General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Cambusbarron Pharmacy, 10 Main Street, Cambusbarron, Stirling, Stirlingshire, FK7 9NW

**Pharmacy reference:** 9011633

**Type of pharmacy:** Community

**Date of inspection:** 24/03/2022

## Pharmacy context

This is a community pharmacy in Cambusbarron. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines' use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs). 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 good working practices. And they show they are managing dispensing risks to keep services safe. The pharmacy does not always document mistakes team members make. But they receive feedback to learn from their mistakes and improve their dispensing. The pharmacy keeps the records it needs to by law, and it suitably protects people's private information.

### Inspector's evidence

The pharmacy had introduced new processes to manage the risks and help prevent the spread of coronavirus. And a plastic screen at the medicines counter acted as a protective barrier between team members and the public. The pharmacy limited the number of people in the waiting area to four at a time and it provided hand sanitizer at the entrance to the pharmacy. Team members had access to hand sanitizer, and they were wearing face masks throughout the inspection to reduce the risk of cross infection. The pharmacy used documented working instructions to define the pharmacy's processes and procedures. Team members had recorded their signatures to show they had read and understood them. And sampling showed the procedures were up to date. This included the 'dispensing' and 'accuracy checking' procedures which had been reviewed on 9 May 2021. A business continuity plan provided each team member's contact details. It also provided information about the pharmacy's utilities and alternative arrangements in the event of failures.

The pharmacy employed a trainee 'accuracy checking dispenser' (ACD) and the pharmacist knew to introduce an annotation so that the ACD knew to only to check prescriptions that had been seen by a pharmacist. Dispensing of multi-compartment compliance packs was carried out by experienced dispensers. They followed the pharmacy's procedure for the assembly of packs which had been reviewed in May 2021. Pharmacy team members signed medicine labels to show who had 'dispensed' and who had 'checked' each prescription. The pharmacist was able to identify dispensers to help them learn from their dispensing mistakes and an electronic platform for recording near miss errors was available. Team members had recorded a few errors but had not recorded any since the beginning of 2022. The team discussed dispensing risks amongst themselves and agreed when changes were needed to manage dispensing risks. This included separating nifedipine/nefopam and atorvastatin/esomeprazole. They also knew to highlight look alike and sound alike medicines when they received new medicines into stock. The pharmacy recorded dispensing incidents, but they did not always provide information about the root cause analysis or the improvements they had made to safeguard patient safety. The pharmacy trained its team members to handle complaints and it had defined the complaints process in a procedure for team members to refer to. The procedure had last been reviewed in May 2021. The pharmacy did not display a notice to provide information about how to complain. But team members were able to show they had resolved complaints in the past. This had included a complaint about different brands of the same medication.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurances in place which were valid until 29 April 2022. The pharmacist displayed a responsible pharmacist notice and mostly kept the RP record up to date except for a few gaps when the finish time was missing. Team members maintained the electronic controlled drug registers and kept them up to date. They checked and verified the balances once a month. The pharmacy had introduced a

process to help them keep track of controlled drugs that had been dispensed into multi-compartment compliance packs. Team members recorded the information on a post-it note, attached it to the pack and placed it into the CD cabinet for safe-keeping until it was needed. They removed the packs when they were needed and updated the CD register at the time. This managed the risk of post-it notes becoming dislodged from the packs. People returned controlled drugs which they no longer needed for safe disposal. Team members kept electronic records of the destructions which included an audit trail to confirm that destructions had taken place. Team members filed prescriptions so they could be easily retrieved if needed. They kept records of supplies against private prescriptions and supplies of 'specials' and they were up to date. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. It used a shredder to securely dispose of confidential waste. A notice in the waiting area informed people about its data protection arrangements. The pharmacy trained its team members to manage safeguarding concerns. And it had introduced a policy for team members to refer. This included an up-to-date list of contact details for the key agencies such as the community addictions team (CAT). Team members knew to speak to the pharmacist whenever they had cause for concern. This included concerns about failed deliveries or collections of multi-compartment compliance packs. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. This helped to protect children and vulnerable adults.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

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.

### Inspector's evidence

The pharmacy's workload had increased significantly since the start of the coronavirus pandemic. A new part-time medicines counter assistant had been appointed to help manage the extra workload. A second pharmacist supported the pharmacist manager one day a week. And another pharmacist provided cover one day per week. This meant that the pharmacy did not have to rely on locum pharmacist cover. Most team members were long-serving and experienced in their roles and responsibilities. The pharmacy team included one full-time pharmacist, one part-time pharmacist, one full-time trainee pharmacy technician, two full-time dispensers and one full-time delivery driver. The pharmacist supported team members to learn. This included providing an update when the pharmacy had introduced a new National Patient Group Direction (PGD) for the supply of desogestrel, a progestogen-only pill for bridging contraception. They printed and cascaded new versions of the NHS pharmacy first medicines formulary. And they discussed the changes so team members were up to date. Team members had recently learned about two new vaccination services that had been recently introduced. They knew about the new Covid-19 vaccination service. And they also knew about a new NHS travel vaccination initiative.

