General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: John P Fenton & Sons Ltd, 8A Greenhills Square, East Kilbride, Glasgow, South Lanarkshire, G75 8TT

Pharmacy reference: 9011402

Type of pharmacy: Community

Date of inspection: 19/10/2023

Pharmacy context

This is a pharmacy in East Kilbride in Glasgow. Its main activity is dispensing NHS prescriptions. It provides a range of services including the NHS Pharmacy First Plus service, NHS and private travel vaccinations and provides some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. It also provides deliveries of medicines for people.

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 to help guide team members to deliver the pharmacy's services safely and effectively. And it mostly keeps the records required by law. Team members have the skills to respond appropriately to concerns about vulnerable adults and children. And they know to keep people's private information secure.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs), which were prepared in October 2020 and were relevant to the pharmacy's practice. These included SOPs for dispensing, controlled drugs (CD), responsible pharmacist (RP), and date checking. They were due to be reviewed by the superintendent (SI) pharmacist. A sample showed that team members had signed to say they had read, understood, and would follow them. The SI was an independent prescriber (IP) and delivered the NHS pharmacy first plus service, and they described how they did this within their competencies. The pharmacy provided both NHS and private travel vaccinations and a private ear micro-suction service. The risks associated with the services were managed by a service level agreement (SLA) for the NHS vaccination service. And the pharmacy used an NHS consultation form for assessing suitability of vaccinations for people. It used the NHS consultation form for the private vaccination service to guide clinical decision making.

The pharmacy recorded near miss errors identified during the dispensing process. There were two separate paper records which were used for the main dispensary downstairs and for an upstairs dispensary where multi-compartment compliance packs were prepared. The team member who made the error was responsible for recording the details when it was identified by either the pharmacist or an accuracy checking pharmacy technician (ACPT). Across the two dispensaries, errors had regularly been recorded over the three-month period checked. Team members captured the details of the errors but there was generally a lack of insight documented as to why the error may have happened. So, team members may have missed opportunities to learn from them. The SI explained there were frequent informal discussions between pharmacists and team members regarding near misses. The pharmacists regularly collated data produced from near misses to help identify any trends. And these were documented and discussed with team members. On occasion, the discussions would involve reminders to record near misses if it was discovered this had not been completed. The pharmacy also recorded errors identified after a person had received their medicines. These were usually completed by a more senior member of the team such as the SI or an ACPT. Reports included contributing factors such as photos of two similarly packaged medicines which had been involved in a previous incident.

The pharmacy had a SOP detailing the roles and responsibilities for team members. And team members understood their responsibilities. There were protocols for the ACPTs to follow when checking. For example, one ACPT felt comfortable to check CDs and the other did not. The RP notice was displayed prominently in the retail area of the pharmacy. A team member explained that they had, on a few occasions, labelled prescriptions before the pharmacist had arrived in the morning. This involved signing in the responsible pharmacist on the patient medication record (PMR) to gain access to the system. So, team members did not fully understand what could and couldn't be done in the absence of the RP. It was confirmed with the pharmacists that this practice would stop. The pharmacy did not have a formal complaints procedure, but the SI explained any complaints were usually resolved at a local level within the pharmacy. They explained that, in response to feedback received from people who reported waiting some time to hand in their prescriptions, they had a secure box built for people to

leave their prescriptions. The pharmacy had current professional indemnity insurance which covered the services provided.

The pharmacy's CD registers were kept on paper, and these mostly complied with requirements. The SI confirmed the resolution of some CD balance checks following the inspection. The sample of the pharmacy's private prescription register checked was in order and corresponding prescriptions were available. Records of unlicensed medicines included details of the person who received the medication so any queries could be resolved. The RP record mainly appeared in order, although the RP had not always completed the time they ceased being the RP.

The pharmacy had a general data protection regulations (GDPR) policy which all team members had read. Confidential waste was kept separately and collected by a third-party company for shredding. The pharmacy had a safeguarding policy and up-to-date contact details of people to contact if they had concerns regarding people. The SI explained how they had worked with other healthcare professionals to help a person get the appropriate care. The pharmacists were members of the PVG scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to manage the workload and deliver its services safely and effectively. The pharmacy supports team members to improve their knowledge and obtain relevant qualifications for their role.

Inspector's evidence

The pharmacy team at the time of the inspection included the SI, one regular pharmacist who was the RP, a locum pharmacist, a trainee pharmacist, two ACPTs, two dispensers and a medicines counter assistant (MCA) who was a trainee. There was team member working who was completing work experience. The team further comprised of a trainee dispenser, a dispenser who had recently passed her pharmacy technician course and was waiting to be registered, a MCA, two pharmacy students and three delivery drivers. The SI regularly assessed whether there were sufficient team members for the workload and as a result had started recruitment for a further full-time dispenser. Team members were observed to be working well together to manage the workload. Part-time team members were able to increase their hours so there was contingency for absences.

Team members were given opportunities to develop their knowledge and team members were supported to complete additional qualifications. Ongoing training included for topics such as valproate dispensing and the introduction of new NHS services. Team members were allocated training time to complete their qualification studies. The pharmacists had completed training to provide medicines and advice under the pharmacy first scheme. The SI was trained as an IP. They had completed additional training to be able to deliver travel vaccinations and explained what was within their competence to prescribe to people. Team members in training were appropriately supervised by either the SI or the other regular pharmacist. All team members received annual appraisals from the SI.

