General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 102 Union Street, Larkhall, South Lanarkshire, ML9 1EF

Pharmacy reference: 9010554

Type of pharmacy: Community

Date of inspection: 08/02/2023

Pharmacy context

This is a community pharmacy on a main street in Larkhall, a small town on the outskirts of Glasgow. Its main activities are dispensing NHS prescriptions, providing people with multi-compartment compliance packs to help them take their medicines correctly and providing a substance misuse service. The pharmacy treats people for a variety of conditions under the NHS Pharmacy First scheme and delivers medicines to people in their homes.

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 up-to-date written procedures to help team members work safely and effectively. And they appropriately reflect on any errors they make to inform changes to improve working practices. Team members mostly keep the records they need to by law. And they keep people's confidential information secure. They know what to do to help protect vulnerable adults and children in their community.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help the team work safely and effectively. Team members accessed them online and had completed an electronic declaration to confirm that they would follow them. And all team members had completed the SOPs relevant to their role and were working from the most up to date versions. But SOPs were hard to find on the online system and so it was not easy for team members to find a specific SOP if they needed reminding of a process. SOPs were updated every two years, and those requiring urgent reading were communicated to the team directly from the area manager.

Team members regularly recorded errors identified during the dispensing process known as near misses. The pharmacist recorded the error at the time on paper and this was transferred to an electronic reporting system every other day, or whenever there was a quiet period. Paper records were available, and these showed well recorded details of near misses. But team members did not know how to access past near misses recorded electronically and so opportunities to identify and review common trends may be missed. Team members had informal discussions together regarding any learnings from near misses and felt able to suggest improvements to help prevent recurrence of errors in the future. For example, team members had highlighted to each other that amlodipine 5mg and 10mg tablets looked very similar in terms of packaging. And they highlighted the need for careful selection of the different strengths by using stickers on the shelf where they were kept. Team members also recorded details of errors that had been identified after the person had received their medicines, known as dispensing incidents. Details of such incidents were captured on an electronic system which the team were unable to access. Team members explained that a recent dispensing error highlighted that packs of medicines containing less than the full quantity were not always marked or identified as such. This had led to a person receiving a lesser quantity than was prescribed. They reflected on their procedures and made suggestions for necessary changes to help prevent a recurrence. Team members explained that all errors recorded electronically were sent to the superintendent (SI) pharmacist’s team at the company’s head office for review.

Team members were aware of responsible pharmacist (RP) regulations and knew what could and could not be carried out in the absence of the RP. They were able to refer to SOPs so they could remind themselves, if necessary, of the procedures to follow if a pharmacist did not arrive to open the pharmacy. This included telephoning the area manager and informing the NHS Health Board if the pharmacy was not open. The RP notice was prominently displayed in the retail area and reflected the correct details of the pharmacist on duty. The pharmacy had current professional indemnity insurance.

The pharmacy had a complaints procedure which was displayed in the retail area of the premises. Team members explained that any complaints were usually resolved in the pharmacy by the pharmacist. But

any that could not be resolved were referred to the SI pharmacist's team at head office. They provided people with the required contact details in the form of a telephone number and email.

The pharmacy kept the records required by law, with a few omissions. It kept it's RP record on paper and it was mostly completed accurately, but some days were missing the required details of who was the RP on duty and when. The team leader was aware of this and had planned to contact the pharmacists involved and ask them to update the records. Records of private prescriptions were mostly for veterinary prescriptions and the prescriptions were well organised and filed alphabetically for easy referencing. On some records there was information missing, such as the date of supply and the date the prescription was written. The pharmacy had not received any prescriptions for specials unlicensed medicines since 2019, however it retained accurate historical records of the "certificates of conformity".

The pharmacy kept electronic records of controlled drugs (CDs) which, from the sample seen, complied with regulations. Team members carried out weekly balance checks of the CD stock against the register running balance. Random sampling of a medicine confirmed that the physical quantity matched the quantity in the register. Records of CDs returned by people were kept electronically. But the pharmacy didn't record the name of the team members involved, and therefore an accurate audit trail was not maintained.

