General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Unit B, New Carron Village, Ronades Road, Falkirk, Stirlingshire, FK2 7TA

Pharmacy reference: 9011250

Type of pharmacy: Community

Date of inspection: 21/02/2020

Pharmacy context

This is a community pharmacy located in New Carron Village in Falkirk. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It 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 blood pressure and a smoking cessation service. The pharmacy moved premises in October 2020. And this was its first inspection.

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	2.2	Good practice	The pharmacy team members complete regular training relevant to their roles. And the pharmacy provides time during the working day to support them to do so.
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 identify and mostly manage the risks with the pharmacy's services. They understand their role in protecting vulnerable people. And they are up to date with safeguarding requirements. People using the pharmacy can provide feedback about the services they receive. And team members know to follow the company's complaints handling procedure. The 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. The pharmacy keeps the records it needs to by law. And it keeps people's private information secure. The pharmacy has written working instructions that are in place to keep services safe. But the team doesn't always follow these instructions. So, some processes for checking prescriptions cannot evidence a full audit trail and are not always robust.

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 company used a web-based system. And it notified the team members when new procedures had been issued. This ensured they read them and kept up-to-date in their roles. The team members did not always follow the procedures to help keep the pharmacy services safe. For example, the accuracy checking technician (ACT) was carrying out accuracy checks on prescriptions that had not been annotated by the pharmacist. And instead they referred to the pharmacists' annotations on multi-compartment compliance pack documentation. For example, a sample showed the pharmacist had last checked/annotated the document in 2018. The 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 team members used the pharmacy's web-based system to record some of their near-misses. And they knew to focus on improving reporting due to the low number of records. The pharmacy team discussed ways to prevent errors. And the pharmacist reminded the team members to take care when selecting medication to manage quantity, strength and formulation risks. The pharmacist managed the incident reporting process. And the pharmacy team members knew when incidents happened and what the cause had been. For example, the pharmacist had introduced an extra check following an incident. And they now circled the strength and the quantity on the pack to confirm they had checked them.

The pharmacy used a complaints policy to ensure that team members handled complaints in a consistent manner. And the company displayed a notice to inform people about its complaints process. The pharmacy invited people to provide feedback about the services they received. And the pharmacist had conducted a survey just before the pharmacy moved to the new premises. The feedback showed a few concerns about out-of-stock medicines. And the pharmacy team had taken this on board. The team members had implemented a 'top 50' of frequently used medicines. And they used minimum stock labels on the shelf-edges, so they did not run out of stock.

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 and up to date. 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 provide access to medicines and advice. And a sample showed that the trimethoprim PGD was valid until October 2020.

The pharmacy did not display a notice to inform people about its data protection arrangements. And it did not inform people about how it kept their personal information safe. The company regularly trained the team members to comply with its data protection arrangements. And they knew how to safely process and protect personal information. The team members used designated bags to dispose of confidential waste. And these were regularly collected for off-site shredding. The team members archived spent records for the standard retention period.

The pharmacy displayed a chaperone notice beside the consultation room. And it used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The pharmacy team had been trained to follow the company's safeguarding policy. And this ensured the pharmacy team knew how to handle concerns. The team members knew to monitor supplies of multi-compartment compliance packs. And this ensured they identified packs that people had not collected on time or people who were not at home when they expected them to be. The team members spoke to the pharmacist when they had concerns. And they contacted carers or the surgery to make further enquiries when needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And it ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And they identify and discuss their learning needs at review meetings to keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. And the pharmacy team members support each other in their day-to-day work. They can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

Inspector's evidence

The number of NHS prescription items dispensed had increased over the past year. And the number of retail sales had increased since the pharmacy had moved. The number of team members had remained the same. And this was due to the new pharmacist manager reviewing the working practices, introducing structured rotas and improving the performance and productivity of the pharmacy team. The pharmacist monitored the pharmacy's growth. And they discussed the capacity and capability with the area manager to ensure it continued to meet the needs of the service. The pharmacy replaced team members when they left. And a new part-time dispenser had been appointed around 8 months ago.

The pharmacy kept training qualifications on-site and at its head office. And the following team members were in post; one full-time pharmacist, one full-time accuracy checking technician (ACT), one part-time pharmacy technician, three part-time dispensers, one delivery driver and two students who mostly worked on a Saturday. The pharmacy managed annual leave requests. And it maintained minimum levels by authorising only one team member to be off at the same time. The team members submitted annual leave requests in advance to help arrange cover. And the team members and students worked extra when cover was needed.

The pharmacy manager carried out performance reviews to help the team members improve and develop in their roles. And the dispenser had recently enrolled onto the NVQ pharmacy services level 3 course. The pharmacy supported the team members in training. And it provided protected learning time in the work-place when it was able to. The company provided structured training. And this ensured the team members stayed current in their roles. The company had introduced a new operating system. And it had provided both e-learning and on-site training to ensure it supported the team members to carry out routine dispensing tasks using the new system. The company notified the team members when they needed to undertake training. And they had completed the following training over the past six months; flu vaccination, smoking cessation, 'falsified medicines directorate' (FMD), sodium valproate and the pregnancy protection programme, confidentiality and safeguarding vulnerabilities. The company tested the team once they had completed e-learning. And this provided assurance that learning had been effective.

