General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: LP North Twelve Limited, The Health Centre Site, 146 Dalmellington Road, AYR, Ayrshire, KA7 3PR

Pharmacy reference: 1097483

Type of pharmacy: Community

Date of inspection: 19/04/2023

Pharmacy context

This community pharmacy is in a medical centre in Ayr. The pharmacy's main services are dispensing NHS prescriptions and delivering medicines for some people to their homes. The pharmacy supplies several people with their medicines in multi-compartment compliance packs to help them take their medicines. The pharmacy offers the NHS Pharmacy First 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 pharmacy suitably identifies and manages the risks associated with its services. It has up-to-date written procedures that the pharmacy team follows. And it generally completes all the records it needs to by law. The pharmacy protects people's private information properly. Pharmacy team members respond correctly when errors occur. They generally discuss what happened and they take appropriate action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). All team members had read the SOPs and all but one team member had signed the SOPs signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions known as near misses. This included keeping a record of the near miss errors. A sample found the team members mostly recorded the cause of the near miss error, their learning from the error and the actions they had taken to prevent the error happening again. The pharmacy had a procedure for managing errors that were identified after the person had received their medicines known as dispensing incidents. The pharmacy completed checks of the team's compliance with the SOPs and a review of near miss errors. The outcome from the checks fed into a monthly team meeting. The pharmacy manager had used this process to remind the team to always complete the near miss record. And to highlight to the team medicines that looked alike and where names sounded alike. The team member responsible for preparing the multi-compartment compliance packs had reminded the team to check the packs returned from the offsite dispensary pharmacy for any medicines that had to be added. As there had been a few occasions when these had been missed and the person had not received all their medication. The pharmacy had a procedure for handling concerns raised by people using the pharmacy services. And a leaflet provided people with information on how to raise a concern with the pharmacy team.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers generally met legal requirements. An IT issue over a few days had prevented access to the electronic RP record but a paper version had not been used during this time, so there were records missing. The only record of the pharmacist on duty was the log for the CD keys. The balance of CDs recorded in the registers was regularly checked against the physical stock, to identify errors or missed entries. A random check of the balance of one medicine against the CD register found it was correct. The team members had completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding offsite. They kept sensitive material in restricted areas and they displayed details on how the pharmacy protected people's confidential information.

The pharmacy had safeguarding procedures and guidance for the team to follow. The RP was registered with the protecting vulnerable group (PVG) scheme. And team members had access to contact numbers for local safeguarding teams. They were aware of the Ask for ANI (action needed immediately)

initiative, which helped people experiencing domestic abuse. The delivery driver reported any concerns about the people they delivered to, and the team took appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they are good at supporting each other in their day-to-day work. They discuss ideas and identify ways to support the effective delivery of the pharmacy's services. And they complete ongoing training to help them develop their knowledge and skills.

Inspector's evidence

The pharmacy was supported by regular locum pharmacists. The pharmacy team consisted of experienced team members and new team members. The full-time pharmacy manager was an accuracy checking technician (ACT). And was supported by two full-time dispensers, one part-time dispenser, a part-time trainee dispenser and a part-time medicines counter assistant. At the time of the inspection a regular locum pharmacist, the pharmacy manager and three dispensers were on duty.

The team members on duty at the time of the inspection worked well together and supported each other. A daily rota was used to allocate key tasks to team members to ensure they were completed. And this rotation of tasks helped to make sure they knew how to do different tasks. This provided continuity especially at times of unplanned absence which may impact on the team's workload. The manager was also training experienced team members on specific tasks such as completing the weekly checks of the team's compliance with the SOPs and the review of dispensing errors.

Trainees in the team were given protected time at work and received support from experienced team members. One dispenser reported that the allocated training time and support had helped her complete the training within a few months, which had ultimately supported the team with its workload. The team members used company online training modules to keep their knowledge up to date. And they had some protected time to complete the training. The team held regular meetings and team members could suggest changes to processes or new ideas of working. The team was given in the moment feedback from the pharmacy manager and pharmacist. Team members had not received a formal performance review for several months.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

Team members kept the pharmacy premises tidy and hygienic. And the pharmacy provided separate sinks for them to use when preparing medicines and washing their hands. In response to the COVID-19 pandemic the pharmacy had installed a clear plastic screen on the pharmacy counter. And there was hand sanitising gel for the team to use. Since the last inspection team members had rearranged the pharmacy to ensure the dispensing benches were free of clutter. And they had removed the large number of tote boxes that had been stored on top of each and were covering most of the floor space in the dispensary.

