General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Mcintyre & Cairns Chemists, 27-29 Craigneuk Street, WISHAW, Lanarkshire, ML2 7XD

Pharmacy reference: 1042606

Type of pharmacy: Community

Date of inspection: 17/03/2022

Pharmacy context

The pharmacy is an independent, traditional community pharmacy. It is on a small parade of shops on the outskirts of Wishaw town centre. It provides a range of services including dispensing prescriptions and selling over-the-counter medicines. It provides a range of other services including a prescription collection service and a medicines' delivery service. It also provides substance misuse services, 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 in general it has suitable procedures to identify the risks associated with its day-to-day services.

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 hand sanitiser at different locations in the waiting area and inside the pharmacy for people and the team to use. Team members had access to personal protective equipment in the form of masks and gloves if they needed them. The team had a cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. Team members could work an appropriate distance from one another for much of the time across the pharmacy's two main dispensing areas. The pharmacy team recorded its mistakes and it reviewed them regularly. But its records did not indicate what the team member involved had learned or what they would do differently in future to prevent similar mistakes. But the responsible pharmacist (RP) highlighted and discussed mistakes as they happened to enable team members to reflect and learn. The RP recognised that records should provide enough detail to monitor mistakes, learn as much as possible from them and promote continued improvement.

The pharmacy had a set of SOPs to follow. But they had not been updated for several years. So, they were in need of review. Team members had read the SOPs relevant to their roles. They appeared to understand their roles and responsibilities and were seen consulting the RP or his colleague, the superintendent pharmacist (SP), when they needed their advice and expertise. The RP had placed his RP notice on display showing his name and registration number as required by law. People could give feedback on the quality of the pharmacy's services. Team members described the pharmacy as having a low number of complaints. And any complaints were generally dealt with at the time by the RP or the SP. In general, the team sought feedback from conversations with people as well as staff at the homes it supplied medicines to. And it was clear that the pharmacy team had a good relationship with its customers. It had received thank you cards from people who were grateful for the team's help and support with providing their medicines. The pharmacy team had placed a notice on display which gave details of how people should make a complaint if they needed to. And if necessary, the team could provide details of the local NHS complaints procedure for the local health board which were available online. 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 04 December 2022. It is understood that when this date is reached the pharmacy will renew its insurance arrangements for the following year.

The pharmacy generally kept its records in the way it was meant to. Including the RP record, private prescription records, unlicensed specials records and controlled drugs (CD) registers. And it had a CD destruction register for patient returned medicines. This was up to date with team members having undertaken destructions regularly. The pharmacy also had the appropriate records for supplies made under the NHS Pharmacy First service and 'Medicines Care Review' (MCR) serial prescriptions. And it

maintained and audited its CD running balances. During the inspection a check of a product in stock matched the running balance in the pharmacy's CD register. The pharmacy's team members understood the need to protect people's confidentiality. Confidential paper waste was discarded into separate waste containers. And shredded daily. People's personal information, including their prescription details, were kept out of people's view. The RP had completed appropriate safeguarding training. Other team members had been briefed. They had a good understanding of their safeguarding responsibilities and knew to report any concerns to social services, the police or a person's GP as appropriate. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy manages its workload safely and effectively. And its 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 RP on duty. The RP worked alongside the SP with whom he often shared his shift. On the day of the inspection the rest of the team consisted of three dispensing assistants (DAs), a healthcare assistant (HCA) and a delivery driver. Two of the DAs had completed their NVQ2 training, and the third was still in training. The majority of the pharmacy’s team members had worked at the pharmacy for several years and were known to people in the local community.

