General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cleland Pharmacy, Unit 8, Cleland Shopping Centre, Main Street Cleland, MOTHERWELL, Lanarkshire, ML1 5QN

Pharmacy reference: 1042572

Type of pharmacy: Community

Date of inspection: 05/09/2024

Pharmacy context

This is a community pharmacy in the town of Motherwell in Lanarkshire. Its main activity is dispensing NHS prescriptions. It provides a range of services, including NHS Pharmacy First and NHS Pharmacy First Plus. And it has some private prescribing services including for weight loss and travel vaccinations.

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's written procedures and risk assessments help manage risk so that team members can deliver services safely and effectively. Team members record mistakes made in the dispensing process to help learn from them. And the pharmacists suitably audit the private prescribing services to help identify any learnings to ensure the services continue to be provided safely. The pharmacy keeps the records required by law. Team members keep people's private information secure and respond effectively to concerns about the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy has standard operating procedures (SOPs) which were designed to help team members to deliver the services safely. These included SOPs about dispensing, the responsible pharmacist (RP) and controlled drug (CD) management. The SOPs were electronic and were easily accessed for team members to refer to if needed. A sample of SOPs seen showed they had been reviewed in March 2024 by the superintendent (SI) pharmacist. Team members signed electronically to confirm they had read them. And the majority of team members had read them. A delivery driver had not read the SOP for delivering medicines to people in their homes. The pharmacy provided both NHS and private prescribing services. It had an SOP about the NHS Pharmacy First Plus service. And it had risk assessments for both the NHS Pharmacy First Plus service and its private weight loss and travel vaccination services. The risk assessments were comprehensive and demonstrated that risks were identified, assessed and additional control measures were put in place where necessary. The pharmacist independent prescribers (PIPs) used up- to-date national and local Health Board guidelines when prescribing to ensure they were prescribing appropriately.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. The person who made the mistake was responsible for electronically recording the details about it. And records showed what action was taken and what learning points were identified. The pharmacist reviewed the records and identified common mistakes. And had discussions with team members as to how to prevent the same or a similar mistake from occurring. For example, team members separated sertraline and sildenafil on the shelves where they were kept. And the pharmacist had explained the difference between two different forms of a salbutamol inhaler to team members. The pharmacy electronically recorded errors that were identified after they had reached a person, known as dispensing incidents. The pharmacist discussed errors with team members and, in response to a recent dispensing incident, had put warnings on a person's patient medication record (PMR) about the error. The SI was also aware of dispensing incidents that occurred in the pharmacy. The pharmacy had processes to review the quality of the prescribing services it provided. The SI completed audits to ensure the prescribing safeguards in place were effective. They reviewed a sample of prescribing consultations to determine whether decisions were appropriate. The completed audits were reviewed by the pharmacy's other PIP.

The pharmacy had a documented complaints policy. Team members aimed to resolve any complaints or concerns informally. For any complaints that could not be resolved, people were provided with the email address for the SI. People were given the opportunity to provide feedback by scanning QR codes and providing verbal feedback for the pharmacy's clinics. And feedback received was generally positive. The PIPs signed their private prescriptions and other paperwork associated with the prescribing

services, so there was an audit trail in place. Team members were aware of the tasks that could and could not be completed in the absence of the RP. The pharmacy had recently employed an accuracy checking pharmacy technician (ACPT) who had had discussions with the pharmacist and SI about what they felt comfortable checking. And they had items double checked by one of the pharmacists as part of their probation before they were able to check independently.

The pharmacy had current professional indemnity insurance. And it provided indemnity for the PIPs. The RP notice was prominently displayed in the retail area and reflected the correct details of the pharmacist on duty. The RP record was completed correctly. The pharmacy recorded the receipt and supply of its CDs electronically. A sample of records showed they were completed correctly. Team members completed regular checks of the stock held against the register running balance for tablets and capsules. For liquid medicines used in the substance misuse service, this was last completed in July 2024. CDs returned by people who no longer needed them were recorded on receipt and their destruction was completed in the presence of a registrant. The pharmacy kept certificates of conformity for unlicensed medicines known as “specials” and it recorded details of who the medicine was supplied to which provided an audit trail. The pharmacy kept complete records of its supply of medicines against private prescriptions and associated prescriptions were kept. The SI provided blank copies of the consultation templates used for the private travel and weight loss services and of the notification letter sent to people’s GP informing them of treatment prescribed.

