General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Deans Pharmacy, 63 Main Road, Maddiston, FALKIRK, Stirlingshire, FK2 0ZL

Pharmacy reference: 1098843

Type of pharmacy: Community

Date of inspection: 31/01/2020

Pharmacy context

This is a community pharmacy in the village of Maddiston. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines delivery service. It provides substance misuse services. 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 pharmacy team members identify and mostly manage the risks with the pharmacy's services. They understand their role in protecting vulnerable people. And they are up to date with safeguarding requirements. People using the pharmacy can provide feedback about the services they receive. And team members know to follow the company's complaints handling procedure. The pharmacy team members record and discuss mistakes that happen whilst dispensing. And they use this information to learn and reduce the risk of further errors. The pharmacy keeps the records it needs to by law. And it keeps people's private information secure. The pharmacy has written working instructions that are in place to keep services safe. But the team doesn't always follow these instructions. So, some processes for checking prescriptions cannot evidence a full audit trail and are not always robust.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. The team members had signed to confirm they followed the procedures. But they did not always follow the procedures to help keep the pharmacy services safe. For example, the accuracy checking technician (ACT) carried out the final accuracy check before the pharmacist had annotated prescriptions to show they had carried out the clinical check. The delivery driver obtained signatures to confirm receipt of controlled drugs. But they did not ask people to sign to confirm receipt of other medicines. The pharmacy team members signed dispensing labels to show they had completed a dispensing task. And the pharmacist and the ACT checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The pharmacy team members recorded information about the near misses. And they carried out monthly reviews to identify patterns and trends and areas for improvement. The pharmacist discussed the findings with the pharmacy team. And they made sure they knew about the agreed improvements. A sample review showed they had discussed; quantity errors made whilst dispensing prescription balances, transcription errors made during telephone calls and selection errors involving co-codamol. The team members were aware of look-alike and sound-alike medication. And they had separated amlodipine/amitriptyline and atenolol/allopurinol.

The pharmacist managed the incident reporting process. But they did not always document incidents to show what the root cause had been. For example, they had not followed-up on an alleged dispensing incident when they were told about it. And they did not take the opportunity to identify any service risks or areas for improvement. The pharmacy used a complaints policy. And this ensured that team members handled complaints in a consistent manner. The pharmacy displayed a notice to encourage people to speak to the pharmacist. And to discuss any aspect of the service they had received. The pharmacy provided a feedback form with pre-paid postage to encourage people to provide feedback about the services they received. And feedback had been mostly positive with no areas for improvement identified.

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 31 October 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 few months. 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 improve access to medicines and advice. And a sample showed that the trimethoprim PGD was valid until August 2020.

The pharmacy did not display information about its data protection arrangements. And it did not tell people how it safeguarded their 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. The pharmacy arranged for confidential waste to be uplifted for off-site shredding. And they archived spent records for the standard retention period. The pharmacy used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. And it used a policy to keep the team members informed about its safeguarding arrangements. The team members knew to refer concerns to the pharmacist when they recognised the signs and symptoms of abuse and neglect. And they provided examples of people not collecting multi-compartment compliance packs on time. Or when the delivery driver had been unable to deliver a pack. And they spoke to the surgery about their concerns to ensure people received the support that they needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

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 workload had increased slightly over the past year. And this was mostly due to an increase in front counter sales. The pharmacist carried out regular reviews. And they confirmed that the pharmacy continued to have the right number of team members for the services it provided. The pharmacy replaced team members when they left. And it had recently increased someone's hours to cover a planned period of absence. The pharmacy kept training qualifications on-site. And the team members were experienced and knowledgeable in their roles. The following team members were in post; one full-time pharmacist with a second pharmacist working one day per week, one full-time accuracy checking technician (ACT), one full-time trainee medicines counter assistant (MCA), two full-time dispensers, one pre-registration pharmacist, one Saturday pharmacy student and one delivery driver. 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 company employed a relief dispenser to provide essential cover. And the Saturday student worked extra during the summer when most team members took holidays. The pharmacist supported team members to learn and develop. And they were providing the trainee medicines counter assistant with protected learning time to complete their coursework.

