General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Motherwell Pharmacy, 148c Logans Road, MOTHERWELL, Lanarkshire, ML1 3NY

Pharmacy reference: 1100950

Type of pharmacy: Community

Date of inspection: 16/03/2022

Pharmacy context

This pharmacy is situated in a small local shopping centre. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs to help people take their medicines safely. It also provides a smoking cessation service, emergency contraception service and a range of other services under the Pharmacy First scheme. The inspection was undertaken during the Covid-19 pandemic.

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 generally identifies and manages the risks associated with providing its services. It largely keeps the records it is required to by law and protects people's personal information well. Team members know how to protect vulnerable people. Team members respond appropriately when mistakes happen during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) available. The superintendent pharmacist (SI) explained that these were due to be reviewed and gave an assurance that he planned to do this in the next month. Team members had read the SOPs which were relevant to their roles. The team had been routinely ensuring infection control measures were in place and cleaned the pharmacy regularly through the day. Team members had been provided with personal protective equipment (PPE). The SI explained that the necessary risk assessments to help manage Covid-19 had been completed and this included occupational ones for the staff. As a result of the risk assessment screens had been fitted at the counter.

The pharmacy had not been consistently recording dispensing mistakes which were identified before the medicine was handed out (near misses) but those where the medicine was handed to a person (dispensing errors) were recorded. Prior to the pandemic it was seen that near misses were being recorded regularly. Due to staffing issues this had stopped. It was seen that the team had restarted recording near misses and the SI and pharmacy manager had briefed all team members on the importance of recording near misses. The team had picked up that there had been an increase in picking errors in the different formulation of painkillers. Team members had been briefed and the team had discussed how this could be avoided. Dispensing incidents were investigated, recorded, and analysed. As a result of past errors, the pharmacy had changed SOPs, and separated some medicines on the shelves. Diazepam had been moved to a separate drawer and gabapentin had been separated on the shelves.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and following suggestions from a previous inspection a feedback box had been placed in the public area of the pharmacy. Complaints were dealt with by the SI and pharmacy manager.

Responsible Pharmacist (RP) records were generally well maintained, although some pharmacists were occasionally not signing out. The pharmacy had not supplied any private prescriptions or emergency supplies or dispensed any unlicensed medicines recently. There was one invoice for an unlicensed medicine seen but records for this had not been made. Controlled drug (CD) registers were kept electronically. A register was available for CDs that people had returned, records of these had not been made as they were received.

Assembled prescriptions were stored behind the counter and people's private information was not visible to others using the pharmacy. Team members had read SOPs for data protection and confidentiality. Confidential paperwork and dispensing labels were segregated and shredded.

All team members had read the SOP for safeguarding and were aware of the steps that they would take in the event that they had any concerns. The SI described an incident where a safeguarding concern had been flagged with the local contact.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services provided, and they do the right training for their roles. They work effectively together and are supportive of one another. The pharmacy supports its team members with ongoing training.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the SI, the RP, two pharmacy technicians, a trainee dispenser, a trained dispenser, and a trainee medicines counter assistant (MCA). The SI explained that through the course of the pandemic the pharmacy had faced staffing issues with a number of staff leaving and the team was finding it difficult to recruit. There had also been an increase in the number of team members who were sick at any given time. The pharmacy was in the process of recruiting and had interviews lined up in the days following the inspection. They had also advertised for a new role of pharmacy receptionist who would only be responsible for dealing with administrative tasks and answering the phone. The pharmacy team was observed to be able to manage the workload on the day of the inspection. One of the pharmacists dealt with queries relating to and checking the multicompartment compliance packs and other administrative tasks and the other pharmacist dealt with walk-in prescriptions.

Individual performance and development were monitored by the pharmacy manager who held appraisals with each of the team members. Team members were also provided with ongoing feedback by the SI and pharmacy manager.

The trainee MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She consulted with colleagues before selling any medicines and always had another more experienced team member working alongside her. She was aware of the maximum quantities of certain medicines which could be sold over the counter.

Team members on formal training courses were allocated set-aside time to study. They were well supported by their colleagues and would speak to one of the team members if they had any questions. Team members were trained on new services that the pharmacy was due to provide and were encouraged to complete training for services they were interested in. The SI described that he was trying to introduce a more structured programme for ongoing training as things settled after the pandemic.

Team members discussed issues as they arose. Team meetings were also held on a weekly basis where team members were able to share ideas, concerns, and feedback. The pharmacy manager briefed any team member who was not present during the meeting. Team members who worked on Saturdays were briefed by the SI as he worked at the pharmacy on Saturday. There were no targets set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy premises were large, bright, clean, and organised. There was a large stock room and a separate large room was used to manage the multi-compartment compliance pack service. Cleaning was carried out by team members in accordance with a rota. There was ample workspace which was clutter-free and clear. Workbenches were also allocated for certain tasks. A sink was available for the preparation of medicines. Hand sanitiser was also available for team members to use. A consultation room was available. The room allowed a conversation at a normal level of volume to take place inside without being overheard. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely delivers its services in a safe and effective manner. The pharmacy obtains its medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts.

