions until all the necessary checks had been completed. For example, ensuring that prescriptions for controlled drug were correct.

The pharmacy maintained the pharmacy records it needed to by law. The pharmacist in charge kept the responsible pharmacist record up to date. And public liability and professional indemnity insurance were in place and valid until April 2020. The pharmacy team members kept the controlled drug registers up to date. And they had last checked and verified the balance on 8 October 2019 with methadone balances checked every week. The inspector counted oxycodone 30mg stock. And the quantity was corroborated by referring to the controlled drug register. The pharmacy had been commissioned to keep drugs used in palliative care. And the pharmacy team carried out regular checks to ensure that

stock was in date and available for use. The team members recorded controlled drugs that people returned for destruction. But, only the pharmacist had recorded their signature against the last 12 items. 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 seen to be valid until August 2020.

The pharmacy displayed a notice which informed people about its data protection arrangements. And the team members 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 locum pharmacist had registered with the protecting vulnerable groups (PVG) scheme. And this helped to protect children and vulnerable adults. The company did not provide formal training to help then recognise the signs and symptoms of abuse and neglect. But, the pharmacy team members knew to refer concerns to the pharmacist when they had concerns. For example, the delivery driver had called on the emergency services on a few occasions when he found people collapsed in their homes.

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 uses performance reviews. And it encourages the team members to enrol on training programmes. But, it does not provide on-going training so that all team members are able to develop in their roles. The pharmacy team members support each other in their day-to-day work. And they can speak up at regular meetings to improve their working practices.

Inspector's evidence

The pharmacy had experienced a slight increase in the number of NHS prescription items it dispensed. And this was partly due to it increasing the number of multi-compartment compliance packs it dispensed. The pharmacist carried out reviews to confirm the pharmacy had the necessary capacity. And to ensure that the team members were trained to carry out the roles they needed to. For example, the pharmacy technicians had been trained and accredited to carry out the final accuracy checks. The company did not use performance targets to grow services. And it was satisfied with the level of service that the pharmacy team had achieved.

A locum pharmacist was providing cover at the time of the inspection. And they were knowledgeable and familiar with the pharmacy operations due to having worked there in the past. The pharmacy team members were long-serving and experienced. And they kept their training qualifications on-site. The following team members were in post; one full-time pharmacist, one full-time trainee accuracy checking technician (ACT), one part-time accuracy checking technician (ACT), three part-time dispensers, one part-time medicines counter assistant (MCA), one Saturday MCA and one delivery driver. The pharmacist managed annual leave. And they allowed only one team member to take leave at the one time. The pharmacist used a planner so that cover was arranged in advance. And the team members worked extra to provide cover when needed.

The company used performance reviews to identify areas for development. And the pharmacist was about to carry out the annual review. The pharmacist supported the pharmacy team to develop. For example, one of the dispensers was being supported to improve their IT skills. The team member was making progress. And they were now able to produce the backing sheets that they attached to the multi-compartment compliance packs. The company had trained the pharmacy technicians to carry out final accuracy checks. And they knew only to check prescriptions that had been clinically checked and annotated by the pharmacist.

The company did not provide a schedule of ongoing training. But, the pharmacist kept the team members up-to-date with changes. For example, they had provided updates about data protection requirements and the free condom service. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had asked for shelving to be erected in a side room. And they were in the process of rearranging stock, such as moving slower moving items, such as dressing, into the side room.

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 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 and stored multi-compartment compliance packs in a separate room at the rear of the pharmacy. The pharmacist supervised the medicines counter from the checking bench. And they 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 separate booth, and both were professional in appearance.

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 step-free access. And a power-assisted door provided unrestricted access for people with mobility difficulties. The pharmacy displayed its opening hours in the pharmacy window. And displayed leaflets in the waiting area and in the consultation room. The pharmacy team members used dispensing baskets. And they kept prescriptions and medicines contained throughout the dispensing process. The pharmacist attached stickers to the prescription bags. And the team members knew to call on the pharmacist, so they could provide safety messages and counselling when needed. For example, checking that people taking warfarin medication were having their blood tested regularly.

The pharmacy team members identified people that were suitable for the chronic medication service (CMS). And they informed the pharmacist who spoke to people about their medicines and helped when they were having difficulties. The team members checked that people were collecting their medication when expected. And they highlighted potential compliance issues. For example, they had identified someone who was not collecting their medication on time. The pharmacist had arranged a multi-compartment compliance pack. And they had contacted a family member who was now providing more support. The pharmacy dispensed multi-compartment compliance packs for around 85 people. And the team members had read and signed the working instructions to ensure that dispensing was safe and effective. A separate rear room was used to assemble and store the packs. And this kept disruptions and the risk of dispensing errors to a minimum. The team members used trackers to manage the work-load. And this supported them to dispense medication in good time. The team members isolated packs when they were notified about prescription changes. And they kept a record of changes in the person's notes. The team members supplied patient information leaflets. And they annotated descriptions of medicines inside the pack. The team members recorded when packs were collected. And this helped them to identify people that were having difficulties taking their medicines on time.

The pharmacy team members poured methadone doses once a week for around 12 people. And they obtained an accuracy check from another qualified team member at the time of dispensing. The team members retrieved doses from the controlled drug cabinet when they were needed. And the pharmacist checked the doses against each prescription at the time of supply. The team members kept the pharmacy shelves neat and tidy. And purchased medicines and medical devices from recognised suppliers. The pharmacy used two controlled drugs cabinets. And they kept them organised to manage the risk of selection errors. The pharmacy team members carried out regular stock management activities. And they highlighted short dated stock and part-packs during regular checks. But, they did not always update their records when they had carried out the checks. The team members monitored and recorded the fridge temperature. And they demonstrated that the temperature had remained between

two and eight degrees Celsius.

The pharmacy team members accepted returned medicines from the public. And they disposed of them in yellow containers that the health board collected. The pharmacy team members acted on drug alerts and recalls. But, they had not retained the records to show they had acted on a November alert for affected ranitidine medication. 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 spoke to people to confirm they had been provided with safety messages. 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.

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). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. And the team members had labelled measures for methadone. The pharmacy provided 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.