The pharmacist branch managers attended a regular off-site meeting that was chaired by the superintendent who provided updates on company changes and new initiatives. The superintendent had provided an update about the company's performance review process. And the pharmacist had planned to carry out individual performance reviews in the next month following significant changes to the pharmacy team. The pharmacy supported the team members to learn and develop. And the pharmacist was about to approve a new dispenser's application to enrol onto the NVQ pharmacy services level 3 course. The pharmacist met with the team members each morning. And they discussed service priorities and concerns if they had any.

The pharmacy did not provide structured training. And the pharmacist updated the team members when services changed or in response to new initiatives. For example, they had recently briefed the team members about how to endorse prescriptions when they had supplied stoma products and specials. And this ensured they were remunerated for the dispensing services they were providing. The pharmacist had reviewed the smoking cessation service specification. And they had briefed the team about providing NRT products on the second week, and not the first week as they had been doing.

The pharmacy provided the pre-registration pharmacist with regular protected learning time each week. And the pharmacist met with the trainee to ensure they were making good progress and to provide extra support if needed. The pre-registration pharmacist was gaining experience in providing all

aspects of community pharmacy. For example, providing advice and supplies via the pharmacy first service under the supervision of the pharmacist. And carrying out dispensing and helping to provide assurance that the pharmacy was operating in a safe and effective way.

The company did not use numerical targets to grow the services it provided. And the team were focussed on professionalism and 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 highlighted the risks associated with multi-compartment compliance pack dispensing when prescribed items were not available to dispense. And they had suggested placing affected prescriptions into pink baskets until all items were available to be dispensed all at once. And this had been working well and had reduced the number of errors.

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 some 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 well-equipped consultation room. And the team members locked it when it was not in use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know what services are available to them. The pharmacy sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team up to date about high-risk medicines. This means team members know when to provide people taking these medicines with extra information and support. The pharmacy team follows working instructions for most of its services. But it does not always ask people to sign to show they have accepted a delivery of their medication at home. This means the team members are unable to confirm that medicines have been correctly delivered.

Inspector's evidence

The pharmacy had step free access. And it provided unrestricted 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 had trained the pharmacy team to speak to people about their medicines. For example, they attached safety stickers to prescriptions bags. And the team members knew to check that people were up-to-date with blood tests. The pharmacist had trained the ACT to speak to people about the chronic medication service (CMS). And they shared relevant information with the pharmacist. Such as someone not collecting their anti-epileptic medication on time.

The pharmacy team members used dispensing baskets. And they always kept prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 260 people. And this had increased by around 40 over the previous year. The team members had read and signed the company's working instructions to confirm that dispensing was safe and effective. And they used an allocated area that was sufficient in size and layout to safely assemble and check the packs. The team members isolated packs when people's prescription needs had changed/were changing. For example, when they went into hospital. The team members used supplementary records to support the dispensing process. And they updated them following prescription changes. The team members carried out regular checks to ensure that people collected their medication on time. And this helped them to identify potential compliance issues which they referred to the pharmacist. The team members supplied patient information leaflets. And they provided descriptions of medicines to support people to take their medicines. The pharmacy provided a text service. And the team members notified people when their medication was ready for collection or to provide the delivery time. The delivery driver obtained signatures to confirm that people had received controlled drugs. But they did not ask people to sign for other medication.

The team members dispensed methadone and buprenorphine doses for around 20 people. They dispensed the doses the day before they were due. And they obtained an accuracy check at the time of dispensing. The team members retrieved prescriptions when people arrived for their doses. And they obtained a final accuracy check at the time of supply to confirm that doses that were in accordance with the prescriber's instructions. The team members had recently introduced supplementary records that they referred to when dispensing. And this managed the risk of prescriptions being missed and doses not being dispensed on time.

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 two separate cabinets. And this managed the risk of selection errors, for example, they kept multi-compartment compliance packs in a dedicated cabinet to avoid congestion and selection errors.

The team members kept records of drug alerts and recalls. And they were able to show they had checked for ranitidine stock in response to a recent drug recall with none found. The pharmacist had trained the team members about the valproate pregnancy protection programme. The team members 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 pharmacist had provided training about the Falsified Medicines Directive (FMD). And the pharmacy had the necessary tools to meet the system's requirements. But it had not yet introduced the scheme and it had no clear plan to do so.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. But it does not always carry out the necessary maintenance to all its equipment to provide assurance it is fit for purpose.

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. And the measures for methadone were highlighted, so they were used exclusively for this purpose. The pharmacy used a blood pressure monitor. But the pharmacy team were unable to confirm when it had last been replaced or re-calibrated. 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.