General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Care Pharmacy, Unit 4 Cradlehall Shopping Centre, Highland, IV2 5WD

Pharmacy reference: 9011463

Type of pharmacy: Community

Date of inspection: 28/06/2021

Pharmacy context

This is a new community pharmacy in a small shopping centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it offers a medicines' delivery service to vulnerable people. The pharmacy team members advise on minor ailments and medicines' use. And they supply a range of over-the-counter medicines.

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 acts to help keep members of the public and team members safe during the Covid-19 pandemic. It keeps the records it needs to by law and keeps confidential information safe. Team members securely dispose of personal information when it is no longer required. The pharmacy's policies and procedures show how it identifies and manages risks to keep services safe. And team members make improvements to prevent dispensing errors.

Inspector's evidence

The pharmacy had processes to manage the risks and help prevent the spread of coronavirus. A poster on the entrance door informed people that a maximum of two people was allowed in the waiting area at the one time to maintain a safe two-metre distance from each other. People were seen to be following the guidelines without any instruction from the pharmacy team members. Hand sanitizer was available in the waiting area and in the dispensary. The responsible pharmacist and one dispenser were on duty at the one time. They wore face masks and kept a safe distance from each other and when speaking to people at the medicines counter. A kitchen was available and used for comfort breaks. Only one team member at a time used the room so they could safely remove their face mask. The pharmacy used working instructions to define the pharmacy's processes and procedures. Team members had recorded their signatures to show they understood and followed them. A new dispenser had recently started working at the pharmacy and were about to read and sign the documents. The pharmacy had risk management procedures in place. Team members were required to sign medicine labels to show who had ‘dispensed’ and who had ‘checked’ each prescription. This was to help them learn about their near miss errors through feedback, and to help them avoid the same mistakes in the future. Sampling showed team members had signed most of the labels except for a few of those attached to multi-compartment compliance packs. The pharmacy used a form to record the errors. One entry had been documented since the pharmacy started operating in February 2021. The pharmacist explained this was due to the high level of accuracy in dispensing within the pharmacy team. Examples of improvements were provided to manage the risk of selection errors. This included separating Depakote/Epilim and olanzapine tablets due to the risk profile of the medication. Team members had been re-arranging the shelves due to the pharmacy getting busier. But the shelf-edge caution label for valproate had not been moved to reflect the new storage arrangements. The pharmacy trained team members to follow its complaints policy so they were effective at handling concerns. It did not display a notice or contact details to support people to raise a complaint should they need to. But it used a suggestions box to encourage feedback. The pharmacy used a template form to support team members to carry out investigations into dispensing incidents. The form was also designed to show any learnings and improvements it had made to prevent a recurrence. No complaints or dispensing incidents had been reported since the pharmacy opened. Feedback about the pharmacy’s services had been very positive. The pharmacist was planning on providing an ear syringing service due to the level of enquiries he had received. And he was about to enrol on training before introducing the new service.

The pharmacy maintained the records it needed to by law, and the pharmacist in charge kept the responsible pharmacist record up to date. It kept its private prescription forms in good order and kept a record of the supplies it made. The pharmacy had public liability and professional indemnity insurance in place. They were valid until 7 February 2022. The pharmacy used an electronic controlled drug

register. The pharmacist carried out stock checks once a week. Sampling showed that actual stock matched the registered stock. The controlled drug cabinet had ample space to safely quarantine stock that was awaiting destruction. A controlled drug destruction register was being used to record controlled drugs that people returned for disposal. The pharmacy provided a prescription delivery service. This helped vulnerable people and those shielding to stay at home. The driver wore PPE at the time of delivery and kept a record of the deliveries they made. The pharmacy provided training so that team members understood data protection requirements and knew how to protect people's privacy. The pharmacy did not display a notice or inform people about how it used or processed their information. Team members used a shredder to dispose of confidential waste and spent records. The pharmacy provided training so that team members understood how to protect children and vulnerable adults. It did not use a safeguarding policy or keep contact details for key agencies should a referral be necessary. The pharmacist and dispenser were registered with the protecting vulnerable group (PVG) scheme. This helped to protect children and vulnerable adults. Team members knew to speak to the pharmacist whenever they had cause for concern. For example, they monitored the collection and delivery of multi-compartment compliance packs and acted when people either didn't collect them on time, or when there were failed deliveries.

Principle 2 - Staffing ✔ Standards met

Summary findings

Most of the pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. They complete training as and when required. And, they learn from the pharmacist to keep their knowledge and skills up to date. Pharmacy team members speak-up and make suggestions to help improve pharmacy services.