Team members were aware of their responsibilities regarding the General Data Protection Regulations (GDPR) and were provided with company training, which they completed annually. Team members kept confidential information separately for offsite destruction by a third party company. They had undertaken company training regarding their responsibilities for protecting vulnerable adults and safeguarding children. They provided an example of a person who they had helped by contacting a healthcare professional and getting them appropriate care. The team also contacted the superintendent's office to seek advice if they had any concerns about vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members who work well together to manage the workload. And they complete appropriate ongoing training to help them develop in their roles. But some team members have experienced a delay in their accredited training until the pharmacy has a regular pharmacist to support them.

Inspector's evidence

The pharmacy had a regular locum RP, four trained dispensers and one trainee dispenser working at the time of the inspection. A dispenser had recently become the team leader as there was no current pharmacist manager in position. Another of the dispensers was due to start an accredited training course to become a pharmacy technician once there was a resident pharmacist to support their training. The trainee dispenser was also awaiting a resident pharmacist to help them complete their training. There was no clear plan as to when this would be.

Team members were observed to be working safely and effectively together to complete tasks and they were seen to be managing the workload. They were observed referring to the pharmacist for advice, if necessary, when selling medicines over the counter. They gave examples of the support they gave to people who requested to purchase medicines liable to misuse. There were contingency plans in place to cover staff holidays and absences, as team members from the company's other pharmacies in the area worked in the pharmacy when needed. Team members from this pharmacy provided support on occasion to other pharmacies when needed. They reported this did not impact on the completion of their own workload.

Team members completed regular training by the company that was relevant to their role such as GDPR training. And this was communicated to them through an online hub. Each team member accessed their own learning portal, so they had a clear indication of the modules they were required to complete. They had protected learning time throughout the week to keep their learning up to date.

Team members had regular informal conversations concerning any issues identified and they openly shared learnings about incidents that occurred. They felt comfortable making suggestions to improve working practices within the pharmacy. The newly appointed team leader explained she had reflected on her own development and had completed the required paperwork for her yearly review. She was awaiting a 1-2-1 meeting with her line manager to discuss her performance and set any future objectives. And she planned to hold similar reviews with team members once she had been given sufficient training in how to do so.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, tidy and well organised. And they provide a suitable space for the pharmacy's services. The pharmacy has appropriate facilities so people can have confidential conversations with team members.

Inspector's evidence

The pharmacy was clean, tidy, and free from clutter and trip hazards. The dispensary was well organised and long benches meant there was sufficient space for separating tasks safely and effectively. Medicines were kept neatly on shelves to minimise any selection errors. There was a sink in the dispensary which provided water for professional use. Team members explained they had discovered an issue during the previous week whereby the water was discoloured, they had reported it to maintenance and the issue was resolved the same day. Toilet facilities for team members were clean and hygienic and provided hot and cold water for hand washing.

Access to pharmacy medicines and the dispensary were restricted by a barrier. Team members could easily see people waiting to access services and the pharmacist could intervene in conversations at the pharmacy counter if necessary. There was a separate semi-private area next to the medicines counter where supervision of medicines took place. The positioning of a wall ensured people’s privacy was maintained. The pharmacy had a room where people could have private conversations with team members. It was within the retail area and was kept secure via a keypad when not in use. The room had appropriate space and facilities such as a desk, chairs, and a sink to allow the provision of services and private conversations. There was good lighting throughout the premises and the temperature was ambient.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services safely and effectively. And it mostly stores and manages its medicines as it should. Team members keep good records to make sure people receive their medicines when they need them. And they advise people about their medicines to help make sure they have the required information for their healthcare needs.

Inspector's evidence

The pharmacy had a step free access and a power assisted door to help provide ease of access for people, including those with limited mobility and those with pushchairs. The pharmacy provided a range of NHS Pharmacy First services including treatment for urinary tract infections, shingles, and impetigo. And it provided emergency contraception services. Patient group directions (PGDs) were available for the pharmacist to refer to, but these were out of date. The locum pharmacist confirmed that he was trained and competent to provide the services and had provided an up-to-date signed document confirming this to the NHS Health Board. Team members knew how to access the most up-to-date copies of the documents online and explained they would update the paper copies. The pharmacy provided supervised doses of medicine for people using an automated dispensing machine to measure doses. They felt this allowed them to manage the workload and provide the service safely and accurately.

