General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Balfron Pharmacy, 67 Buchanan Street, BALFRON, Stirlingshire, G63 0TW

Pharmacy reference: 1042975

Type of pharmacy: Community

Date of inspection: 30/01/2020

Pharmacy context

This is a community pharmacy in the village of Balfron. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service. And it dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers a smoking cessation service.

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 team members work to professional standards. And they understand their role in protecting vulnerable people. The team members follow most of the working instructions that are in place to keep services safe. And they know to follow the company's complaints handling procedure. People using the pharmacy can provide feedback about the services they receive. And the pharmacy team members record and discuss mistakes that happen whilst dispensing. They use this information to learn and reduce the risk of further errors. But they do not always collect detailed information about the causes of mistakes to help inform the changes they make. The pharmacy keeps the records it needs to by law. And the pharmacy team know how to keep confidential information.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. The team members had not signed all the instructions. And the pharmacy was not always able to provide assurance that the team was following safe practices. For example, they had not signed the instructions for dispensing multi-compartment compliance packs, date checking and recording near-misses. The team members signed dispensing labels to show they had completed a dispensing task. And the pharmacist checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The team members were responsible for documenting near-misses. And they had recorded some errors since the previous inspection. The pharmacist had carried out reviews to identify risks in the dispensing process. And the team members had agreed to take more time when dispensing to manage the risk of errors. The team members knew about the risks associated with look-alike and sound-alike medications. And they had separated a few medicines such as paroxetine/pravastatin and the different strengths of citalopram to manage selection risks.

The team members knew to apologise when people reported dispensing incidents. And they passed any complaints to the pharmacist who carried out an investigation to identify the cause and take remedial action if necessary. The pharmacist confirmed they had not received any recent complaints. And the last reported incident had resulted in the pharmacy team separating amitriptyline and amlodipine to manage the risk of a similar incident in the future. The pharmacy team members had read the complaints policy. And this provided assurance that the team members handled complaints in a consistent manner. The pharmacy displayed a complaints notice for all to see. And this encourage people to discuss their concerns and helped the team members make the necessary improvements.

The pharmacy maintained the records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity insurance in place. And it was valid until 8 July 2020. The pharmacy team members kept the controlled drug registers up to date. And they checked the balances at the time of dispensing, with a full balance check carried out every two to three weeks. The pharmacy team recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions (PGDs) to provide access to medicines and advice. And the pharmacist accessed the PGDs on the Health Board’s website.

The pharmacy displayed information about its data protection arrangements. And it informed people

about how it safeguarded personal information. The pharmacy trained the team members during induction to comply with confidentiality arrangements. And they knew how to safely process and protect personal information. For example, they shredded spent labels and they archived spent records for the standard retention period.

The locum pharmacist had registered with the protecting vulnerable group (PVG) scheme which helped to protect children and vulnerable adults. And the pharmacist had briefed the team members about vulnerable people so they could monitor individuals that were having difficulties. The team members knew to highlight concerns. And they had referred someone who visited the pharmacy every day when they had behavioural changes. The pharmacist had contacted the GP to discuss the matter. And to ensure the individual received the help that they needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete ad-hoc training. And, they learn from the pharmacist to keep their knowledge and skills up to date. The pharmacy team members support each other in their day-to-day work. And they can speak up and make suggestions to improve how they work. The team members speak about mistakes that happen. But they do not always discuss the reasons for the mistakes. And this prevents them from learning from each other.

Inspector's evidence

The pharmacy had been inspected on 3 July 2019 when a standards not all met had been recorded. The pharmacy had failed to demonstrate that its team members had the necessary training qualifications. And it had failed to demonstrate its team members had been enrolled onto a recognised training course in accordance with minimum training requirements. The pharmacy displayed the team member's training qualifications. But it was unable to produce evidence that a long-serving team member was qualified to carry out their role. The regular pharmacist was off-duty. And a locum pharmacist was providing cover for the first time. The regular pharmacist contacted the inspector after the inspection. And provided evidence that she had enrolled the team member onto the medicines counter course.

The locum pharmacist was being supported by two well established and experienced team members at the time of the inspection. And the following team members were in post; one full-time pharmacist, two part-time dispensers, one part-time medicines counter assistant (MCA) and one part-time trainee MCA. The pharmacist managed annual leave requests. And they maintained minimum levels by authorising only one team member to take leave at any one time. The pharmacy's sister branch was located a short distance away. And the team members could call on support whenever this was needed. One of the dispenser's was working extra at the time of the inspection. And they were providing cover for someone who was on leave.