Inspector's evidence

The pharmacy's workload had continued to increase since its opening in February 2021. Two part-time dispensers worked at the pharmacy. They were both available to increase their hours to meet increasing workload demands. The pharmacist manager was currently recruiting another part-time dispenser. And the company was in the process of recruiting a pharmacist to work part-time on regular days. A part-time driver provided the pharmacy's delivery service. They had read and signed the standard operating procedure that defined the delivery process. But they had not been enrolled on an accredited course to show they had the necessary knowledge and skills. The pharmacist had been considering the skill-mix at the pharmacy. They were planning on enrolling one of the dispensers on training so they would be eligible to register as a pharmacy technician. They were also planning on arranging First Aid training so that team members could assist in emergencies. The pharmacist supported team members to develop their knowledge and skills. One of the dispensers had little experience of the NHS Pharmacy First service and had been developing their knowledge through reading about it. Another dispenser had been keeping a training diary. A sample of entries showed they had learned about the following topics using the Turas system; smoking cessation, travel health and the Medicines Care Review service. Team members had kept up to date with the relevant coronavirus guidance. This included how to keep themselves and other people safe. They understood the need for whistleblowing and felt empowered to raise concerns when they needed. The dispensers had worked in different pharmacies. The pharmacist manager and the superintendent pharmacist encouraged them to apply their previous experience to develop the pharmacy's policies and procedures. The superintendent had been onsite the week before. One of the dispenser's had suggested running health campaigns such as summer health and coughs and colds in winter to help people care for themselves and others. This was agreed and team members were discussing how to proceed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy, secure and is well maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members. It has made suitable changes to its premises to help reduce the risk of spreading coronavirus.

Inspector's evidence

This was a new purpose built pharmacy. The premises was large and workstations were at least two metres apart. Only two team members were on duty at the one time. This allowed them to keep a safe distance from each other for most of the day. Dispensing benches had been arranged for different tasks. The pharmacist used a dedicated area for carrying out final accuracy checks and other tasks. The dispenser used a large central island to assemble prescriptions. They had ample space for multi-compartment compliance pack dispensing. The consultation room provided access to team members in the dispensary via a small window. This provided a safe and confidential environment to protect people's privacy. The consultation room was sound-proofed and was well-equipped with a sink and running water. Team members also used the sink for hand washing and the preparation of medicines. They cleaned the room on a regular basis and in between consultations. The pharmacist observed and supervised the medicines counter from the checking bench. They could intervene and provide advice when necessary. The pharmacy was clean and well maintained. Team members cleaned and sanitised the pharmacy on a regular basis to reduce the risk of spreading infection. This included frequent touch points such as keyboards and telephones. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are accessible. It generally manages its services to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and it stores them properly. But it does not always label medicines according to regulations. This means it could use medicines that are not suitable to supply.

Inspector's evidence

The pharmacy had a step-free entrance which provided access for people with mobility difficulties. It advertised its services and opening hours in the windows at the front of the pharmacy. And it displayed leaflets at the medicines counter for people to select. The pharmacy used dispensing baskets to manage the risk of items being mixed-up. Dispensing benches were organised and clutter-free. Team members kept the pharmacy shelves neat and tidy. A large controlled drug cabinet had ample storage space. It was well-organised to manage the risk of selection errors. The pharmacy purchased medicines and medical devices from recognised suppliers. A few ‘pre-packs’ were being kept on the same shelves as multi-compartment compliance packs. Team members had attached handwritten labels to the containers. But they had not included the batch number and expiry date. This meant that affected stock could not be identified and removed when necessary. For example, in the event of a drug recalls or reaching its expiry date. Team members carried out monthly expiry date checks and highlighted products that were short dated. They recorded the checks, so they knew when the next one was due. No out-of-date medicines were found after a check of around 12 randomly selected medicines. A medical fridge was used to store medicines. Team members monitored and recorded the fridge temperatures every morning. The records showed that the temperatures had remained between two and eight degrees Celsius.

The driver delivered medicines across Inverness and Nairn to people in their homes. They had read and signed the standard operating procedure. Due to coronavirus they knew not to ask people to sign to confirm receipt of their medication. They kept a record of the deliveries so they could respond to queries. The pharmacy used a standard operating procedure to define the risks associated with valproate supplies. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. The pharmacist knew to contact prescribers if they received new prescriptions for people in the at-risk group. Team members supplied warning cards each time they made a supply. The pharmacy used a standard operating procedure to define the assembly process for dispensing medicines in multi-compartment compliance packs. Team members used separate shelves to store the packs. This was kept organised and tidy, so they were easy to locate. Supplementary records were used to support the team members to safely assemble and dispense the packs. A ‘backing sheet’ was retained and kept up to date with a list of the person's current medication and dose times. Team members checked prescriptions against the ‘backing sheets’ before they started dispensing and discussed any changes with the relevant prescriber. They annotated descriptions of medicines in the pack and supplied patient information leaflets with the first pack of the four-week supply. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Team members accepted unwanted medicines from people for disposal. They put on disposable protective gloves before handling the packages and processed the waste after it had been quarantined for three days. Drug alerts were prioritised, and

team members knew to check for affected stock so that it could be removed and quarantined. The pharmacist saved the emails that drug alerts were attached to. But they did not record information about the checks, such as when they had been carried out and what the outcome had been.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy’s equipment is clean and well-maintained. It uses equipment appropriately to protect people's confidentiality. It takes precautions so that people can safely use its facilities when accessing its services during a pandemic.

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. 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 members. The pharmacy had a cordless phone, so that team members could have conversations with people in private. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks and gloves.

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.