General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Health Centre Pharmacy, 17 Manse Road, NEWMAINS, Lanarkshire, ML2 9AX

Pharmacy reference: 1042583

Type of pharmacy: Community

Date of inspection: 15/03/2022

Pharmacy context

This is a health centre pharmacy in Newmains. Newmains is on the edge of the larger town of Wishaw. The pharmacy provides a range of services including dispensing prescriptions for people at home and for the residents of residential and care homes. It has a small range of over-the counter medicines and other pharmacy related products for sale. And it provides a range of other services, including a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. And it supplies medicines on the NHS Pharmacy First service. This pharmacy was inspected during the COVID-19 pandemic when restrictions had been mostly lifted in Scotland.

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 has written procedures in place to help ensure that its team members work safely. And it has insurance to cover its services. The pharmacy team has adapted its working practices suitably to minimise risks to people's safety during the COVID-19 pandemic. And it knows how to protect the safety of vulnerable people. The pharmacy protects people's private information appropriately. And it has adequate procedures to identify the risks associated with its services. But it is not thorough enough in ensuring that all of its records are kept up to date.

Inspector's evidence

The pharmacy had put measures in place to keep people safe from infection during the COVID-19 pandemic. It had put screens up at its medicines' counter. And it had placed hand sanitiser at different locations in the waiting area and inside the pharmacy for people and the team to use. The team had a regular cleaning routine and had access to personal protective equipment in the form of gloves and masks. Team members worked in smaller teams in each dispensing area. And so, they could work appropriately distanced from one another for most of the time. The pharmacy had a business continuity plan to ensure that people could still get their medicines if its services were disrupted. The pharmacy team discussed its mistakes and reviewed them regularly. The responsible pharmacist (RP) highlighted and discussed errors and near misses at the time with the team member involved. This enabled team members to reflect and learn. The team had separated stock and labelled shelves to draw attention to look-alike and sound-alike (LASA) medicines. This included amitriptyline and amlodipine. But during the pandemic, when the team had a heavier-than-usual workload it had not always recorded its mistakes. And the records it had made did not contain much detail. The RP was also the superintendent (SP) and had been reviewing process since joining the team approximately six months previously. She recognised that it was important to learn as much as possible from mistakes to help prevent them from happening again. And she agreed that mistakes should be recorded. And that records should identify what could be done differently next time to prevent mistakes and promote continued improvement.

The pharmacy had a set of SOPs to follow. And these were currently under review. Team members had read the SOPs relevant to their roles. Support staff appeared to understand their roles and responsibilities and were seen consulting the RP when they needed her advice and expertise. The RP had placed her RP notice on display showing her name and registration number as required by law. People could give feedback on the quality of the pharmacy's services. And it had examples of positive feedback in customer 'thank you' cards on a team notice board. Team members described a few complaints which were often related to high expectations involving the time taken to get people's medicines ready after they had requested their prescriptions. As a result the RP had met with the local surgery team. And between them they had agreed that the information provided on prescription forms about when prescriptions would be ready should include the additional time needed by the pharmacy to order and dispense the medicines too. The pharmacy had a complaints procedure. In general, the team sought feedback from conversations with people as well as staff at the homes it supplied medicines to. The pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints procedure for the local health board online. But customer concerns were generally dealt with at the time by one of the regular pharmacists or by the head office team if necessary. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance

protection for the pharmacy's services and its customers. It had professional indemnity and public liability insurance in place until 30 November 2022. When that date is reached the pharmacy will renew its insurance arrangements for the following year.

In general, the pharmacy kept its records in the way it was meant to. Including its RP record, its unlicensed specials records and its controlled drugs (CD) registers. The pharmacy had a CD destruction register for patient returned medicines. Team members had undertaken destructions regularly. And so this register was up to date. The pharmacy generally maintained and audited its CD running balances. And during the inspection a check of products in stock was found to match the running balance in the pharmacy's electronic CD register. The pharmacy also kept records of its private prescriptions. But there had been an eight-month gap in its record keeping. The RP recognised that the pharmacy should ensure that all of its essential records are kept up to date. And so she had put a process in place to address this by setting aside half an hour each day for a member of the team to complete the records.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed general data protection regulation (GDPR) training. Confidential paper waste was discarded into separate waste containers. And it was collected regularly for confidential destruction by a licensed waste contractor. The pharmacy kept people's personal information, including their prescription details, out of public view. The RP had completed appropriate safeguarding training. And she had registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme. Other team members had been briefed. And they knew to report any concerns to the RP. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages its workload safely and effectively. And team members support one another. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