Team members had good relationships with the adjacent GP surgery and worked well with them to resolve problems and obtain advice. Team members felt comfortable discussing their mistakes and ensured there was an open and honest culture. They felt comfortable raising concerns or making suggestions for improvement with the regular pharmacist or SI. And the pharmacy had a whistleblowing policy. Team members knew the appropriate questions to ask when selling medicines to people, and they were aware of the need to ensure that any repeated requests for medicines liable to misuse were referred to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy. It provides a suitable space for the services it delivers. It has soundproofed rooms where people can access services and have private conversations with team members.

Inspector's evidence

The pharmacy was clean and tidy portrayed a professional appearance. There was a large retail area and a spacious dispensary towards the rear of the premises and there was an additional dispensary where the dispensing of medicines into multi-compartment compliance packs took place. There were various dispensing benches which provided space for team members to complete different tasks. Medicines were stored neatly on shelves.

There were two soundproofed consultation rooms where people could have private conversations with team members and access services. One of the rooms where clinical services were delivered had a sink which provided hot and cold water. And there was a suitable designated waiting area outside the consultation room. There was a separate sink in the dispensary for the preparation of medicines and the toilet facilities provided hot and cold water and soap for handwashing. The pharmacy was cleaned once a week by an external cleaning company. The medicines counter acted as a barrier to restrict unauthorised access to the dispensary. The pharmacist was positioned in a way that allowed for intervention in conversations at the medicines counter if necessary. The pharmacy was well lit throughout, and the temperature was comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages the delivery of its services well. And it has suitable procedures to ensure people receive their medicines when they need them. The pharmacy stores and manages its medicines appropriately. And team members carry out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy had a step-free entrance which provided ease of access to those with limited mobility and with pushchairs. The pharmacy advertised its opening hours and services it provided at the front door of the pharmacy. The pharmacy team referred people to other local pharmacies for services it did not provide, such as yellow fever vaccinations.

The prescribing pharmacist assessed and treated people for common ailments under the NHS Pharmacy First Plus scheme. Details of the consultation, including clinical notes and medicines prescribed, were recorded on the person's PMR and were shared with the GP. Pharmacists had online access to the current patient group directions (PGDs) for the services provided in this way.

The pharmacy delivered medicines to people in their homes and prepared people's medicines ahead of the driver arriving to collect them. The drivers used sheets with people's names and addresses on and these were annotated with stickers that highlighted whether a CD or fridge line was to be included with the delivery. The driver did not ask people to sign for routine deliveries, but people were asked to sign a separate sheet to confirm receipt of their CD.

The pharmacy team members used baskets when dispensing to keep people's prescriptions and medicines together and reduce the risk of errors. They used stickers as part of the dispensing process to highlight if a fridge line or controlled drug or intervention by the pharmacist was required. And team members signed dispensing labels to indicate who had dispensed a medication and who had checked it, so team members involved in each stage could be identified. The pharmacy dispensed and supervised the administration of medicine for some people. Team members prepared doses in advance to help manage the workload. The pharmacists were aware of their additional responsibilities when clinically checking higher-risk medicines including valproate and knew that additional counselling was required for these people. Team members were aware of the pregnancy prevention programme for valproate. The SI confirmed counselling had been provided for a person taking valproate who was in the at-risk group.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct time. And there was contingency for absences as every team member was trained to provide the service. The pharmacy kept up-to-date records with information about the medications people took and when. The GP surgery communicated changes to the pharmacy, and these were recorded on the person's PMR as soon as they were received. Team members ordered prescriptions in advance so there was time to resolve any queries. They provided people with details and information of their medicines, including what the medicines looked like so they could be identified in the pack. The labelling included warnings such as when the medicine caused drowsiness. And they supplied patient information leaflets (PILs) every four weeks so people had information to help them take their medicines.

The pharmacy had an up-to-date rota for checking the expiry dates of medicines. The process was organised so that expiry dates of medicines throughout the entire dispensary were checked every six months and any short-dated medicines were highlighted for use first. A couple of medicines seen on the shelves had not been highlighted as short-dated. From a random sample checked all were within their expiry date. Medicines with a shortened expiry date on opening were marked with the date of opening. The pharmacy had two fridges and the contents kept neat and tidy. Team members recorded the fridge temperature daily, with one exception in the past two weeks. Records showed that if the temperature had deviated out with the recommended 2-8 degrees that action was taken such as the fridge being reset and checked later the same day. Pharmacy only medicines were stored behind the medicines counter to allow pharmacist supervision of sales. The team received alerts about drug alerts and recalls via email. These were actioned and kept in an electronic folder within the email inbox.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses the equipment and facilities in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to clinical reference resources and access to the internet which provided up-to-date information to help with effective provision of its services. It had equipment available for the services provided, including crown marked measuring cylinders for measuring liquids. And these were marked to highlight which were for water and which were for liquid medicines. There were sharps bins and in-date adrenaline pens used for the provision of vaccination services.

The pharmacy's computer systems were password protected and positioned to prevent unauthorised access to confidential information. Prescriptions awaiting collection were stored in a way which prevented unauthorised people from seeing private information.

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.