General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: New Stevenston Pharmacy, 246 Clydesdale Street, NEW STEVENSTON, Lanarkshire, ML1 4JH

Pharmacy reference: 1042581

Type of pharmacy: Community

Date of inspection: 22/01/2024

Pharmacy context

This is a busy pharmacy in the village of New Stevenson in Motherwell. Its main activity is dispensing NHS prescriptions. It provides some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. And it provides the NHS Pharmacy First service and a medicines delivery service for people in their homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 help manage risk so its team members can provide services safely. Team members record errors made during the dispensing process so they can learn from them. They generally keep the records required by law and keep people's private information secure. They know how to respond effectively to concerns for people accessing the pharmacy's services.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. These included controlled drug (CD) management, responsible pharmacist (RP) and dispensing SOPs. The SOPs had been reviewed in March 2023. A sample of SOPs seen showed that team members had signed to confirm their understanding and compliance with them. This included a newly employed team member who had received time to begin reading and signing the SOPs.

The pharmacy recorded errors identified during the final checking process known as near misses. The team member who made the error was responsible for recording the details of the error so they could learn from it. Records showed that errors were being recorded, but that full details of the errors, including what medicines had been dispensed in error and the potential causes of the error, were not always captured. This meant that opportunities to learn from the mistake may be missed. Team members did not formally review the data to identify trends, but they had informal conversations regarding the errors. They had taken action to prevent a recurrence of the same or a similar error occurring. This included separating medicines that looked-alike or sounded-alike (LASA) on the shelves where they were kept or placing warning stickers on shelves next to medicines involved in near misses. The pharmacy recorded errors identified after a person had received their medicines known as dispensing incidents. Team members recorded the details on paper and notified the person's GP of the error. The pharmacy had details of one report involving a controlled drug which had not been reported to the controlled drug accountable officer (CDAO). The pharmacist was unaware of the need to report such incidents to the CDAO and resolved to report them in the future. Team members aimed to resolve any concerns of complaints informally. The superintendent pharmacist (SI) worked in the pharmacy part-time and team members were able to escalate any complaints they could not resolve to the SI.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. They knew which tasks could and could not be completed in the absence of the RP. The RP record was generally compliant, with one minor error where the pharmacist had already signed to confirm the time they would cease to be RP that day. The pharmacy had paper-based CD records. Entries of medicines supplied were in order, but the address of the supplying wholesaler was missed on occasion. Team members checked the physical stock level of tablets and capsules matched with those in the CD register on a weekly basis. And pharmacists checked stock levels of medicines used in the supervision service on the days the medicine was administered. The pharmacy recorded details of CD medicines returned by people who no longer needed them. It kept electronic records for its supply of private prescriptions, and the sample seen were in order.

The pharmacy had a privacy notice displayed on the front door of the pharmacy informing people of how their data was used. Team members had received some training regarding information governance

(IG) and general data protection regulations (GDPR) when the regulations came into place. They separated confidential waste for shredding on site. The pharmacy had a safeguarding folder which gave team members some information about safeguarding, such as signs to look out for. Delivery drivers had completed some additional training on safeguarding as part of their accredited training courses. Team members, including the delivery drivers, confirmed they knew to report any concerns to the pharmacist. They gave an example of a recent safeguarding incident they had dealt with. Each team member was part of the protecting vulnerable groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and qualified team members to help manage the workload. Team members receive ongoing learning to help develop their skills and knowledge. There is an open and honest culture amongst the team. And they know how to suitably respond to repeated requests for medicines liable to misuse.

Inspector's evidence

The pharmacy team at the time of the inspection comprised a part-time pharmacist, who was the RP, an accuracy checking pharmacy technician (ACPT), four dispensers, and a medicines counter assistant. A dispenser had recently been employed and had completed their pharmacy technician qualification and was awaiting annotation on the register. The pharmacy employed an additional two dispensers who were not present during the inspection, one of whom was a trainee dispenser and pharmacy student. It employed two part-time delivery drivers who delivered medicines to people in their homes during the week. And there was another part-time pharmacist who was also the SI and mentor for the trainee dispenser. The pharmacist at the time of the inspection confirmed that an additional pharmacist worked in the pharmacy on Wednesday mornings. Team members had completed, or were in the process of completing, accredited training for their roles. They received regular opportunities to update their knowledge and skills and had recently completed training on a new service for the administration of naloxone in an emergency. And they received protected learning time during quieter periods to complete their learning. The pharmacists had completed training to provide the NHS Pharmacy First service and had signed associated patient group directions (PGDs) to confirm they would comply with them. And they had shared the signed declarations of competency with the Health Board.

The pharmacy team were observed working well together to manage the workload. Annual leave was planned in advance, so workload was managed to cover team members holidays. Rotas were prepared ahead of time, so the pharmacy ensured there was a suitable deployment of team members at appropriate times to support the safe delivery of services. Part-time team members increased their hours if necessary to provide support during periods of absence. Some team members had specific tasks for which they were responsible, such as the weekly CD stock balance check. There was contingency in place to ensure that these tasks were completed by other nominated team members when the responsible person was absent. There was an open and honest culture amongst the team and team members felt comfortable to raise concerns or make suggestions for change with management.

