General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Neilston Pharmacy, 55 Main Street, NEILSTON, Renfrewshire, G78 3NH

Pharmacy reference: 1042912

Type of pharmacy: Community

Date of inspection: 02/06/2021

Pharmacy context

This is a community pharmacy on a small parade of shops in Neilston. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it offers a medicines' delivery service to vulnerable people. The pharmacy provides substance misuse services and dispenses private prescriptions. The pharmacy team members advise on minor ailments and medicines' use. And they supply a range of over-the-counter medicines.

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 acts to help keep members of the public and team members safe during the Covid-19 pandemic. It keeps the records it needs to by law, and keeps confidential information safe. Team members securely dispose of personal information when it is no longer required. The pharmacy's policies and procedures show how it identifies and manages risks to keep services safe. Team members mostly follow the procedures. But they do not always record their signatures when they are required to. This means the pharmacy cannot always show who is accountable for parts of the dispensing process. Team members discuss dispensing mistakes and make improvements to avoid the same errors happening again.

Inspector's evidence

The pharmacy had introduced new processes to manage the risks and help prevent the spread of coronavirus. Posters on the entrance door reminded people visiting the pharmacy to wear a face covering as required by law. And informed them the waiting area could only accommodate a maximum of three people to allow them to maintain a safe two-metre distance from each other. People were seen to be following the guidelines without any instruction from the pharmacy team members. Hand sanitizer was available in the dispensary but not in the waiting area. A Perspex screen was in place at the medicines counter. This acted as a protective barrier between team members and members of the public. Pharmacy team members were wearing face masks throughout the inspection, and they used a separate storeroom for breaks. Only one team member used the storeroom at the one time. This meant they could remove their face mask during comfort breaks. The pharmacy used working instructions to define the pharmacy's processes and procedures. Most of the team members had recorded their signatures to show they understood and followed them. A new dispenser had just started working at the pharmacy, and they were about to read and sign the documents. Sampling showed the procedures for 'assembly and dispensing', and 'final accuracy checking' had been reviewed within the last three years. The pharmacy had risk management procedures in place. Team members were required to sign medicine labels to show who had 'dispensed' and who had 'checked' each prescription. This was to help them learn about their near-miss errors through feedback, and to avoid the same mistakes in the future. Sampling showed most of the labels had been signed except for those attached to multi-compartment compliance packs.

An 'accuracy checking technician' (ACT) was responsible for carrying out the final accuracy checks for packs. But the pharmacist did not annotate prescriptions to show they had 'clinically checked' them. Instead they annotated the medication records that the team members used to help with dispensing, for example, the records showed the time of day a dose was to be taken. This meant there was a risk that the ACT was carrying out final accuracy checks on prescriptions that the pharmacist had missed and had not clinically checked. The pharmacy relied on the dispensers and the ACT to check new prescriptions and highlight any changes when they were processing them. Only then would the pharmacist carry out another 'clinical check' and annotate the record as they had done before. The number of near miss records showed that team members were effective at identifying their mistakes. And they provided a few examples of changes they had made to manage the risk of recurrences. For example, they had separated carbamazepine and carbamazepine MR tablets to manage the risk of selection errors. The pre-registration pharmacist carried out a review at the end of the month. But they

were on annual leave and the records were not available. The pharmacy trained team members to follow a complaints policy so they were effective at handling concerns. Most of the people using the pharmacy had provided positive feedback about the quality of the services provided throughout the pandemic. The pharmacy used an online form to support team members to investigate and report dispensing incidents to show it had acted on safety concerns.

The pharmacy maintained the records it needed to by law, and the pharmacist in charge kept the responsible pharmacist record up to date. It kept its private prescription forms in good order and kept a record of the supplies it made. The pharmacy had public liability and professional indemnity insurance in place, and they were valid until September 2021. The pharmacy used an electronic controlled drug register. And the pre-registration pharmacist was responsible for carrying out stock checks once a week. They checked and verified each item once a month. Expired stock awaiting destruction had been placed in a labelled bag at the bottom of one of the cabinets well away from other stock. A controlled drug destruction register was being used to record controlled drugs that people returned for disposal. Only one item was awaiting destruction, and it had been documented in the register. The pharmacy provided a prescription delivery service. This helped vulnerable people and those that were shielding to stay at home. The driver wore PPE at the time of delivery and kept a record of the deliveries they made. The pharmacy provided training so that team members understood data protection requirements and they knew how to protect people's privacy. The pharmacy did not display a notice or inform people about how it used or processed their information. Team members used a shredder to dispose of confidential waste and spent records. The pharmacy used a child protection policy which included contact numbers for the key agencies. It provided training so that team members understood how to protect children and vulnerable adults. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. This helped to protect children and vulnerable adults. Team members knew to speak to the pharmacist whenever they had cause for concern. For example, they monitored the collection and delivery of multi-compartment compliance packs and acted when people either didn’t collect them on time, or when there were failed deliveries.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. They complete training as and when required. And, they learn from the pharmacist to keep their knowledge and skills up to date. Pharmacy team members speak-up and make suggestions to help improve pharmacy services.