The pharmacy team was up to date with health and safety training. This included how to use 'visual display units' (VDUs) safely, manual handling and working at height whilst using the kick-stool to retrieve stock. The pharmacy provided protected learning time for trainees undergoing formal courses. This ensured they were supported and made satisfactory progress with their courses. The trainee pharmacy technician was undergoing 'accuracy checking dispenser' (ACD) training to gain the necessary knowledge and skills to carry out final accuracy checks. The trainee and the pharmacist had discussed the initiative and knew to introduce extra control measures to manage dispensing risks. This included annotating prescriptions to provide the authority to carry out the final accuracy check. Team members were proactive at suggesting areas for improvement. One of the dispensers had gained significant experience through working in different types of pharmacies. They had discussed new ways of working to improve the pharmacy's processes. This included the labelling and assembly of methadone doses every three or four days instead of once a day. This had helped to better manage the workload.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises adequately support the safe delivery of services. And the pharmacy 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

The pharmacy had adequate well-segregated areas for the different dispensing activities. A series of dispensing benches were organised and clutter free. Workstations were at least two metres apart and team members kept a safe distance from each other for most of the day. The pharmacist supervised the medicines counter from the checking bench. They were able to intervene and provide advice when necessary. A separate large area was used to store multi-compartment compliance packs. Team members kept the storage shelves for the packs well-organised. This included separating packs for delivery and packs for collection.

The pharmacy had two sound-proofed consultation rooms. The rooms provided a confidential environment for private consultations. The pharmacist used one of the rooms to provide travel vaccinations and Covid-19 vaccinations. And used the other room to provide supervised consumption services. Team members cleaned the rooms in between consultations. A sink in the dispensary was available for hand washing and the preparation of medicines. Team members cleaned and sanitised the pharmacy at least once a day to reduce the risk of spreading infection. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment to store medicines and to provide services. A separate area was used for comfort breaks. It was sufficient in size for team member to remove and renew their face masks whilst managing the 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 for people. And it generally manages its services well to help people receive appropriate care.

### Inspector's evidence

The pharmacy advertised its services and opening hours in the windows at the front of the pharmacy. A step-free entrance and an automatic door provided unrestricted access for people with mobility difficulties. The pharmacist provided access to 'prescription only medicines' via 'patient group directions' (PGDs). This included Covid-19 and travel vaccinations. They used one of the consultation rooms to administer vaccinations and cleaned the room in-between sessions. Team members kept stock neat and tidy on a series of shelves. And they managed the stock to ensure it was fit for purpose. The pharmacy had two separate fridges to keep stock at the required temperature. One was used for general stock. And the other was used to store vaccines in the consultation room. Both fridges were organised and well-managed and the fridge in the consultation room was locked to prevent unauthorised access. Team members monitored and documented the temperature of the fridges to show they were operating within the accepted range of 2 and 8 degrees Celsius. A date-checking matrix showed that team members checked stock every three to six months. This provided assurance that the pharmacy only supplied medicines that were within their expiry date. Sampling showed that medicines were in date. Part-packs were highlighted and this helped to manage the risks of quantity errors. The pharmacy used two controlled drug cabinets for extra security. And they provided adequate space to segregate stock items and manage the risk of selection errors. Items awaiting destruction were kept well away from other stock. Team members knew about high-risk medicines. This included 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. And team members 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 increased over the course of the pandemic. The pharmacy had defined the assembly and dispensing process in a documented procedure for team members to refer to. The procedure was up to date and had last been reviewed in May 2021. Team members used trackers to manage the dispensing process. This helped them to order new prescriptions and ensure they had sufficient time to process subsequent supplies. Supplementary records which contained a list of the person's current medication and dose times were kept up to date. Team members checked prescriptions against the master records for accuracy before they started dispensing packs. They discussed queries with the relevant prescriber and they only made changes to packs on receipt of a new prescription. Team members did not always record their signatures to show who had dispensed and who had checked the packs. This meant they may not always receive feedback to help them learn about their dispensing mistakes. A dedicated area was used by the driver to organise the deliveries that were due. This included checking lists for prescriptions that were due for delivery and planning their route. They knew

to be mindful of people that were unsteady on their feet and took extra time to let them answer the door and take delivery of their prescriptions. Team members used a large notice board in the dispensary to provide extra information about the deliveries that were due, such as fridge items and controlled drugs. The driver kept a supply of face masks, gloves and hand sanitizer in the delivery vehicle and used them during their deliveries. Team members accepted unwanted medicines from people for disposal. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Drug alerts were prioritised, and team members knew to check for affected stock so that it could be removed and quarantined straight away. Team members annotated and retained the drug alerts in a folder to show what the outcome of the checks had been. For example, benzylpenicillin injection had been recently checked with no stock affected.

## 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 had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures to dispense methadone doses. They highlighted the measures, so they were used exclusively for this purpose. 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. The pharmacy used a cordless phone. This meant that team members could carry out conversations in private if needed. The pharmacy used cleaning materials for hard surface and equipment cleaning. Team members cleaned and sanitised the pharmacy at least once a day. 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. |