General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Deans Pharmacy, 398 Coltness Road, Coltness, WISHAW, Lanarkshire, ML2 8JZ

Pharmacy reference: 1104543

Type of pharmacy: Community

Date of inspection: 16/03/2022

Pharmacy context

This is a community pharmacy in Coltness on the outskirts of Wishaw. The pharmacy provides a range of services including dispensing prescriptions for people at home and for people living in residential and care homes. It has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a range of other services, including a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. And it supplies medicines on the NHS Pharmacy First and NHS Pharmacy First Plus service. The pharmacy was inspected during the COVID-19 pandemic when restrictions had been mostly lifted in Scotland.

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 has written procedures in place to help ensure that its team members work safely. And it has insurance to cover its services. The pharmacy team has adapted its working practices suitably to minimise risks to people's safety during the COVID-19 pandemic. And it knows how to protect the safety of vulnerable people. The pharmacy protects people's private information appropriately. And it has suitable procedures to identify the risks associated with its day-to-day services. But the pharmacy is not always thorough enough in keeping all of its records up to date.

Inspector's evidence

The pharmacy had put measures in place to keep people safe from infection during the COVID-19 pandemic. It had put screens up at its medicines' counter. And it had hand sanitiser at different locations around the premises for people and the team to use. Team members had access to personal protective equipment in the form of gloves and masks and were observed wearing masks. The team had a cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. The pharmacy was relatively spacious. This allowed team members to work at individual workstations either on their own or in smaller groups. And so, they could work appropriately distanced from one another for much of the time. The pharmacy had a business continuity plan to ensure that people could still get their medicines if its services were disrupted. The pharmacy team recorded its mistakes and it reviewed them regularly. But its records did not contain much detail. And they did not indicate what the team member had learned or what changes they would make to their dispensing procedures to prevent similar mistakes from happening again. But the responsible pharmacist (RP) highlighted and discussed mistakes as they happened with the team member involved, to enable them to reflect and learn. Team members demonstrated that they had separated stock and labelled shelves to draw attention to look-alike and sound-alike (LASA) medicines. It was evident that they had separated risperidone tablets and ropinirole tablets in this way to help the team identify the correct one. The RP recognised that records should provide enough detail to monitor mistakes, learn as much as possible from them and promote continued improvement.

The pharmacy had a set of SOPs to follow. And these were currently under review. Team members had read the SOPs relevant to their roles. They appeared to understand their roles and responsibilities and were seen consulting the RP and his colleague pharmacist when they needed their advice and expertise. The RP had placed his RP notice on display showing his name and registration number as required by law. People could give feedback on the quality of the pharmacy's services. Team members described having had a few complaints. Complaints had been related to people's expectations involving the time taken to get their medicines ready after they had requested their prescriptions from the surgery. This was a busy pharmacy with a high dispensing workload. So the owner had introduced a dispensing robot to help improve the speed and accuracy of dispensing. The owner had also installed an automated collection point from where people could collect their medicines without having to enter the pharmacy. This had helped reduce complaints and improve levels of customer satisfaction. The pharmacist ensured that the collection point was only used when it was appropriate for the people using it and for the nature of the medicines they were taking. The pharmacy had a complaints procedure in place. In general, the team sought feedback from conversations with people as well as staff at the homes it supplied medicines to. The pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS

complaints procedure for the local health board online. But customer concerns were generally dealt with at the time by the regular pharmacists or by the head office team if necessary. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers. It had professional indemnity and public liability insurance in place until 30 October 2022. It is understood that when this date is reached the pharmacy will renew its insurance arrangements for the following year.

The pharmacy generally kept its records in the way it was meant to. Including its RP record, its private prescription records, its unlicensed specials records and its controlled drugs (CD) registers. And it had a CD destruction register for patient returned medicines. This was up to date with team members having undertaken destructions regularly. In general, the pharmacy maintained and audited its CD running balances. But during the inspection a check of a product in stock did not match the running balance in the pharmacy's electronic CD register. This was due to a medicine having been dispensed and supplied few days earlier without the supply being recorded. But the pharmacy's electronic CD register had an alert system which left a message for the team when a CD was dispensed. So, the RP felt that the message would have prompted the team to make the record, when a CD was next dispensed. But he recognised that records of CD supplies should be made shortly after supply and that the pharmacy should ensure that all of its essential records are accurate and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And had completed general data protection regulation (GDPR) training. Confidential paper waste was discarded into separate waste containers. And it was collected regularly for confidential destruction by a licensed waste contractor. People's personal information, including their prescription details, were kept out of public view. The RP had completed appropriate safeguarding training. Other team members had been briefed. And they knew to report any concerns to the RP. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages its workload safely and effectively. And team members support one another. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services. But some team members need more training for the work they do.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours and found the regular RP on duty. The RP worked alongside a second pharmacist with whom he shared the majority of shifts. On the day of the inspection the rest of the team consisted of a trainee pharmacist, three NVQ2 qualified dispensing assistants, two healthcare assistants, one of which was the pharmacy's supervisor, and a delivery driver. The pharmacy also had a support assistant who had not yet completed any dispensing assistant training. The assistant was observed putting stock data into the pharmacy robot's computer system. And putting stock into the robot to be mechanically identified, picked and stored. This was an automated process involving the computerised identification of medicines by their identification codes. But the same assistant was later observed putting stock away on the pharmacy's shelves, a day-to-day dispensing activity which requires dispensing assistant training.