Team members knew the appropriate questions to ask when selling medicines over the counter. Team members knew to be vigilant to repeated requests for medicines liable to misuse and referred these to the pharmacist, who had conversations to help people and referred them to their GP if necessary. The pharmacy did not set its team members targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services it provides. It has a suitable consultation room where people can have private and confidential conversations with team members if necessary.

Inspector's evidence

The premises were split over two levels with the retail area to the front of the premises and the dispensary at the rear. The pharmacy had a medicines counter in the retail area which acted as a barrier to the dispensary and prevented unauthorised access. The dispensary was spacious and portrayed a professional appearance. And it was neat and tidy. There was a good workflow and there were different bench spaces dedicated to different tasks. The pharmacist's checking bench was situated centrally in the dispensary which allowed for effective supervision of dispensary tasks. And they could intervene in conversations at the medicines counter if necessary. Team members cleaned the dispensary daily. The dispensary had a clean sink area which provided hot and cold water and soap for handwashing. The toilet facilities were clean and team members used the sink in the dispensary adjacent to the toilet for handwashing. Lighting was bright throughout, and the temperature was comfortable.

The pharmacy had a lockable consultation room which allowed people to have private conversations with team members and access services from the pharmacist. It had two chairs, a desk and a sink which provided hot and cold water. The room was small in size and stored boxes of consumables used in the dispensing process which reduced the overall space available. There was a separate area where people had doses of medicine supervised. This area was situated behind a wall adjacent to the medicine counter and provided a degree of privacy. The pharmacist used this area to complete some consultations with people, but if they required more privacy, they used the consultation room for the consultation.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. And it makes them accessible to people. Team members carry out checks to ensure that medicines remain fit for supply. And they know how to respond appropriately to concerns that medicines might not be suitable to supply.

Inspector's evidence

The pharmacy had level access from the street and an automatic door which provided ease of access for those in wheelchairs or with prams. It advertised a range of services it provided on the outside of the pharmacy. The pharmacy provided services such as the NHS Pharmacy First service and the provision of emergency hormonal contraception. These services were underpinned by PGDs for which the pharmacist had the most up-to-date paper copies kept in folders for easy referencing.

Team members used baskets to keep people's prescriptions and medicines together to reduce the risk of errors. Team members signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved at each stage. Stickers were attached to prescriptions to highlight the inclusion of a CD, fridge line, or if the pharmacist wished to speak to a person when they collected their medicine. Team members were aware of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicines safely. They knew about a recent update regarding the supply of valproate in the original manufacturer's packs and issued warning cards to people in the at-risk category. The pharmacy supplied some people with valproate alongside their multi-compartment compliance packs. They had conversations with a person's GP regarding the most appropriate way to issue the valproate to the person but had not completed any formal risk assessments. The pharmacist checked that people taking other higher-risk medicines, such as methotrexate, were monitored to ensure the supply was appropriate. Team members asked people appropriate questions when handing out medicines to confirm they were issuing them to the correct person.

The pharmacy provided a delivery service taking medicines to people in their homes. The drivers asked people to sign to confirm receipt of the delivery and kept records so that any queries could be resolved. And fridge lines were prioritised, so they were out of the fridge for as short a time as possible. The driver returned medicines that could not be delivered back to the pharmacy. The pharmacy supervised the administration of medicine to some people. Team members managed the service by preparing the doses ahead of them being required. The pharmacy provided some people with their medicine in multi-compartment compliance packs to help them take their medicines. The ACPT was the person responsible for the management of the service. Prescriptions were ordered a week in advance of them being required so that any queries could be resolved in a timely manner. Each person had a medication record sheet that contained a copy of their medicines and dosage times. And changes to their medication were communicated from the person's GP and documented on their record and in a communication book. Team members provided descriptions of the medicines in the pack so they could be easily identified. And they provided people with the necessary information to take their medicines effectively, including warnings and patient information leaflets (PILs).

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only medicines (P) were stored behind the medicines counter which ensured sales of these medicines were supervised by the

pharmacist. Team members had a process for checking the expiry date of medicines. And the pharmacist confirmed date checks were completed as part of their checking procedure. Records showed that date checking of some sections of the dispensary had last been completed in November. And medicines going out of date in the next six months were marked for use first. Medicines with a shortened expiry date on opening were marked with the date of first opening.

The pharmacy had a fridge for medicines that required cold storage. Team members recorded the temperatures daily. Although there were a few omissions of maximum or minimum temperatures, the temperatures recorded showed the fridge was operating within the required range of 2-8 degrees Celsius. Team members received notifications about drug alerts and recalls via email. They printed and signed to confirm they had been actioned and stored them for future use. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had access to up-to-date reference sources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had crown stamped measuring cylinders which were marked to identify which were for water and which were for medicines. The pharmacy had a carbon monoxide monitor used in the provision of the smoking cessation service.

The pharmacy had cordless telephones so that conversations were kept private. And it stored medicines awaiting collection in the dispensary in a way that prevented people from seeing people's private information. Confidential information was secured on computers using passwords. Computer screens were positioned within the dispensary so that only authorised people could see them.

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.