Inspector's evidence

The pharmacy’s workload had increased slightly over the past year due to coronavirus. Three long-serving team members had retired, and the pharmacy was in the process of recruiting replacements. A part-time dispenser from another branch had just started and was undergoing accuracy dispenser training. The pharmacist and the ACT were supporting the trainee in their roles. Team members were well established and had worked at the pharmacy for many years. This included one full-time pharmacist, one part-time ACT, one full-time dispenser, two part-time dispensers, one part time medicine counter assistant, one full-time delivery driver and one pre-registration pharmacist.

The pharmacist was supporting the pre-registration pharmacist to develop their knowledge and skills. They held regular meetings to ensure they were gaining the relevant experience. The pharmacy did not carry out individual performance reviews and it did not provide regular structured training. Team members had kept up to date with the relevant coronavirus guidance. This included how to keep themselves and other people safe. For example, they were carrying out twice-weekly Covid-19 testing to confirm they were free from the virus. Team members understood the need for whistleblowing. They felt empowered to raise concerns when they needed to and suggest areas for improvement. The previous year they had introduced a communications diary. This ensured that important messages were relayed to the responsible pharmacist and other team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy, secure and is well maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members. It has made suitable changes to its premises to help reduce the risk of spreading coronavirus.

Inspector's evidence

Workstations were at least one metre apart and team members could keep their distance from each other for most of the day. Dispensary benches had been arranged for different tasks, and a dedicated bench was being used to assemble and check multi-compartment compliance packs. The consultation room provided access to a small window for team members to provide methadone doses. They cleaned the room on a regular basis. The pharmacist observed and supervised the medicines counter from the checking bench, and they could intervene and provide advice when necessary. The consultation room was sound-proofed and was well-equipped with a sink and running water. It provided a confidential environment to have private consultations. A dispensary sink was available for hand washing and the preparation of medicines. The pharmacy was clean and well maintained. Team members cleaned and sanitised the pharmacy twice a day to reduce the risk of spreading the infection. This included frequent touch points such as keypads and telephones. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are accessible. It generally manages its services to help people receive appropriate care. It has alternative arrangements in place for people who have difficulty accessing the premises due to steps at the entrance. The pharmacy gets its medicines from reputable sources and it stores them properly. But it does not always label medicines according to regulations. And it does not always state the contents of medicine containers. The team carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy had a stepped entrance which restricted access for some people with mobility difficulties. It did not have a portable ramp available and a pressure operated pad had not been working for some time. The pharmacy had an arrangement with someone who used a wheelchair. The person phoned the pharmacy before they arrived, and a team member attended to them at the entrance. The pharmacy used dispensing baskets to manage the risk of items being mixed-up. Dispensing benches were organised and clutter-free. Team members kept the pharmacy shelves neat and tidy. Three controlled drugs cabinets were well-organised to manage the risk of selection errors. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members carried out monthly expiry date checks and they attached stickers to highlight products that were short dated. They recorded the checks, so they knew when the next one was due. No out-of-date medicines were found after a check of around 12 randomly selected medicines. Two fridges were in use. One was used mostly for insulin and the other for prescriptions that had been dispensed and awaiting collection or delivery. Team members monitored and recorded the fridge temperatures every morning. The records showed that the temperatures had remained between two and eight degrees Celsius.

The delivery driver kept a record of the prescriptions they delivered to people in their homes. The driver didn't ask people to sign for receipt of their medication due to coronavirus. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. And shelf-edge caution stickers highlighted what the risks were. The pharmacist confirmed they had carried out a risk assessment for all the people they supplied valproate to. They knew to contact prescribers if they received new prescriptions for people in the at-risk group. Team members supplied warning cards each time they made a supply. The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people. This had remained at the same level throughout the pandemic. It had introduced a documented procedure for team members to follow, but they had not signed it to show they followed the dispensing process. Team members kept the storage area for the packs organised. And they checked the area once a week to ensure packs were being collected on time. They knew to contact the surgery or the person's representative if they had concerns. Supplementary records in the form of a 'backing sheet' contained a list of the person's current medication and dose times, and they kept them up to date. They checked prescriptions against the 'backing sheet' for accuracy before they started dispensing. Queries were discussed with the relevant prescriber. Team members annotated some descriptions of medicines in the pack and supplied patient information leaflets once a month. The pharmacy dispensed methadone doses the day before they were due. The pharmacist checked the dispensed doses against each prescription, and placed them in the controlled drug cabinet until they were needed. The pharmacist

checked the doses for a second time at the time they supplied them. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Team members accepted unwanted medicines from people for disposal. They put on disposable protective gloves before handling the packages and processing the waste for destruction. Drug alerts were prioritised, and team members knew to check for affected stock so that it could be removed and quarantined. A recent drug alert for carbimazole in May 2021 had been checked with no affected stock found.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy’s equipment is clean and well-maintained. It uses equipment appropriately to protect people's confidentiality. It takes precautions so that people can safely use its facilities when accessing its services during a pandemic.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used crown-stamped measuring equipment. An elastic band had been wrapped round one of the measures. This showed it was to be used only for measuring methadone. A methadone pump was in use and it was calibrated before measuring doses to provide assurance it was measuring accurately. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team members. The pharmacy had a cordless phone, so that team members could have conversations with people in private. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. 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.