Team members were aware of their responsibility to keep people’s private information secure. The pharmacy had a NHS data privacy notice and company privacy notice on display in the retail area that informed people of how their data was used. Team members separated confidential information which was uplifted for shredding by a third-party company. They were also aware of their responsibility to safeguard vulnerable adults and children. The pharmacy had safeguarding and chaperone policies for team members to refer to. And the pharmacists would escalate any concerns to the GP. The pharmacists and trainee pharmacists were registered with the protecting vulnerable groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and training team members to manage the workload safely and effectively. Team members in training are appropriately supervised by the pharmacists. And the prescribing pharmacists complete and maintain training to ensure the prescribing services are delivered in a safe way. Team members ask appropriate questions when helping people with their healthcare needs.

Inspector's evidence

The pharmacy employed a full-time resident pharmacist who was the RP at the time of the inspection. They were supported by two trainee pharmacists and an ACPT. The pharmacy further employed two trainee dispensers and two delivery drivers who were not present during the inspection. The SI worked regularly in the pharmacy and arrived during the inspection. Team members had either completed accredited training or were completing accredited training for their roles. The pharmacy's two trainee pharmacists were jointly tutored by both the resident pharmacist and the SI. And the resident pharmacist was tutor for the trainee dispensers. The trainee pharmacists received protected learning time each week and had fortnightly meetings with their tutors to review progress as well as working alongside the resident pharmacist daily. Other team members who had completed their accredited training ensured they maintained their skills and knowledge by reading pharmacy magazines. And any updates that team members were required to be aware of were shared by the SI and resident pharmacist. The PIPs had completed face to face training with an external training provider to be able to provide travel vaccinations, and they had recently completed an online refresher course about this to keep their knowledge up to date. And they had completed additional training to administer the Yellow Fever vaccinations. For their weight loss services the PIPs had received training from the manufacturer of the weight loss medicine.

Team members were observed to work well together to complete the workload. There was an open and honest culture and team members felt comfortable raising professional concerns with either the pharmacist or SI. Annual leave was planned in advance so that contingency arrangements could be made. The pharmacy aimed to have only one person absent at a time, but if necessary part-time team members could support periods of absence. The pharmacists covered each other's annual leave. Team members received six-monthly appraisals. The pharmacy did not set its team members targets.

Team members were observed asking appropriate questions when selling medicines over the counter to people. They knew to be vigilant to repeated requests for medicines liable to misuse, for example, medicines containing codeine. Team members referred any identified instances to the pharmacists who had supportive conversations with people. And they gave an example of referring a person to their GP for assessment.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean and suitable for the services it provides. It has appropriate facilities for people who require privacy when accessing the pharmacy's services.

Inspector's evidence

The pharmacy premises comprised of a small retail area with a medicines counter. And the dispensary, which was also small, was positioned behind the medicines counter. The medicines counter acted as a barrier to prevent unauthorised access to the dispensary. And the dispensary was screened from view of people in the retail area so that tasks could be completed privately and without distraction. Team members cleaned the pharmacy daily and completed a more thorough clean weekly. The dispensary, although small, had different bench spaces for the completion of different tasks. And the SI had recently installed a temporary worktop over the dispensary sink to provide additional bench space. Although the worktop covered the sink, it had been designed in a way that allowed team members to still access it. Due to the small size of the pharmacy, the pharmacist was easily able to supervise the dispensary and medicines counter.

The pharmacy had a lockable soundproofed consultation room for consultations to take place privately. It was accessed from the retail area for people and from the dispensary for team members. The room had a computer, desk and chairs for consultations to be completed comfortably. There was a sink which provided hot and cold water. The pharmacy had a toilet which provided separate handwashing facilities. Lighting provided good visibility throughout and the temperature was comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages its services well. And they are accessible to people. Team members complete suitable checks on medicines to ensure they remain fit for supply. And they provide people with the relevant information to take their medicine safely. They respond appropriately to notifications about the safety of medicines.

