General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Inverkip Pharmacy, 2 Kip Park, Main Street, Inverkip, Greenock, Inverclyde, PA16 0FZ

**Pharmacy reference:** 9011569

**Type of pharmacy:** Community

**Date of inspection:** 17/05/2022

## Pharmacy context

This is a community pharmacy beside other shops in a local centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers 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. The inspection was completed during the COVID-19 pandemic.

## 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

Pharmacy team members follow written procedures to help them safely carry out tasks. Team members discuss and record details of mistakes they make while dispensing. And they review them to help team members identify common pattern or trends. But the pharmacy does not proactively review its procedures to identify any new risks with its services. The pharmacy keeps the records it needs to by law, and it keeps people's personal information safe and secure. The team is adequately equipped to manage any safeguarding concerns.

### Inspector's evidence

The pharmacy had introduced new processes to manage the risks and help prevent the spread of coronavirus. Team members monitored the waiting area to limit the number of people there. And there was never a build-up even though a café was located next to the pharmacy. Hand sanitizer was available at the medicines counter for people to use. And a plastic screen provided a protective barrier between team members and people using the pharmacy. Face masks were worn throughout the day. And hand sanitizer used to protect against infections.

The pharmacy used documented working instructions to define the pharmacy's processes and procedures. And team members had recorded their signatures to show they had read and understood them. The procedures did not show who had authorised them for use. And the company had not reviewed the procedures since January 2018. This included the working practices for 'assembly and dispensing', 'assemble and supply of controlled drugs' and 'hand-out of prescriptions. Pharmacy team members signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist was able to identify dispensers to help them learn from their dispensing mistakes. Team members had recently recommenced documenting their near miss errors. And documentation showed the pharmacist had carried out a formal near miss review to identify patterns and trends and areas for improvement. This included selection errors involving bendroflumethiazide 2.5mg and bisoprolol 2.5mg medications. And team members had separated the items and added a shelf-edge caution label to highlight the risk.

The pharmacy did not display a notice or provide information to help people complain if they needed to. But it had defined the process in a documented procedure which had been last reviewed in January 2018. Team members had evidenced they had read the procedure and knew how to effectively handle complaints. The pharmacist recorded dispensing incidents on an electronic form. The form included a section to record information about the root cause and the mitigations to improve patient safety.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurances in place which were valid until 28 February 2023. The pharmacist displayed a responsible pharmacist notice, but it was not visible from the waiting area. The responsible pharmacist record was up to date and showed which pharmacist had been on duty when the pharmacy was operating. The pharmacy had started using an electronic controlled drug register in April 2022. And team members evidenced they checked and verified the stock balances once a week. People returned controlled drugs they no longer needed for safe disposal. And a destructions register showed the pharmacist had signed the records to confirm that destructions had taken place. Team members filed

prescriptions so they could be easily retrieved if needed. And records of supplies against private prescriptions and supplies of 'specials' were up to date. The pharmacy did not display a notice to inform people about how it used and processed their personal information. Team members knew to keep personal information out of sight of people in the waiting area. But they were not using the pharmacy shredder and instead were ripping up labels and disposing them alongside the general waste. One label with person identifiable information was seen in the bin. The pharmacy had not introduced a policy to set out its approach to safeguarding vulnerable children and adults. Team members knew to discuss any concerns with the pharmacist. And this included concerns about failed deliveries or collections of multi-compartment compliance packs. The pharmacist provided an example of when she had visited someone at home and called an ambulance due to their health condition deteriorating. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. This also helped to protect children and vulnerable adults.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

Pharmacy team members mostly 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.

### Inspector's evidence

The pharmacy's workload had remained stable since its relocation in April 2021. And the company had not needed to increase the number of team members working at the branch. The responsible pharmacist had worked there for several years. And two new experienced dispensers had started around September 2021. The company employed relief pharmacists and a regular locum provided cover whenever it was necessary. The pharmacy team was established, and individuals were experienced and competent in their roles and responsibilities. For example, one of the dispensers knew to monitor sales of codeine containing products. And they provided advice so that people knew they were for short term use only. The team included one full-time pharmacist, one full-time dispenser, two part-time dispensers and another dispenser who worked on a Saturday and provided extra cover when necessary. Two part-time delivery drivers also worked at the pharmacy and covered for each other when they were off. One of the delivery drivers was new in post, and they had read the relevant working instructions. But the company had not enrolled them on the necessary 'Delivering Medicines Safety and Effectively' training course for delivery drivers.

The pharmacist supported team members to learn. And kept them up to date with new services and changes to established services. This included changes to the list of products available via the NHS pharmacy first service. The provider of the collection point had delivered on-site so that team members were competent to operate the system. And one of the dispensers had undergone training and was accredited to provide a new 'ear and hearing health check-up' service. The training included attendance at webinars, online training and initially being observed by the system provider whilst carrying out micro suction for ear wax removal. The dispenser carried out the procedures under the supervision of the pharmacist. And they knew to refer to the pharmacist when they needed to. For example, when they had observed 'bumps' inside the ear that they were unfamiliar with. The system provider used a remote review platform to provide connectivity with ENT specialists. And the concern was communicated for expert advice which they provided.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises adequately support the safe delivery of services. And the pharmacy suitably manages the space for the storage of its medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

### Inspector's evidence

This was a new, purpose-built pharmacy which presented a professional appearance to the public. It had well-spaced out dispensing benches. And team members were able to work a safe two metres distance apart from each other for most of the day. Each of the benches were used for specific dispensing tasks. This included a separate bench for carrying out final accuracy checks. And another bench for dispensing multi-compartment compliance packs. The dispensing benches were clutter free. And dispensing baskets kept prescription items well-contained.