The pharmacy's main activity was to dispense NHS prescriptions. And it provided large print labels for people who had some visual impairment. The pharmacy had certain parameters to identify prescriptions to be dispensed at the company's offsite hub pharmacy. Once the information from these prescriptions had been inputted into the system, it was checked by the pharmacist for clinical suitability and accuracy, before being submitted to the hub for dispensing. The hub returned the dispensed medicines, sealed in bags, usually after 48 hours. Team members explained that this helped them with workload. They dispensed any prescriptions that didn't meet the agreed parameters in the pharmacy. They used baskets to keep prescriptions and medicines together so that they didn't become mixed up. And they initialled dispensing labels which provided an audit trail of who was involved in the dispensing process. The pharmacy used stickers to highlight actions required for team members when handing out presrcriptions. This included stickers for intervention by the pharmacist or when there was a CD or a fridge line to be handed out. Team members were ware of their additional responsibilites surrounding the dispensing of valproate to people in the at-risk group, explaining they always issued the medication with the patient card. The pharmacist explained how they had the required conversation with people who were eligible.

The pharmacy dispensed some people's medicines into multi-compartment compliance packs to help people take their medicines. Each team member was trained to provide the service. The process was well organised, and each person had a designated folder in which their prescriptions were kept alongside a chart. This detailed which medicines they took and when. It also contained communications about any medication changes. The team ordered people’s prescriptions two weeks in advance which allowed time to resolve any queries on prescriptions. Team members utilised a tracker to track the different stages in the process so it was clear to all team members involved. The team provided patient information leaflets to people and it put descriptions of the medicines on the pack to help people identify their medicines. But these lacked some detail, for example the colours of different capsules

could be recorded if there was more than one in the pack.

The pharmacy kept robust audit trails for the pharmacy's delivery service, using barcode scanning. Team members scanned a barcode on people's bag labels and the driver updated the information when deliveries were complete, recording information such as the date and time of completion of deliveries. This meant queries involving deliveries could easily be resolved.

The pharmacy kept pharmacy medicines in the retail area in clear plastic boxes which were labelled with a notice to ask for assistance if the medicine was required. These medicines were stored within sight of the medicines counter. On occasion people had selected medicines themselves and team members then highlighted the need to ask for assistance instead of selecting the medicines themselves. At the time of the inspection, pharmacy only (P) packs of paracetamol were discovered on open sale in the retail area. The team leader explained this should have been a dummy pack and immediately removed them.

The pharmacy had fridges which were kept neat and tidy. And records of daily temperatures were kept, but several days recorded temperatures were missing, meaning that opportunities to identify any inappropriate storage conditions may be missed. However, temperatures taken on the day of inspection showed that the fridges were in working order and within the recommended temperature ranges.

The pharmacy had an electronic date checking rota and the system highlighted on a weekly basis which areas of the dispensary were to be date checked. And the records seen were up to date. Team members identified any medicines with expiry dates in the next six months and highlighted these with stickers or marked them for use first. Random sampling of several lines confirmed medicines were in date. The pharmacy received notifications about drug alerts and recalls via email or their communication hub. Team members explained how these were printed off and kept indicating the action taken. The pharmacy segregated patient returned medicines and these were disposed of appropriately. It kept its CD cabinets neat and tidy. And patient returned controlled drugs and out-of-date controlled drugs were kept separetely to avoid becoming mixed up with routine stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs, and it mostly completes regular checks to ensure they are suitable to use. It uses its equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had up-to-date reference sources. These included both paper and electronic versions of the British National Formulary (BNF) and BNFc (for children). The pharmacy used a blood pressure monitor, but the team did not know when this had last been calibrated. And a carbon monoxide level monitor, used as part of the smoking cessation service, did not work. Team members explained that they had emailed the relevant people to try and have this fixed, but they had received no response. The team used an automated system to measure methadone and they explained how it was calibrated daily and how this was checked for accuracy by the pharmacist.

The pharmacy had equipment for measuring liquids and these were marked to identify which were used to measure liquid medicines and which were for water. There was a cordless phone so that the team could have conversations in a private area of the pharmacy. Confidential information was kept secure by use of password protected computers that were positioned so that only authorised people could view the screens. And patient identifiable information on medicines awaiting collection was kept secure by positioning these behind a wall in the dispensary.

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.