General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Central Pharmacy Ltd, 31 Main Street, UDDINGSTON, Lanarkshire, G71 7EP

Pharmacy reference: 1042602

Type of pharmacy: Community

Date of inspection: 27/10/2021

Pharmacy context

This is a community pharmacy in the centre of the village of Uddingston, Lanarkshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It delivers medicines for some people to their homes and supplies some people with their medicines in multi-compartment compliance packs to help them with taking their medicines. The pharmacy team advises on minor ailments and provides the NHS Pharmacy First service. The pharmacy has a 24-hour collection point which allows people to collect their dispensed medicines at any time, including outside of the pharmacy's opening hours. The inspection was completed during the COVID-19 pandemic.

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 team generally follows written procedures that are in place to help team members manage the risks associated with the services the pharmacy provides to people. Team members discuss why near miss errors happen during the dispensing process and put into place ways they can reduce the risk of similar errors happening again. The pharmacy suitably protects people's private information, and the team members are confident in their ability to help safeguard vulnerable adults and children. The pharmacy keeps most of the records it needs to by law.

Inspector's evidence

The pharmacy had introduced many ways to keep the pharmacy team and people who visited the pharmacy safe from infection during the COVID-19 pandemic. Team members had completed assessments of their own personal risk of COVID-19. There were plastic screens installed at the pharmacy counter which created a barrier between the pharmacy team and people in the retail area. The team had placed bottles of hand sanitiser on the pharmacy counter and around the dispensary. The pharmacy had a large retail area and so people were able to easily socially distance from each other. There were three seats in the retail area for people to use while they waited to speak to a team member or while their prescriptions were being dispensed. The team had positioned the seats over two meters apart from each other to help support social distancing. The team regularly cleaned surfaces like work benches and door handles. Most people visiting the pharmacy wore a face covering but not all team members were doing so. The inspector reminded the team of the importance of wearing a face covering within a healthcare setting.

The pharmacy had a set of written standard operating procedures (SOPs) which were well organised with an index to help find a specific SOP. There were SOPs on various processes like the management of controlled drugs (CDs) and dispensing medicines in multi-compartment compliance packs. During the inspection, the team was seen to be following the SOPs. The pharmacy reviewed the SOPs every two years to make sure the pharmacy's current ways of working were up to date. The latest review was due in June 2021. The pharmacy's superintendent pharmacist (SI), who had recently joined the pharmacy was in the process of completing the review. There wasn't an SOP for the use of the pharmacy's 24-hour collection point although the SI explained that one was in the process of being written. Each team member had signed the SOPs that related to their role. The roles and responsibilities of the team were detailed in a separate SOP. Team members were aware of the tasks they could and couldn't carry out in the absence of a responsible pharmacist.

The pharmacy had a process in place to record and report near miss errors made during dispensing. For example, if the team members had dispensed the wrong quantity or the wrong strength of the medicine. If the responsible pharmacist (RP) spotted a near miss error, they asked the team member to rectify the mistake as soon as possible. Team members were asked why the near miss error might have happened and to think about how they could stop it happening again. Team members recorded details of near miss errors into a near miss log. They recorded details such as the time and date of the error and any contributing factors. Each team member had their own individual log. They analysed their individual near miss logs for any trends or patterns and suggested changes that could be made to the way they worked to reduce the risk of similar errors happening again. They had recently noticed several errors that involved three medicines with similar names, sildenafil, sertraline and sumatriptan. And they

suggested separating them on the dispensary shelves to reduce the risk of them being selected by mistake during the dispensing process. Team members explained since the three medicines had been separated, they hadn't made any near miss errors involving them. The SI was immediately informed about any dispensing errors that had reached people. The SI recorded any details of these errors on an online reporting system. People who used the pharmacy could speak to a team member if they wanted to make a complaint or raise a concern. They raised any concerns with the SI if the team couldn't resolve the issue.

The pharmacy displayed an expired indemnity insurance certificate. Following the inspection, the pharmacy sent the inspector evidence of up-to-date indemnity insurance which expired in May 2022. An RP notice was clearly displayed behind the pharmacy counter. It was displaying the name and registration number of the RP on duty. The pharmacy had an electronic RP record. But in a sample seen, there were no recorded times for when RP duties had ended on each day. This wasn't in line with legal requirements. Team members discussed putting a daily reminder on the computer system that would alert them a few minutes before the pharmacy to close for the day. The reminder would remind the RP to sign out before they left the pharmacy. The pharmacy kept registers for controlled drugs (CDs), and they met legal requirements. Every few weeks, the team checked the balances in the registers against the pharmacy's stock to make sure they matched. During the inspection, three randomly selected CDs were balance checked. The balances were correct. The pharmacy kept records of CDs that were destroyed after people had returned them. The pharmacy occasionally dispensed private prescriptions and kept accurate records of supplies.