Inspector's evidence

The pharmacy was easily accessible. Aisles were wide and allowed easy access to the medicines counter. Services were appropriately advertised to people. Team members knew what services were available locally and also used the Health Board website to signpost people to other providers where needed. The pharmacy was able to produce large print labels, had a hearing loop and a delivery service was offered to those people who were unable to access the pharmacy. Some team members were multilingual and the pharmacy had a few team members who spoke Urdu as this had been requested by people. The pharmacy was looking into offering a travel service following a request from the Health Board.

Prescriptions were handed in at the counter, marked with an estimated time of collection and passed to the dispensers who processed and dispensed the prescriptions and left them for the pharmacists to check. In most cases assembled prescriptions were handed out by the pharmacists. It was very rare that the pharmacists had to self-check and the SI said there were mostly two pharmacists working. Dispensed and checked by boxes were available on labels which were observed to be used. Colour coded baskets were used to separate prescriptions, preventing incorrect transfer of items between people as well as help to manage the workflow.

The SI was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. Additional checks were carried out when people collected medicines which required ongoing monitoring.

Repeat prescriptions were ordered by the pharmacy but people were required to call in or email their request to start the process. Prescriptions were collected from the surgery by the driver. Prescriptions for the multicompartment compliance packs were ordered automatically, the computer system was used to track when prescriptions were due to be ordered. The pharmacy was looking into introducing an application which people could use to order their prescriptions from. The application would track where in the dispensing journey the prescription was and update the person. A message would be sent once the prescription was ready to collect.

Some people's medicines were supplied in multi-compartment compliance packs. An agreement was reached between the pharmacy, the surgery and person before anyone was enrolled on the service. The pharmacy ordered prescriptions on behalf of people for this service. To help organise and manage the service each person had their own separate labelled box which was used to store any prepared packs and notes. A master sheet was used to record all the medicines the person was taking and this was compared against the prescription each time. Any changes were updated on the master sheet. This ensured that all communication was available for all team members including pharmacists to see. Team members contacted the surgery with any queries. In the event that a person was admitted into hospital their box was placed on a separate labelled shelf, the master sheet was updated and the team waited

until a discharge note was received from the hospital. Packs were prepared by the dispensers and checked by the pharmacists. Assembled packs were labelled with mandatory warnings. Patient information leaflets (PILs) were routinely supplied. Product descriptions were not always recorded. This could make it difficult for someone to identify their medicines. Some unsealed packs were also seen on the shelf, these had been prepared in the days prior to the inspection. The SI gave an assurance that he would ensure product descriptions were included and packs would not be prepared until all queries were resolved.

The pharmacy followed the service specifications for NHS services. The SI explained patient group directions (PGDs) for unscheduled care, the Pharmacy First service, smoking cessation, and emergency hormonal contraception (EHC) had all been signed and sent to the Health Board. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. Pharmacists signed all Pharmacy First forms and these were processed by the pharmacy manager.

The pharmacy provided a delivery service. Signatures were no longer obtained when medicines were delivered and this was to help infection control. The drivers made a record of the date and time of delivery, a record was also made of any attempted deliveries. In the event that someone was not available medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers. Medicines were organised on shelves in a tidy manner. Fridge temperatures were monitored daily and recorded for the main fridge. Records seen showed that the temperatures were within the required range for the storage of medicines. The small fridge was not routinely used to store medicines, however, at the time of the inspections was being used to store vaccines for another branch. The temperature of this was not recorded. The temperature at the time of the inspection was suitable for the storage of medicines. CDs were held securely.

Expiry-date checks were carried out every three months. Short dated stock was marked and transferred to other branches. A date-expired medicine was found on the shelves checked; the SI explained that due to staffing issues a full date-check had not been carried out since the new year. Pharmacists checked expiry dates when checking assembled prescriptions. Out-of-date and other waste medicines were kept separate from stock and stored securely until collected by licensed waste collectors. Drug recalls were received via email, they were printed, actioned, and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment. Equipment was clean and ready for use. Separate measures were used for liquid CDs to avoid contamination. Two medical fridges of adequate size were available. The SI was surprised to see that the smaller fridge was being used to store vaccinations as this was not to be used for storing medicines. He arranged for the vaccinations to be collected by the sister branch who had ordered the stock. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens faced away from people using the pharmacy.

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.