Inspector's evidence

The pharmacy displayed its opening hours and services offered on the front door and window. It had a small step up into the retail area from the street. There was an accessibility button on the front window which alerted team members that a person required assistance accessing the pharmacy. Team members provided large print labels for people who had visual difficulties. And they had access to translation services for people whose first language was not English. They referred people to other service providers for services they did not provide. There were healthcare leaflets for people to read or take away.

Team members used baskets to keep prescriptions and medicines together and reduce the risk of them becoming mixed up. And they used stickers to highlight the inclusion of a fridge line or CD on a prescription. The pharmacist highlighted on the person's bag label if referral to the pharmacist was required when team members handed out their prescriptions. Team members signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of who was involved in each stage of the process. They were aware of the Pregnancy Prevention Programme for valproate and of the requirement to ensure people received the appropriate information to take their medicine safely. They were aware of the recent update to dispense valproate in the manufacturer's original pack and confirmed they did not have anyone in the at-risk category.

The pharmacy provided both NHS and private prescribing services. The services were provided from the pharmacy's consultation room. The pharmacists followed up-to-date guidance to ensure their prescribing decisions were appropriate. And they communicated any prescribing decisions made to the persons' GP with people's consent. The pharmacist relied on the information that people provided about their medical history during the consultation. They used the patient medication record (PMR) to verify information if the person had used the pharmacy previously. The pharmacists used patient group directions (PGDs) for services delivered as part of the NHS Pharmacy First service and they had printed and signed the PGDs to confirm their competency to provide the service.

The pharmacy had a delivery service, taking medicines to people in their homes. The drivers used an electronic platform to record the deliveries. And they prioritised items requiring cold storage on the delivery route. People signed to confirm receipt of their CDs. Medicines that were unable to be delivered were returned to the pharmacy and the delivery driver left a note to contact the pharmacy to rearrange the delivery. The pharmacy provided some people with their medicine in multi-compartment compliance packs to help them take their medicines at the correct times. The pharmacy ordered the prescriptions three to four weeks in advance so that any queries could be resolved. Each person had a medication record sheet which detailed the medication and administration times. Changes to people's medicines were communicated from the GP surgery and the person's medication record sheet was updated. Team members provided descriptions of the medicines in the pack so they could be identified

and provided patient information leaflets monthly so people had the correct information about their medicines.

The pharmacy sourced its medicines from recognised wholesalers. Medicines were stored neatly on the dispensary shelves and pharmacy only (P) medicines were stored behind the medicines counter which ensured the sales of these were supervised by the pharmacist. Team members had a process for checking the expiry date of medicines. Checks were completed weekly over a period of three months. Any medicines expiring in the next six months were highlighted for use first and a list was kept of the medicines. Team members then removed them the month before they were due to expire. A random selection of ten medicines found none past their expiry date. The pharmacy had a fridge for storing medicines that required cold storage. Team members recorded the fridge temperatures daily and records showed they were within the required two and eight degrees Celsius. They recorded action taken when a fridge anomaly was identified. The pharmacy received notification via email and on an online platform about drug alerts and recalls. The pharmacists read the alert, discussed the details with team members and stored it in an email folder to show it was complete. Medicines returned by people who no longer needed them were kept separately for uplift and destruction by the Health Board.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members used the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to a range of online resources including the British National Formulary (BNF) and British National Formulary for children (BNFc). Pharmacists used resources to assist with their prescribing decisions including National Institute for Clinical Excellence guidelines and travel vaccination information websites such as Travax and Fit for Travel. The pharmacy had equipment used for the NHS Pharmacy First service including an oximeter, otoscope, thermometer, blood pressure monitor and in-date adrenaline kits. The pharmacy had crown stamped measuring cylinders which were marked to identify which were for liquid medications and water.

The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines in way which ensured people's private information was protected. Confidential information was secured on computers using passwords. And they were positioned in way which meant only authorised people could see the information on the screens.

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.