The pharmacy had a defined professional area. And items for sale in this area were healthcare related. The pharmacy had a large, soundproof consultation room. The team used this for private conversations with people and offered the room as a private space for people receiving supervised doses of their medication.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible and help people to meet their healthcare needs. Team members manage the pharmacy services well to make sure people receive their medicines when they need them. They store medicines properly and they regularly check to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance through an automatic door and there was plenty of room in the retail area for people to move around. The pharmacy had an information leaflet providing people with details of the services it offered and the contact details of the pharmacy. And team members gave people information on how to access other healthcare services when required. Team members wore name badges detailing their role, so people knew who they were speaking to. They asked appropriate questions of people requesting over-the-counter (OTC) medicines and they monitored people's requests to buy OTC medicines to ensure the supplies were suitable. Any concerns regarding a person's request to buy an OTC medicine were referred to the pharmacist. A poster from NHS Ayrshire and Arran advised people of the timescales for ordering their prescriptions and collecting them from the pharmacy. This was a recent initiative from the NHS and was designed to help support the team to manage concerns raised by people about the supply of their medicines. The NHS Pharmacy First service was popular as it helped people obtain medication such as treatments for a urinary tract infection without delay. The pharmacy dispensed private prescriptions issued by the company's online Doctor service which included prescriptions for weight loss medications. There were procedures in place for this service and the pharmacist when completing the clinical check of the prescription would raise queries with the prescriber. For example, the pharmacist contacted the prescriber when the person's body mass index (BMI) was not within the specified range for prescribing.

The pharmacy provided multi-compartment compliance packs to help around 60 people take their medicines. Most packs were dispensed at the company's offsite pharmacy hub. The team followed procedures on how to process prescriptions in this way. This involved the team entering the prescription data which was checked for accuracy by the pharmacist who also clinically checked the prescribed medicines before the data was submitted. The team usually prepared prescriptions one week before supply to allow time to deal with issues such as missing items and the dispensing of the medication into the packs. And they requested prescriptions earlier when there was a bank holiday due. The team member preparing the packs worked at a separate computer station in a small, dedicated area of the dispensary. Other team members knew to not disturb their colleague whilst they were undertaking this task. Each person had a record listing their current medication and dose times. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. Completed packs were stored on dedicated shelves in box files labelled with the person's name and address. The team scanned the prescriptions returned by the offsite dispensing hub to confirm receipt and to identify any incomplete prescriptions that were to be dispensed at the pharmacy.

The pharmacy supplied medicine to several people daily as supervised and unsupervised doses. The doses were prepared using an electronic pump which was linked to a laptop. Team members inputted

prescription information into system on the laptop to ensure the pump measured the required doses and printed labels.

The pharmacy provided limited space for the team to separate the dispensing and checking of prescriptions. To manage this the team used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription and a sample found that the team completed both boxes. Clear bags were used to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The pharmacy kept a record of the delivery of medicines to people. Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to provide to people when required. But they didn't review people prescribed valproate to identify anyone who met the PPP criteria. They reported no-one prescribed valproate met the PPP criteria. The pharmacist and ACT kept a record of the conversations held with people prescribed higher-risk medicines so they could refer to them when required at a later date.

The pharmacy obtained medication from several reputable sources. Team members checked the expiry dates on stock but the document to record this activity had only one entry. Medicines with a short expiry date were marked to prompt the team to check the medicine was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening so the team could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. There were medicinal waste bins to store out-of-date stock and patient returned medication. And out-of-date and CDs returned for destruction were separated from in-date stock in CD cabinets that met legal requirements. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people’s private information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided which included a range of CE equipment to accurately measure liquid medication. There was a large fridge with a glass door that enabled the team to check the stock without prolong opening of the door. And the pump used for measuring some people’s medicines was regularly cleaned and calibrated to ensure the correct amount of medication was supplied each time.

The pharmacy computers were password protected and the team positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members stored completed prescriptions away from public view and they held private information in the dispensary and rear areas, which had restricted public access. They used cordless phones to ensure conversations with people could not be overheard.

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.