The pharmacist did not carry out individual performance reviews. And although they had registered people with an on-line training provider. The team members had not completed training since around August or September 2019. And this was due to unplanned leave and the additional pressure placed on team members. One of the dispensers could recall completing training. And had learned about the products used to manage head lice infestations. The pharmacist updated the team members whenever there were service changes or new initiatives. For example, they had provided training about the falsified medicines directive (FMD) and the valproate pregnancy protection programme.

The company did not use numerical targets to grow the services it provided. And the team did not feel undue pressure in their day-to-day roles. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had re-arranged shelving so that bulky items were removed from the shelves. And this had made it easier to look for items when people arrived to collect their medication.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises is clean and hygienic. It has consultation facilities to meet the needs of the services it provides. And it has an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

A well-kept waiting area presented a professional image to the public. The pharmacy provided seating. And it provided a few patient information leaflets for self-selection. The pharmacy had allocated areas and benches for the different dispensing tasks. And the team members used a separate rear area to dispense, check and store multi-compartment compliance packs. The pharmacist supervised the medicines counter from the checking bench. And they could make interventions when necessary. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy provided a consultation room. And it was professional in appearance and an appropriate space to have private conversations.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays its opening times and service information in the window. And it is accessible to people with mobility difficulties. The pharmacy has working instructions in place for its services. And this ensures the pharmacy team are supported to work in a safe and effective way. The pharmacy dispenses multi-compartment compliance packs. But it does not always supply extra information to support people to take their medicines. The pharmacy sources, stores and manages its medicines. It updates the pharmacy team about high-risk medicines. And this means that team members know when to provide people with extra information.

Inspector's evidence

The pharmacy had step free access. And the small lip at the entrance did not restrict access for people with mobility difficulties. The pharmacy displayed some healthcare information leaflets in the waiting area. And it provided information about its opening hours in the window. The pharmacist attached 'see pharmacist' stickers to prescription bags. And the team members knew to alert the pharmacist so they could counsel people about their medication. For example, when people were prescribed new medication. And to check that people knew to have regular blood tests when taking some medications. The pharmacist had trained the team members about the valproate pregnancy protection programme. And they knew about the initiative, and where to find the safety leaflets and cards and when to issue them. The pharmacist monitored prescriptions for valproate. But they had not received prescriptions from people that could be affected to confirm they knew about the risks.

The pharmacy team members used dispensing baskets. And they kept prescriptions and medicines contained throughout the dispensing process at all times. The team members had organised the pharmacy benches. And they used a separate rear area to assemble and store multi-compartment compliance packs for around 52 people. The team members isolated packs when people's needs changed. For example, when they went into hospital or their prescription changed. The team members used supplementary records to support the dispensing process. And they updated them following prescription changes. The team members carried out checks. And they identified people when they did not collect their packs and informed the pharmacist. The team members annotated descriptions of each medication on the packs. But they did not routinely supply patient information leaflets. And they only supplied them when people's medication changed. The pharmacy did not provide a delivery service. But the pharmacist carried out a needs assessment. And they made sure they delivered to vulnerable and housebound people when necessary. The team members obtained signatures to confirm that people had received their medication at the time of delivery.

The pharmacy purchased medicines and medical devices from recognised suppliers. The team members carried out regular stock management activities. And they highlighted short dated stock and split-packs during regular checks. The team members monitored and recorded the fridge temperature. And they demonstrated that the temperature had remained between two and eight degrees Celsius. The team members kept controlled drugs in a small cabinet. And it was organised to manage the risk of selection errors. But it was becoming congested due to the level of stock needed to satisfy prescription requests.

The team members acted on drug alerts and recalls. And they recorded the date they checked for affected stock and what the outcome had been. For example, in December 2019 they had checked for ranitidine with stock removed and quarantined.

The pharmacist had provided training about the Falsified Medicines Directive (FMD). And the pharmacy had the necessary tools to meet the system's requirements. The pharmacy team members had used the system in the past. But they had stopped using it due to the limited number of packs that were FMD compliant. The team members accepted returned medicines from the public. And they disposed of them in designated containers that the health board collected for disposal.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

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 measures for measuring liquids. And it used counting equipment for loose tablets and capsules. The pharmacy kept cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. 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. The pharmacy team members had access to a portable phone. And they took calls in private when necessary.

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.