The pharmacy held records that had people's personal information in areas of the pharmacy that could only be accessed by team members. They placed any confidential waste into a separate bin to avoid a mix up with general waste. The waste was collected and destroyed by an external contractor. Team members hadn't completed any formal training on safeguarding vulnerable adults and children. But several team members correctly described some hypothetical situations in which they would raise concerns with the RP on duty. The RP was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the skills to safely provide the pharmacy's services. They manage their workload well, support each other as they work and help each other improve their skills. They can raise professional concerns where necessary and they actively discuss ways the pharmacy can improve the way it manages its services.

Inspector's evidence

The RP during the inspection was a locum pharmacist. The RP was supported by two part-time and one full-time pharmacy assistants. The pharmacy also employed two other part-time pharmacy assistants, a trainee counter assistant, and a delivery driver. The SI was present during the inspection and was supporting the team with the dispensing workload. The pharmacy hadn’t had a full-time pharmacist for several months, but a full-time pharmacist position had been advertised. The pharmacy was using regular locum pharmacists while the position was open. During the inspection, team members were seen to be supporting each other in completing various tasks and managing their workload well.

The pharmacy didn’t provide its qualified team members with a formal, ongoing training programme to help them to continue to improve their knowledge and skills. Team members usually completed training in their own time by reading training material they received in the pharmacy press or provided by manufacturers of medicines. Team members explained they often looked to other, more experienced team members if they felt they needed help with any part of their role. For example, a team member needed some support in learning how to manage the process of dispensing medicines in multi-compartment compliance packs. To help support learning, the team member worked alongside a pharmacy assistant who was more experienced in managing the process. The pharmacy had a formal performance appraisal process in place for its team members. But the process hadn’t been followed since the pharmacy had been without a full-time pharmacist. The SI gave team members informal feedback on their performance.

The team held ad-hoc meetings and there was a team WhatsApp group where team members could talk about professional concerns and ways to improve the pharmacy’s services. The pharmacy had recently agreed to start dispensing medicines for people living in a local care home. The team discussed using different coloured baskets to hold prescriptions and medicines for people living in the care home. This would help them differentiate the baskets from others such as for delivery.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are highly professional are appearance and is kept clean and secure. The team works well to keep tidy the areas where it dispenses medicines. The pharmacy has a suitable sound-proofed room where people can have private conversations with the pharmacy team members.

Inspector's evidence

The premises were modern and provided a very professional image. The dispensary was clean and tidy. The dispensary had a separate area so team members could work separately if needed to reduce distractions. The dispensary was of a suitable size for the volume of services the pharmacy offered. There were some storage areas and a staff room that were kept clean and tidy. There was another counter in the retail area which was signposted as ‘advice’. The counter was on the opposite side of the main pharmacy counter. It was used as a semi-private area where people could have conversations with team members without being overheard by other people at the pharmacy counter.

There was a sound-proofed consultation room used to have fully private consultations with people. There was a sink in the dispensary for professional use. The team had toilet facilities with hot water for handwashing. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of accessible services that support people's health needs. The pharmacy appropriately manages its services. It obtains its medicines from reputable sources. And it mostly stores and manages them as it should. The pharmacy has a well-managed 24-hour collection point to allow people to collect their medicines at any time of day including outside of the pharmacy's opening hours.

Inspector's evidence

The pharmacy had level access from the street to an automatic door which made it easy for people to access the premises with wheelchairs or prams. There were window displays which detailed the pharmacy's opening times and the services it offered to people. Team members had internet access which they used to help people find providers that offered services the pharmacy didn't. The pharmacy provided large-print labels on request to help people who had problems with their sight. A team member described how she provided writing materials to people who had trouble hearing which allowed them to write down what they needed to explain to the team. Team members also made sure they didn't stick any dispensing labels over braille on medicines packaging. Team members were comfortable using Google translate for some people who didn't speak English.

