General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Crawfords Pharmacy, 36 Station Road, SHOTTS, Lanarkshire, ML7 5DS

Pharmacy reference: 1042591

Type of pharmacy: Community

Date of inspection: 28/08/2024

Pharmacy context

This is a community pharmacy within a health centre in Shotts, Lanarkshire. Its main activity is dispensing NHS prescriptions. It provides some services including NHS Pharmacy First and NHS Pharmacy First Plus. It has a delivery service, taking medicines to people in their homes.

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 help team members manage risk and provide services safely. Team members record errors made during the dispensing process and take steps to learn from them and make changes to help prevent the same mistake from happening again. They keep the records required by law and they keep people's private information secure. They know how to respond effectively to concerns for the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. These included SOPs about the responsible pharmacist (RP), dispensing and controlled drug (CD) management. The SOPs had been reviewed by the RP in August 2023 and were due to be reviewed again in August 2025. The SOPs were available in a paper format for easy referencing and team members had signed them to say they understood and would comply with them.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. The near misses were recorded electronically and the person who made the mistake recorded the details about it. And the pharmacist discussed the mistake with the person involved. Team members made suggestions to help prevent the same mistake occurring, including separating different quantities of the same medication. And they had introduced attaching bag labels to completed prescriptions for CDs or fridge lines to ensure that team members selected the correct medicine for a person. The pharmacy recorded mistakes that were not identified until after a person had received their medication known as dispensing errors. The errors were also recorded electronically, and the pharmacist kept a separate paper-based intervention log for errors and clinical queries if they felt more detail was required to be recorded. Again, team members discussed the errors with each other and made suggestions for change to help prevent the same or a similar error from occurring. The pharmacist also alerted the superintendent (SI) pharmacist about any dispensing errors made.

Team member's job roles were printed and kept in the SOP folder so they could refer to them if necessary. The pharmacy had an accuracy checking pharmacy technician (ACPT) who had discussed their checking practices with the pharmacist and they felt comfortable to check all medicines, including CDs. The pharmacist signed the prescriptions to indicate to the ACPT that a clinical check had been completed and it was suitable to be accuracy checked. Team members were aware of the tasks that could and could not take place in the absence of the RP. The pharmacy had a complaints procedure which involved attempting to resolve complaints or concerns informally. If team members were unable to resolve the complaint, it was escalated to the SI. The pharmacy had an electronic device to allow people to write about the service they received. The feedback was sent to the pharmacist on a weekly basis, and this was shared with the team. Feedback the team received was positive.

The pharmacy had current professional indemnity insurance. The RP notice was displayed prominently in the dispensary 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 entries seen showed they were completed correctly. Team members checked the physical stock levels matched those in the CD register on a weekly basis. Team members completed the checks by

printing out a list of the medicines in the pharmacy register and ticked each medicine once confirmed it matched the quantity held. The pharmacy recorded details of CD medicines returned by people who no longer needed them at the point of receipt. And they were separated in the CD cabinet, so they did not become mixed with regular stock medicines. The pharmacy kept certificates of conformity for unlicensed medicines known as “specials” and details of who the medicines were supplied to, which provided an audit trail. It kept complete records for the supply of medicines on private prescription and kept associated paper prescriptions.

Team members were aware of their responsibility to keep people’s private information secure. And they had completed training about General Data Protection Regulation as part of their accredited training courses. The pharmacy separated confidential waste for uplift to the pharmacy’s other branch where it was shredded by a third-party company. Team members were also aware of their responsibility to safeguard vulnerable adults and children. They had a safeguarding policy to refer to in the SOP folder. The team knew to refer any concerns to the pharmacist in the first instance. This included the delivery drivers who knew to refer any concerns about people they were delivering medicines to back to the pharmacy. The RP and the delivery drivers were registered with the protecting vulnerable groups scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to help manage the workload. Team members complete ongoing training and are given opportunities to develop their skills and knowledge. They suitably respond to requests for sales of medicines and support people with their healthcare needs.

Inspector's evidence

The pharmacy employed a full-time pharmacist who was the RP. They were supported by an ACPT, a trained dispenser and a medicines counter assistant (MCA). A second pharmacy technician was not present during the inspection. The pharmacy also had two delivery drivers. Team members had completed accredited training with the exception of the delivery drivers. The SI enrolled the drivers on accredited training following the inspection. Team members who had completed training continued to develop their skills and knowledge and were due to complete training about smoking cessation. They were enthusiastic about learning about medicines they were dispensing, and frequently learned about medicines by asking the pharmacist questions about them. The pharmacist had completed training to deliver the NHS Pharmacy First service and had read and agreed to use patient group directions (PGDs) where appropriate. The pharmacist was an independent prescriber (IP) which allowed them to provide treatment for a wider range of conditions under the NHS Pharmacy First Plus service. They had assessed their own competency and prescribed within this. For example, they felt comfortable to prescribe certain antibiotics for children over five years of age. And for anything they did not feel competent or comfortable to prescribe, they referred the person to their GP. The pharmacist shared a summary of the consultation and a record of medicines prescribed with the person's GP.