The working atmosphere was efficient and organised. The daily workload of prescriptions was in hand and customers were attended to promptly. The pharmacy had a close-knit team. And its members worked regularly together. They were seen to support one another while they attended to their allocated tasks. The trainee pharmacist had regular study time and frequent on-to-one meetings with the RP, who was also her tutor. Remaining team members had regular appraisals or reviews about their work performance. They also felt that they were kept up to date and supported in their work by the RP. And they could raise concerns and discuss issues with him or the other pharmacist. In turn both pharmacists felt that they could discuss any concerns with their line managers and head office team. Both pharmacists could make their own professional decisions in the interest of people and were not under pressure to meet business or professional targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a suitable environment for people to receive its services. They are tidy and organised. And they are sufficiently clean and secure.

Inspector's evidence

The pharmacy was in a small shopping centre in the midst of the local community. And it was bright, modern and airy. It had a counter with a prescription reception area. And pharmacy medicines were kept behind it. The pharmacy also had two consultation room which people could access from the customer area.

The pharmacy had a spacious dispensary, with enough space for its dispensing robot. The robot divided the dispensary in two. Providing a quieter area for dispensing multi-compartment compliance packs away from the bustle of the main dispensary. The majority of the pharmacy’s remaining workspace was used for its other dispensing activities. And it had separate areas for dispensing repeat prescriptions, medicines care review (MCR) prescriptions and instalment prescriptions. Walk-in, acute prescriptions and urgent care prescriptions were dispensed in two areas immediately beside and behind the accuracy checking area, so that they could be dealt with promptly after dispensing.

The team cleaned the pharmacy daily to ensure that contact surfaces were clean. Stock on shelves was tidy and organised. And floors and work surfaces were free from clutter. The pharmacy had staff facilities to the rear in a separate area away from the main dispensary. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. And makes them adequately accessible for people. The pharmacy team gets its medicines and medical devices from appropriate sources. Team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy generally stores its medicines properly. But it is not always thorough enough in ensuring that it keeps all its medicines for dispensing in the appropriate packaging.

Inspector's evidence

The pharmacy had an automated collection point on its outside wall next to its entrance from where some people could collect their medicines. So, they did not need to enter the pharmacy on every visit. The pharmacy had automatic double doors at its entrance and step-free access, which provided suitable access for wheelchair users and for those with mobility difficulties. And its customer area was free of clutter and unnecessary obstacles. The pharmacy had a delivery service for people who found it difficult to visit the pharmacy. And it could also order people's repeat prescriptions for them. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. It provided medicines in multi-compartment compliance packs for people living at home who needed them. And for people living in care home and nursing home environments. The pharmacy labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And its labelling directions also gave the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines and generally with regular repeat medicines. The RP gave people advice on a range of matters. And he would give appropriate advice to anyone taking high-risk medicines. The RP had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP was aware of the precautions he would need to take, and counselling he would give, if it were to be prescribed for someone new.

The pharmacy offered the NHS 'Pharmacy First' service and the NHS 'Pharmacy First Plus' service. Where people could obtain medicines for a range of minor ailments and conditions. Several team members had been trained to supply medicines for a small range of conditions such as coughs and colds. And they followed the local health board protocol and supplied medicines from a specified list. Team members knew when to refer to the pharmacist when someone presented with a condition which they had not been trained to treat such as a urinary tract infection (UTI). The RP was also a pharmacist independent prescriber and could supply people with medicines to treat the condition as appropriate. Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. And team members knew how to process them. The pharmacy had a system for monitoring and tracking supplies so that the team knew when people were due to get their medicines. The system also allowed them to monitor compliance and address any issues. The pharmacy supplied a variety of medicines by instalment. A trained team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the labelled medicines together in individual baskets to keep the instalments together.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate

licences. The team generally stored its medicines, appropriately and in their original containers. But the inspector found a box of Arlevert tablets which contained strips of tablets from different batches. Some of the tablet strips had been part-dispensed with their expiry dates removed. So the outer packaging did not give enough essential information about the medicines it contained, and it did not accurately reflect what was inside it. The inspector discussed this with the RP. It was agreed that team members should review their understanding of the correct procedures to follow when dispensing a split-pack of medicines. And when putting medicines back into stock after dispensing. Stock on the shelves was generally tidy and organised. The pharmacy team date-checked the pharmacy's stocks regularly. And it kept records to help it manage the process effectively. A random sample of stock checked by the inspector was in date. In general, short-dated stock was identified and highlighted. And the team put its out-of-date and patient returned medicines into dedicated waste containers. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies. The pharmacy had several computer terminals which had been placed at individual work- stations around the pharmacy. Computers were password protected. And prescriptions were stored in the dispensary out of people's view. The pharmacy's robot and collection point were maintained regularly. And the team could access stock if the robot was to break down.

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.