The company used targets to grow and improve its services. And the team members were focussed on offering people a prescription collection service. This meant that people did not have to go to the surgery to collect their prescription. And the team members were able to dispense medication in a timely manner to avoid people waiting. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, at the time the pharmacy was being fitted, the

pharmacist had put forward a case to have two-door access to the consultation room instead of the one that the company normally fitted. And this had been agreed and the plans changed.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises is 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 relocated into a much larger premises a short distance away. And it was providing services from a new, modern, purpose-built pharmacy. A large well-kept waiting area presented a professional image to the public. And it provided seating and some patient information leaflets for self-selection. The dispensary was large and well laid out. And it had allocated areas for the different dispensing tasks to carry them out safely and effectively. For example, the driver used a separate rear area to sort orders for delivery. And the pharmacist and the ACT carried out checks at opposite ends of the front bench.

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 had a well-equipped locked consultation room. And the team members used it to provide services such as supervised consumption services and to administer flu vaccinations.

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 an automatic double door provided extra support for people with mobility difficulties. The pharmacy was located next to a large car park. And four parking spaces for disabled people were located next to the pharmacy. The pharmacy provided free Wi-Fi. And it displayed leaflets in the waiting area and consultation room. The team members knew which leaflets were available. And they knew to issue them when they thought they would benefit people.

The pharmacist spoke to people about their medicines. And they attached stickers to prescription bags so that the team members knew to call on them. For example, to speak to people about high-risk medicines. And to ensure that people attended for blood tests when they needed to. The pharmacist had trained the pharmacy team to speak to people about the chronic medication service (CMS). And they registered people with the initiative so they could support them to take their medicines correctly. The pharmacist participated in pilot services. And they had been commissioned by the NHS to provide flu vaccinations to people using opioid substitution services (OST). The pharmacy provided a managed repeat dispensing service (FRPS). And this accounted for around 20% of the prescriptions it dispensed. The service enabled the team members to dispense prescriptions in advance of them being needed. And to utilise a new off-site dispensing hub. The team members had been authorised to send around 360 prescription items per week for dispensing. And they had been trained to follow the necessary procedures. The pharmacist carried out checks before the prescriptions were transmitted to the hub. And they carried out checks on sample prescriptions that had been dispensed and returned by the hub. And this provided assurance that the system was safe and effective.

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 150 people. And the pharmacist had capped the service due to available resources. The team members had read and signed the company's working instructions. And they had signed to confirm that dispensing was safe and effective. The team members used a designated rear bench to dispense and check the packs. And they used a separate storage area to safely store them. The team members isolated packs when people's prescription needs had changed/were changing. For example, when they went into hospital. The team members used supplementary records to support the dispensing process. And they updated them following prescription changes. The team members carried out regular checks to ensure that people collected their medication on time. And this helped them to identify potential compliance issues which they referred to the pharmacist. The team members supplied patient information leaflets. And they provided descriptions of medicines to support people to take their medicines correctly. The pharmacy provided a delivery service to housebound and vulnerable

people. And the delivery driver obtained signatures to confirm that people had received their medication.

The team members dispensed methadone doses for around 50 people using a MethaMeasure machine. And they obtained an accuracy check at the time of registering new prescriptions. And they obtained a final check at the time they made a supply.
The pharmacy purchased medicines and medical devices from recognised suppliers. The pharmacy kept stock on open shelves and drawers. And they had attached shelf-edge/drawer labels to show minimum stock requirements for fast-moving stock items. This ensured the team members continually monitored the stock, so they did not run out.

The team members carried out regular stock management activities. And they highlighted short dated stock and split-packs during regular checks. The pharmacy used three fridges; one for vaccines, one for insulin products and the other for creams and inhalers. 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 used clear bags instead of paper prescription bags for controlled drugs and fridge items. And this allowed the pharmacist to easily carry out additional checks at the time of supply. The team members kept controlled drugs in four separate cabinets. And this managed the risk of selection errors, for example, they kept sugar-free and sugar-containing methadone separate.

The team members acted on drug alerts and recalls. And they recorded the date they had checked for affected stock and what the outcome had been. For example, in February 2020 they had checked ranitidine stock. And they had recorded that they had no stock at the time. The company had trained the team members about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards and when to issue them and when to re-order them. The pharmacist monitored prescriptions for valproate. And they spoke to people that could be affected to confirm they knew about the risks. The company had trained the team members about the Falsified Medicines Directive (FMD) and what it aimed to achieve. But it had not yet embedded the system in their day-to-day processes.

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 pharmacist calibrated the machine to show it was measuring accurate doses. The team members used a blood pressure monitor. And a label showed the next calibration was due in October 2020. 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.