Team members were observed working well together to manage the workload. There was an open and honest culture, and they felt comfortable to raise professional concerns with the pharmacist or SI if necessary. Annual leave was planned in advance so that contingency arrangements could be made. If necessary, part-time team members could increase their hours to support periods of absence, or team members from the company's other pharmacy could assist. The pharmacist's annual leave was covered by other pharmacists working for the company.

Team members asked 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. They referred such requests to the pharmacist who would have supportive conversations and refer people to their GP. 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 appropriate facilities for people requiring privacy when accessing services.

Inspector's evidence

The pharmacy was located next to the adjacent GP practice's waiting area within a larger health centre building. There was no retail space. People were served at a small medicines counter which was positioned behind a window which separated the pharmacy from the rest of the health centre. The dispensary was spacious and had different bench spaces for the completion of different tasks. The pharmacist’s checking bench was situated centrally so they could easily supervise the dispensary and the medicines counter. The dispensary had a sink which provided hot and cold water. Toilet facilities were accessed in the main health centre and were clean and had separate handwashing facilities. Team members cleaned the pharmacy daily. Lighting provided good visibility throughout and the temperature was comfortable.

The pharmacy had a consultation room where people could have private conversations with team members. The room was spacious and had a desk and chairs for consultations to be completed comfortably. The room had a sink which provided hot and cold water.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. Team members source medicines from recognised wholesalers and complete suitable checks on medicines to ensure they remain fit for supply. They provide people with the necessary information to help them take their medicines safely. And they respond appropriately to alerts about the safety of medicines.

Inspector's evidence

The pharmacy had level access from the adjacent GP waiting area which provided ease of access to those using wheelchairs or with prams. The pharmacy provided people who had visual difficulties with large print labels. And they used translation applications on people's mobile telephones to help translate for people whose first language was not English. They signposted people to other pharmacies to access services they did not offer.

Team members used baskets to keep people's 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 a CD. The pharmacist attached notes to people's prescriptions if they wanted to speak to a person when they collected their medication. 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 of the process. 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 medicine effectively. They provided valproate for some people outside the manufacturer's original pack, but they had not yet completed the required risk assessment about this. Team members were observed asking appropriate questions when handing out medication to people to ensure they were provided to the correct person. This included asking if the person had a penicillin allergy. Team members informed people verbally if they were unable to be provided with the full quantity of their prescribed medicine. For any medicines that were out of stock they requested an alternative from the person's GP.

The pharmacy provided a delivery service taking medicines to people in their homes. Each driver maintained a record of the day's scheduled deliveries. The record remained in the pharmacy for team members to refer to so that any queries from people could be answered. Prescriptions with additional items such as CDs or fridge lines were kept separately so the drivers knew to ask for the items. The drivers asked people to sign to confirm receipt of their CDs. Any medicines that were unable to be delivered were returned to the pharmacy and note was left with the person of the attempted delivery. The pharmacy provided some people in the community with their medication alongside medication administration record (MAR) sheets. This allowed people's carers to record when medicines had been given. The pharmacy ordered the prescriptions for these people in advance so that any queries about people's medicines could be resolved. People were provided with their medicines in the manufacturer's original packs which include patient information leaflets, so they had all the necessary information to take their medicine effectively.

The pharmacy sourced its medicines from licensed wholesalers. Medicines were stored neatly on dispensary shelves. Pharmacy only (P) medicines were stored behind the glass window which helped ensure the sales of medicines were supervised by the pharmacist. Team members completed checks on

the expiry date of medicines monthly. Medicines that were due to expire by the end of the year were highlighted on a list which team members then used to remove the medicines approximately a month before their expiry date. Team members checked expiry dates of medicines at the dispensing and final accuracy checking stage. A random selection of ten medicines found none past their expiry date. The pharmacy had a fridge to store medicines that required cold storage. Team members recorded the temperatures daily and records showed this was up to date. And they received notifications about drug alerts and recalls via email. They printed and stamped them to show action had been taken and retained them for future use. The pharmacy kept medicines returned by people who no longer needed them 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 paper and electronic copies of the British National Formulary and British National Formulary for children. As part of their role as IP, the pharmacist accessed National Institute for Clinical Excellence guidelines and local Health Board formularies to help inform their prescribing choices. The pharmacy had crown-stamped measuring cylinders.

The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines awaiting collection in the dispensary in a way that ensured people's private information was secured. Confidential information was secured on computers using passwords. And the screens were positioned in way that 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.