Team members used a series of shelves for stock and multi-compartment compliance packs. And they kept them tidy with packs well-segregated. The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary. A sound-proofed consultation room was available. And it provided a confidential environment for private conversations. A separate treatment room was used to provide substance misuse services. And team members regularly cleaned the surfaces in both rooms in between sessions. A sink in the dispensary was available for hand washing and the preparation of medicines. And team members cleaned and sanitised the pharmacy on a regular basis. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate area was used for comfort breaks. This allowed team members to remove their face masks without being at risk of infections.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are not fit for purpose. The pharmacy provides services which are easily accessible. And it manages its services to help people receive appropriate care.

### Inspector's evidence

The pharmacy had a step-free entrance and provided unrestricted access for people with mobility difficulties. It advertised its services and opening hours at the entrance. And it provided information to help keep people safe from coronavirus. This included information about long Covid. The pharmacist provided access to 'prescription only medicines' via 'patient group directions' (PGDs). They kept 'hard copies' of the PGDs in folders that were easy to access. But they had gone beyond their expiry date. The pharmacist confirmed that they did not use the hard copies and accessed the health board's web pages for the most up to date versions.

Team members kept stock neat and tidy on a series of shelves. And they used a controlled drug cabinet that had adequate space to safely store stock items. The pharmacy purchased medicines and medical devices from recognised UK based suppliers. This included supplies of products used in aesthetic procedures. Team members carried out documented expiry date checks. Sampling showed that items were within their expiry date. The pharmacy used a fridge to store items at the recommended temperature. It was organised, and team members monitored and documented the temperatures daily. This showed it had been operating within the accepted range of 2 and 8 degrees Celsius. Team members knew about valproate medication and the Pregnancy Prevention Programme. And the pharmacist knew to speak to people in the at-risk group about the associated risks. They had recently carried out a safety audit to confirm that people did not fall into the at-risk group. And they discussed the safety risks and the audit findings with the other team members who knew to supply patient information leaflets and to provide warning information cards with every supply.

The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people. This had remained at the same level since the pharmacy's relocation. The pharmacy had defined the assembly and dispensing process in a documented procedure for team members to refer to. But this had not been reviewed since April 2016. The procedure included the assembly and labelling of the original packs which the pharmacist accuracy checked before team members de-blistered into the packs. The pharmacist also checked new prescriptions against previous prescriptions for accuracy before authorising team members to start dispensing the packs. The pharmacy dispensed serial prescriptions for people that had registered with the 'medicines care review' service (MCR). Team members dispensed the medication when people called to say their medication was due. And the pharmacist carried out checks to ensure people collected their medication on time.

The pharmacy had introduced a new 'ear and hearing health check-up' service in November 2021. This was due to a high demand for the service in the area. The service included diagnosing bacterial and fungal infections and carrying out hearing tests. But it was mostly used for ear wax removal. A dispenser provided the service under the supervision of the pharmacist. They cleaned the equipment

with anti-bacterial wipes in between sessions. And safely disposed of the single-use sterile tubes that they used with the otoscope in the clinical waste container in the consultation room.

The pharmacy kept stocks of botulinum toxins and dermal fillers. And provided supplies against private prescriptions from local prescribers. This included an independent nurse prescriber and a few dentists. The pharmacist had confirmed the nurse prescribers' credentials such as 'nursing and midwifery council' (NMC) registration and the clinics 'healthcare improvement Scotland' (HIS) registration. The nurse prescriber personally handed in prescriptions and collected the items once dispensed. The dentists emailed prescriptions to the pharmacy, and the delivery driver collected the original prescription at the time of delivery. The pharmacist did not see the people for whom the items were prescribed. They checked prescriptions to ensure they complied with legal requirements. And they also checked the patients address to identify the risk of someone not being seen during a face-to-face consultation with the prescriber. The pharmacist produced several patient medication records to show that supplies were within safe limits. They had not needed to make an intervention due to prescribing concerns.

The pharmacy had been using a collection point machine since September 2021. And people could collect their prescriptions at their own convenience even when the pharmacy was closed. The new system had reduced the footfall in the pharmacy. And it had reduced the risk of infection due to the coronavirus pandemic. The pharmacy had carried out a risk assessment before its installation. And it had excluded high risk medications such as controlled drugs and items that required refrigeration. Team members used green baskets to highlight prescriptions that were to be placed in the collection point. And they checked the machine for uncollected items which they then removed. PIN numbers expired after one week and team members issued people with a new PIN to collect their prescription.

The delivery drivers followed a schedule and they kept records to show the items they had delivered. They kept a supply of face masks, gloves, and hand sanitizer in the delivery vehicle, and they used them during deliveries. They knew to keep at a safe distance from people to manage the risk of spreading infection. Team members accepted unwanted medicines from people for disposal. And the pharmacy had medical waste bins to support the team in managing pharmaceutical waste. Team members knew to act on Drug Alert notifications so that affected stock could be removed and quarantined straight away. The pharmacy kept records to show they acted on Drug Alerts. But the last record was for October 2021 even though they had received notifications since then.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people’s private information.

### Inspector's evidence

The pharmacy used a collection point. And the company that provided it was on hand to carry out repairs and support the pharmacy team when there were problems. A five-year service contract was in place. And the company carried out a service once a year. The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF).

At the time of the inspection, team members were using the same measure for all liquids including methadone. This was due to a recent breakage, and they were awaiting delivery of a new measure. The pharmacy had a new blood pressure monitor they had not used. But it did not show when it needed to be replaced or calibrated. The pharmacy stored prescriptions for collection out of view of the waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. A portable phone allowed team members to carry out conversations in private if needed. 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.

## 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. |