Team members used various stickers and put notes on bags containing people's dispensed medicines to use as an alert before they handed out medicines to people. For example, to highlight if a fridge line or a CD that needed handing out at the same time. They used 'speak to pharmacist' stickers to attach to bags to remind the pharmacist to give additional advice to people, for example, to remind people to finish a course of antibiotics. Team members signed the dispensing labels to keep a trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. They used a bench in the centre of the dispensary to carry out the dispensing process, and the pharmacist used a bench closest to the retail area to carry out final checks of prescriptions. As the bench was close to the retail area, the pharmacist could overhear conversations between other team members and people and could intervene if needed. Team members gave owing slips to people on occasions when the pharmacy could not supply the full quantity prescribed. They gave one slip to the person and kept one with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. During the COVID-19 pandemic the driver left the medicines on the person's doorstep before moving away and waiting to watch them pick up the medicines.

The pharmacy had recently installed a 24-hour collection point. The collection point allowed people to collect their dispensed medicines at any time of day, including outside of the pharmacy's opening hours. The team explained the collection point had helped reduce the number of people entering the pharmacy premises. This was helpful during the COVID-9 pandemic as people could collect their medicines without having to come close to team members or other people visiting the pharmacy. Team members asked people for written consent to allow them to store their medicines in the collection point. If they agreed, they were sent a text message explaining that their medicines were ready to collect. The text messages were sent with a six-digit code which people used to enter on the touch screen system.

The team was aware of the need to give people more information about their medicines if they were prescribed medicines that were high-risk or required ongoing monitoring. But team members didn't always record details of any additional counselling given to people. A team member showed the inspector a dispensary drawer that contained various cards and booklets to give to people. For example, steroid emergency cards. And the team knew when to give them to people. Team members showed their understanding of the pregnancy prevention programme for people who were prescribed valproate. They explained the questions they would ask of people to make sure they knew to use appropriate contraception. They knew to take care they didn't place dispensing labels over written warnings on packs and to make sure they attached a warning sticker on the container if valproate was supplied outside of its original packaging.

Some of the prescriptions the pharmacy received were for people who benefitted having their medicines dispensed in a multi-compartment compliance pack. These were dispensed in a separate area away from the retail area. This allowed team members to dispense them without distractions. People received their packs either weekly or monthly depending on their personal needs. The team ordered prescriptions for people from their GP practice. When the pharmacy received the prescriptions, the team checked them against master sheets to make sure they were correct. The master sheets detailed which medicines went in the packs and at what time of the day they were to be taken. For example, in the morning or at bedtime. The packs were supplied with visual descriptions of the medicines to help people identify them. But the pharmacy didn't supply the packs with patient information leaflets unless a medicine was dispensed for a person for the first time. This meant that some people weren't provided with full information about their medicines.

The pharmacy obtained medication from several reputable sources. It stored its Pharmacy (P) medicines behind the pharmacy counter to control sales. Team members were seen asking people who wanted to purchase P medicines, appropriate questions to make sure the medicine they wished to buy was suitable for the symptoms they were describing. Team members checked expiry dates of the pharmacy's medicines. But there wasn't a written procedure explaining how often the checks should be done. They highlighted short-dated medicines using red stickers, but they didn't keep a record of which medicines were short-dated and when they were due to expire. The inspector didn't find any out-of-date medicines after a check of around 20 randomly selected medicines, but an amber bottle was found containing folic acid. The bottle wasn't labelled with an expiry date or batch number. A white cardboard box was found with blister strips of metformin inside. Some of the strips didn't have an expiry date or batch number. The inspector discussed the importance of ensuring expiry dates and batch numbers were visible on all medicines to make sure expired medicines weren't supplied to people. And to help the team identify any medicines using their batch number, for example, if there was a drug recall. The pharmacy had a domestic fridge which it used to store medicines that needed cold storage. The team tidily stored the medicines in the fridge. Each day, the team recorded the fridge temperature records to make sure it was correctly operating. The team recorded the fridge temperatures daily and a sample seen were within the correct range.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it appropriately uses its equipment to protect people's private information.

Inspector's evidence

Team members had access to up-to-date reference sources. The pharmacy used a range of CE quality marked measuring cylinders. It positioned the computer screens so unauthorised people didn’t see any private information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in private. It had a wireless card terminal for contactless transactions and reduce the use of cash during the pandemic. Team members had access to personal protective equipment including face masks and gloves.

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.