General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: RX Pharmacy Carstairs, 73a Lanark Road, Carstairs, LANARK, Lanarkshire, ML11 8QL

Pharmacy reference: 1109111

Type of pharmacy: Community

Date of inspection: 04/12/2019

Pharmacy context

This is a community pharmacy in Carstairs. 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 also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It also 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 work to professional standards. And this helps them to keep services safe. The pharmacy keeps some information about errors when they happen. But this is limited. And it restricts the pharmacy team members ability to make improvements to the way they work. The pharmacy keeps the records it needs to by law. And it provides training to keep confidential information safe. The team members understand their role in protecting vulnerable people. And they contact others to make sure people get the support they need. The pharmacy trains its team members to handle complaints. And this helps them to puts things right when it can.

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. And to show they understood their roles and responsibilities. The pharmacy had displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. The pharmacy team members signed the 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 pharmacy team members recorded their own errors. But they did not always document the root cause. And they did not always provide enough information to identify patterns and trends and improvement action. The team members provided a few examples of improvements. Such as adding a caution label to the shelves used for sertraline and losartan to manage selection risks. The pharmacist managed the incident reporting process. And they used a template report form to record their findings and the outcome of the investigation. For example, when a team member had supplied the wrong quantity of doxycycline medication. The pharmacy team knew about incidents. And they knew about changes to manage the risk of the same thing happening in the future. The pharmacy used a complaints policy to ensure that staff handled complaints in a consistent manner. But it did not display information about its complaints handling process. And it did not inform people about how to complain.

The pharmacy maintained the pharmacy 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 up until February 2020. The pharmacy team kept the controlled drug registers up to date. And they checked and verified the methadone balance every week and the rest of the stock once a month. The pharmacy team members recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each record following a destruction. The pharmacy provided a delivery service to housebound and vulnerable people. And it made sure that people signed for their medication to confirm receipt. 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. But a sample showed that the trimethoprim PGD had gone past its review date of November 2019. And the Health Board was in the process of reviewing and updating the documents.

The pharmacy trained its team members to comply with data protection arrangements during induction. And they knew how to protect people's privacy and confidentiality. The pharmacy did not

promote its data protection arrangements. And it did not inform people that it protected their personal information. The team members separated waste. And they used a shredder to dispose of confidential waste. The pharmacy archived its spent records. And it retained them for the standard retention period.

The pharmacy used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. And the pharmacist had registered with the scheme. The pharmacy did not provide a safeguarding policy. And it had not trained its team members to recognise the signs and symptoms of abuse and neglect. But the team members knew when to refer to the pharmacist. For example, when people did not present for doses that required supervision. And they informed the community addictions team when this happened.

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 had experienced a slight growth in the number of NHS prescriptions it dispensed over the past year. And the pharmacist carried out reviews to provide assurance that the pharmacy team continued to have the capacity and capability to provide its services. The team members were experienced. And they were knowledgeable about their roles and responsibilities. The pharmacy kept some, but not all the team's qualifications on-site. And the following team members were in post; one full-time pharmacist, one full-time pre-registration pharmacist, one full-time dispenser and one part-time medicines counter assistant (MCA). The pharmacist managed annual leave requests. And they allowed only one team member to take leave at a time.

The pharmacy did not carry out individual performance reviews. And it did not provide regular structured training. But the pharmacist updated the pharmacy team whenever there were service changes or new initiatives. For example, they were in the process of reading about common clinical conditions and minor ailments. The pharmacist had trained the pharmacy team to provide safety information when supplying NSAIDS over-the-counter. And they knew to issue information cards to re-enforce the advice that they had been provided with.

The pre-registration pharmacist attended bi-weekly meetings with the pharmacist. And this ensured they were taking advantage of training opportunities. And they were developing the required competencies. The pharmacist had authorised the pre-registration pharmacist to attend off-site smoking cessation and naloxone training. And they were supporting them to attend NES events.

The pharmacy did not use performance targets. And the team members were focussed on providing a professional service for the people that used the pharmacy. The team members felt empowered to raise concerns and provide suggestions for improvement. For example, when they had not registered controlled drugs, they had suggested using a highlighter pen to highlight controlled drug prescriptions. And this had been effective with no missed registrations since the new initiative had been introduced.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises is secure, clean and hygienic. It has a consultation room that is professional in appearance. And it is an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

The pharmacy had a well-kept waiting area. And it provided seating for people whilst they waited to be attended to. The pharmacy provided a consultation room. And people could talk in private with the pharmacy team about their health concerns. The team members had arranged benches for the different dispensing tasks. For example, they dispensed prescriptions that people were waiting on near to the waiting area. And they used an upstairs room to dispense and store multi-compartment compliance packs. The pharmacist observed and supervised the medicines counter from the checking bench. And they could make interventions and provide advice when needed. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services.

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 has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. 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 that team members know when to provide people taking these medicines with extra information.

Inspector's evidence

The pharmacy had a step free entrance. And there was unrestricted access for people with mobility difficulties. The pharmacy displayed its opening hours in the window. And it displayed healthcare information leaflets in the waiting area. The pharmacist had produced a list of common conditions that could be treated on the minor ailments scheme. And they displayed the list at the medicines counter so that people knew to speak to the pharmacist before arranging a GP appointment. The pre-registration pharmacist had sourced an NHS Lanarkshire booklet that informed people about the local health services that were available to them. And they displayed the booklet at the medicines counter. The pharmacist and the pre-registration pharmacist spoke to people about their medication. And they registered people with the chronic medication service (CMS) when appropriate. The pharmacist attached a ‘pharmacist consultation’ sticker to prescription bags when they wanted to speak to people. And the team members alerted the pharmacist when they arrived at the pharmacy. For example, they had been providing advice to people who had been prescribed co-codamol and paracetamol together.

The dispensing benches were organised and clutter free. And the pharmacy team used dispensing baskets to keep prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 124 people who needed extra support with their medicines. And the pharmacy team members used a large upstairs room to dispense the packs. The team members had read and signed working instructions to show they followed safe working practice. And the pharmacist clinically checked prescriptions before they were dispensed. A lead dispenser managed the dispensing process. And they ordered new prescriptions when they issued the last pack. The team members used supplementary records to ensure service continuity. And to support safe systems of work. The team members isolated packs when they were notified about prescription changes. And they used a change form and kept records of changes in the patient’s notes. The team members supplied patient information leaflets. And they annotated descriptions of medicines on the pack.

The team members kept the pharmacy shelves neat and tidy. And they kept controlled drugs in two cabinets that they organised and kept clutter free. The pharmacy purchased medicines and medical devices from recognised suppliers. And the team members carried out regular stock management activities, highlighting short dated stock and part-packs during regular checks. The team members monitored and recorded the fridge temperatures. And they demonstrated that the temperature had remained between two and eight degrees Celsius. The pharmacy accepted returned medicines from the public. And they disposed of them in yellow containers that the health board collected.

The pharmacy team members acted on drug alerts and recalls. And they kept records and audit trails to

show what the outcome had been. For example, they had checked for Emerade in November 2019 with stock quarantined and returned as instructed. The pharmacy had not implemented the Falsified Medicines Directive (FMD). And the pharmacy team did not know about the initiative, or when it was due to be introduced. The pharmacist had briefed the team members about the valproate pregnancy protection programme. And they knew about the initiative and when to supply patient information cards. The pharmacist monitored prescriptions for valproate. And they added flash notes to the PMR to confirm that people had been provided with safety messages.

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 measuring equipment. And the measures for methadone were highlighted and separated, so they were used exclusively for this purpose. 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 used 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.