Team members had a clear understanding of what their tasks were. And when they should do them. A rota on the wall ensured that tasks were shared to provide an overall level of expertise within the team. And to ensure that the team shared its responsibilities. The working atmosphere was efficient and organised. The daily workload of prescriptions was in hand and customers attended to promptly. The pharmacy had a close-knit team. And its members worked regularly together. And they were seen to support one another to complete their tasks. Team members did not have formal appraisals or regular reviews about their work performance. But they had occasional one-to-ones with the RP who kept them up to date with any changes affecting their work or any new work priorities. They could raise concerns and discuss issues with the RP or SP. And the RP felt that he could discuss any concerns with the SP. Both pharmacists could make their own professional decisions in the interest of people and were not under pressure to meet business or professional targets.

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 on a small parade of shops in the midst of the local community. It had a traditional appearance. And it had a small retail space. It had a medicines counter behind which it kept its pharmacy medicines. And it had a small dispensary. The dispensary was mainly used for walk-in prescriptions, acute prescriptions, urgent care prescriptions and deliveries. These were dispensed in two areas immediately beside and behind the accuracy checking area, so that they could be checked and completed promptly after dispensing. The pharmacy had several rooms to the side and rear of the dispensary. The largest of these provided a quieter area for dispensing. And so, it was used for most of the pharmacy's remaining dispensing activities. These included the management, dispensing and storing of multi-compartment compliance packs. And repeat prescriptions, medicines care review (MCR) prescriptions and instalment prescriptions. The room also had a dispensing hatch which was located away from the main retail space. And access to the hatch was through a separate entrance to that of the main pharmacy. And so people using it could receive their medicines in more private surroundings. And the pharmacy team could supervise and counsel them without other people overhearing.

The pharmacy also had a consultation room which people could access from the customer area. The pharmacy's remaining rooms were used for storing stock and prescriptions. And to provide an area for team members to take rest breaks. The team cleaned the pharmacy daily to ensure that contact surfaces were clean. Stock on shelves was tidy and organised. And floors and work surfaces were free from clutter. 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 always thorough enough in ensuring that it keeps all medicines for dispensing in the appropriate packaging. And it is not always thorough enough in ensuring that it properly labels and packages all the medicines it supplies.

Inspector's evidence

The pharmacy had step-free access, which provided suitable access for wheelchair users and for those with mobility difficulties. And its customer areas were free of clutter and unnecessary obstacles. 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's labelling directions on compliance packs 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. But it had not labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them.

The RP gave people advice on a range of matters. And he would give appropriate advice to anyone taking high-risk medicines. The pharmacy team had additional leaflets and information booklets on a range of medicines. The pharmacy had a small number of people taking sodium valproate medicines. But none of the people taking it were in the at-risk group. The RP was aware of the precautions he would need to take, and counselling he would give, if it were to be prescribed for someone new. The pharmacy offered the NHS 'Pharmacy First' service, where people could obtain medicines for a range of minor ailments and conditions. The service was generally provided by the RP who followed the local health board protocol by supplying medicines from a specified list. Team members knew when to refer to the pharmacist when someone presented for the service.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. And team members knew how to process them. The RP described how he had requested a prescription change from salbutamol inhaler to a combination fluticasone/ vilanterol inhaler for a person who was not managing their asthma well. The MCR had shown that the person was not using a preventative inhaler alongside their reliever (salbutamol) inhaler. So switching to an inhaler which provides ingredients to help both prevent and relieve the symptoms of asthma should provide the person with what they need to better manage their condition. 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 address any issues. The pharmacy supplied a variety of medicines by instalment. A trained team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the labelled medicines together in individual baskets to keep the instalments together. But the inspector found that some dispensed

medicines had not been properly packaged or labelled after dispensing. The inspector discussed this with team members and highlighted the importance of ensuring that people have all the information they need to take their medicines properly.

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 the inspector found a box of metformin tablets and a box of thiamine tablets which contained strips of tablets from different batches. Some of the tablet strips had been part-dispensed and no longer had their expiry dates. So the outer packaging did not give enough essential information about the medicines it contained and did not accurately reflect what was inside it. The inspector also found several loose strips of tablets in amongst the pharmacy's stock. 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 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 its CDs and fridge items appropriately. 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.

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.