The inspector conducted the inspection during the pharmacy’s usual trading hours and found the regular responsible pharmacist (RP) on duty. The RP had the support of a second pharmacist with whom she rotated her shifts. Both pharmacists also overlapped their shifts on some days to help them to complete their workloads. The rest of the team consisted of a trainee pharmacist, a trainee accuracy checker, three NVQ2 qualified dispensing assistants, a trainee healthcare assistant and a delivery driver. The second pharmacist and a further trainee dispensing assistant were not present during the inspection. The pharmacy had a close-knit team whose members worked regularly together. And team members were seen to work effectively with one another. The daily workload of prescriptions was in hand and customers were attended to promptly. Details about processes or updates were provided and discussed verbally. And team members were able to raise any concerns with the RP. In turn the RP felt that she could discuss any concerns with her line management and head office team. The RP could also make her own professional decisions in the interest of patients.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. They are tidy and organised. And they are sufficiently clean and secure.

Inspector's evidence

The pharmacy was a self-contained unit within the health centre. The pharmacy reception was also its counter. And all of the pharmacy's medicines including its over-the-counter medicines were kept behind it. The pharmacy also had a consultation room which people could access from the waiting area. But the RP reported that the room had not been in regular use since the beginning of the pandemic. The majority of the pharmacy's workspace was used for its dispensing activities. And it had separate areas for dispensing repeat prescriptions, medicines care review (MCR) prescriptions and multi-compartment compliance packs. Walk-in and acute prescriptions were dispensed in an area immediately behind the accuracy checking area, so that they could be dealt with promptly after dispensing. Instalment prescriptions were made up and stored in the consultation room. But these were removed and placed in the dispensary when the room was needed for a consultation. When not being used for a consultation, the door to the room was locked.

The team cleaned the pharmacy three times daily to ensure that contact surfaces were clean. Stock on shelves was tidy and organised. And floors and work surfaces were free from clutter. The pharmacy had staff facilities in a separate area away from the main dispensary. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. And makes them adequately accessible for people. The pharmacy team gets its medicines and medical devices from appropriate sources. Team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy generally stores its medicines properly. But it is not thorough enough in ensuring that all medicines for dispensing are labelled and packaged correctly.

Inspector's evidence

The pharmacy shared an entrance with the health centre. The entrance had double automatic doors and was step free. The pharmacy had a delivery service for people who found it difficult to visit the pharmacy. And it could also order people's repeat prescriptions for them. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. It provided medicines in multi-compartment compliance packs for people living at home who needed them. And for people living in care home and nursing home environments. The pharmacy labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And its labelling directions also gave the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines and generally with regular repeat medicines. The RP gave people advice on a range of matters. And gave appropriate advice to anyone taking high-risk medicines. The RP had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines. The RP was aware of the precautions she would need to take, and counselling she would give, if it were to be prescribed for someone in the at-risk group.

The pharmacy offered the NHS 'Pharmacy First' service. Where people could obtain medicines for a range of minor ailments. Several team members had been trained to supply medicines for a small range of conditions such as coughs and colds. And they followed the local health board's protocol by supplying medicines from its specified list. Team members knew when to refer to the pharmacist when someone presented with a condition which they had not been trained to treat such as a urinary tract infection (UTI). Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. And team members knew how to process them. The pharmacy had a system for monitoring and tracking supplies so that the team knew when people were due to get their medicines. The system also allowed them to monitor compliance and support people to take their medicines as intended. The pharmacy supplied a variety of medicines by instalment. A trained team member dispensed these prescriptions in their entirety when the pharmacy received them. And labelled them with the date on which they were to be supplied. The pharmacist checked the instalments and placed the labelled medicines together in individual baskets to keep the instalments together.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines, appropriately and in their original containers. But on occasion, when dispensing compliance packs, team members had to remove medicines from the packs after they had dispensed them. And they put those medicines into plain brown dispensing bottles to be used later. While they had applied a hand-written label containing the name of the product along with its strength and form, the labels did not give all the required information, such as batch number, expiry

date and product license number. This meant that the outer packaging did not give enough information about the medicines inside it. The inspector discussed this with the RP, and it was agreed that team members should review their understanding of the correct procedures to follow when considering the appropriateness of putting medicines back into stock after dispensing. Stock on the shelves was generally tidy and organised. The pharmacy team date-checked the pharmacy's stocks regularly. And they kept records to help them manage the process effectively. A random sample of stock checked by the inspector was in date. In general, short-dated stock was identified and highlighted. And the team put its out-of-date and patient returned medicines into dedicated waste containers. The team stored items in the CD cabinets and fridge as appropriate. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

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Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies. The pharmacy had several computer terminals which had been placed at individual work- stations around the pharmacy. Computers were password protected. And prescriptions were stored in the dispensary out of people’s view.

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.