General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Clyde Pharmacy, 197-199 Roxburgh Street, Greenock, Inverclyde, PA15 4DA

Pharmacy reference: 9011059

Type of pharmacy: Community

Date of inspection: 16/01/2020

Pharmacy context

This is a community pharmacy located close to Greenock Health Centre. 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. And it 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 offers a smoking cessation service.

Overall inspection outcome

✔ **Standards met**

Required Action: Improvement Action Plan

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. They understand their role in protecting vulnerable people. And they are up-to-date with safeguarding requirements. People using the pharmacy can raise concerns. And team members know to follow the company's complaints handling procedure. This means they listen to people and put things right when they can. 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. But they do not always collect detailed information about the causes of mistakes to help inform the changes they make. The pharmacy keeps the records it needs to by law. And the pharmacy team know how to keep confidential information.

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 team members signed 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 pharmacist kept near-miss records. And they monitored the records to identify patterns and trends. The pharmacist spoke to the pharmacy team when they had concerns. And they provided a few examples of changes they had made to stop the same error happening. For example, they had separated azithromycin/azathioprine to manage the risk of selection errors. And they had created a ‘high-risk’ storage area so they knew to take extra care when dispensing certain medications. But they had not made any changes to the area in the past year.

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 recorded a recent incident along-side the near-miss records. And they had not provided information about any improvement action they had taken. The pharmacy displayed a complaint notice. But it was not visible from the waiting area. The pharmacy used a complaints policy. And this ensured that team members handled complaints in a consistent manner. The team members listened to feedback about the services they provided. And they were mindful to provide realistic waiting times to manage people's expectations. This included annotating prescriptions with the time people handed them in. And this helped them to respond constructively to negative feedback.

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 up until April 2020. The pharmacy team members kept the controlled drug registers up to date. And they carried out balance checks once a week. 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 team members used a shredder to dispose of confidential waste. And they had recently started handing back 'repeat slips' due to the amount of confidential waste they generated. The pharmacy team 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 the team members re-read the safeguarding policy every two years. This ensured they knew to refer concerns to the pharmacist when they recognised the signs and symptoms of abuse and neglect. The trainee medicines counter assistant used the consultation area when people were in distress or needed privacy.

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 the number of pharmacy team members had remained the same. The pharmacist carried out regular reviews. And they were confident that they had adequate levels for the services they provided. The pharmacy replaced team members when they left. And it had recently appointed a new team member to replace someone who had worked on a Saturday. The pharmacist supported team members to learn and develop. And they allocated protected learning time for the trainee medicines counter assistant and the trainee pharmacy technician when they needed extra support. This ensured they made progress with the formal training requirements.

Most of the team members had worked at the pharmacy for a significant length of time. And they were experienced and knowledgeable in their roles. The pharmacy kept training qualifications on-site. And the following team members were in post; one full-time pharmacist, one full-time trainee pharmacy technician, three part-time dispensers, two part-time medicines counter assistants (MCAs) and one part-time 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 pharmacist did not carry out individual performance reviews. And they did not provide regular structured training. But they updated the pharmacy team whenever there were service changes or new initiatives. For example, they had provided training about the falsified medicines directive (FMD), the valproate pregnancy protection programme and the chronic medication service (CMS). The team members had learned about the new computer system that had been recently introduced. And they were registered to attend naloxone training that was being provided by the Health Board in the next few weeks. The pharmacist had delegated responsibility to the trainee pharmacy technician. And they had been authorised to check the nhs.net system when the pharmacist was not on-duty.

The company did not use numerical targets to grow the services it provided. And the team were focussed on providing a professional service to people that used the pharmacy. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, one of the dispensers had suggested using an electronic record form to order repeat prescriptions when authorised to do so. And this had replaced the paper system and provided a more reliable audit trail they could refer to if needed.

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 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 consultation room with a private waiting area and seating close by. And it provided consultation booth which the team members used to provide supervised doses.

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 step free access. And it provided unrestricted access for people with mobility difficulties. The pharmacy displayed healthcare information leaflets in the waiting area. And it provided information about its opening hours in the window. The pharmacy team spoke to people about their medicines. And the pharmacist provided extra support when needed. The pharmacy used labels to communicate safety information. For example, the pharmacist attached a 'pharmacist' sticker to prescription bags. And the team members knew to check that people were up-to-date with blood tests.

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 100 people. And the team members had read and signed the company's working instructions to confirm that dispensing was safe and effective. The team members used a separate rear area to assemble and check the packs. And they had ample space to safely store the packs until they removed them for collection or delivery. The team members isolated packs when people's needs changed. For example, when they went into hospital or had prescription changes. The team members used supplementary records to support the dispensing process. And they updated them following prescription changes. The team members carried out checks at the end of the week. And they carried out checks when people did not collect their packs to identify potential compliance issues which they referred to the pharmacist. The team members supplied patient information leaflets when requested. And they routinely provided descriptions of medicines. The pharmacy provided a delivery service. And the delivery driver obtained signatures to confirm that people had received their medication.

The team members used a MethaMeasure to dispense methadone doses for around 100 people. And the team members had read and signed the working instructions to confirm that dispensing was safe. The team members obtained an accuracy check at the time they entered new prescriptions onto the system. And they obtained another check at the time of supply. This ensured they supplied doses that were in accordance with prescriptions.

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 sugar-containing and sugar-free methadone in separate cabinets.

The team members acted on drug alerts and recalls. And they recorded the date they checked for affected stock and the outcome. For example, in December 2019 they had checked for ranitidine with stock found and returned to the supplier. The pharmacy team members had been trained about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards and when to issue them. The pharmacist monitored prescriptions for valproate. And they spoke to people that could be affected to confirm they knew about the risks. The pharmacist had provided training about the Falsified Medicines Directive (FMD). And it had implemented the necessary tools to meet the system's requirements. But it had not yet introduced the scheme due to issues with log-on credentials.

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, so they were used exclusively for this purpose. The pharmacy used a MethaMeasure for dispensing methadone doses. And the team members kept records of the twice daily calibrations to show the machine was measuring accurate doses. 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 portable phones. 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.