General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: CarePoint Pharmacy, 45 Main Street, Calderbank, Airdrie, ML6 9SG

Pharmacy reference: 9012135

Type of pharmacy: Community

Date of inspection: 14/11/2024

Pharmacy context

This is a community pharmacy in the town of Calderbank in Airdrie, Scotland. Its main activity is dispensing NHS prescriptions. It provides NHS services including NHS Pharmacy First and NHS Pharmacy First Plus. And it has private services including prescribing for weight loss. The pharmacy provides multi-compartment compliance packs to people to help them take their medicines correctly. And it has a delivery service, taking medicines to people in their homes.

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's written procedures help team members to manage risk and provide services safely. Team members mostly complete the records required by law. They keep people's private information safe. And they know how to respond to concerns for the welfare of vulnerable people accessing the pharmacy's services. Team members complete some adhoc records about mistakes made during the dispensing process and they take some action to help reduce the risk of a similar mistake happening. But they do not regularly analyse these records which may mean they miss opportunities to learn from them.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which helped team members manage risks to deliver services safely. These included SOPs about controlled drug (CD) management and the responsible pharmacist (RP). The SOPs had been written in the past two years by the pharmacist manager and had been authorised by a previous superintendent pharmacist (SI). The pharmacy's new SI had authorised a new SOP in September 2024 for managed repeat prescriptions. The pharmacy's SOPs were dated to show they were to be reviewed every two years. Team members had signed to say they had read and understood the SOPs.

The pharmacist independent prescriber (PIP) provided prescribing services for both NHS Pharmacy First Plus and a face-to-face weight loss management service. The pharmacist provided private services including ear wax removal (microsuction) and administration of influenza vaccinations. A private blood screening service where the pharmacist collected blood samples from people and sent them to a laboratory for analysis was also provided. The PIP had produced a SOP about how both the NHS and private prescribing services would be delivered. The SOP included risk reduction measures such as ensuring the PIP had appropriate training and appropriate indemnity insurance to provide the services safely. The PIP had considered risks associated with providing the various private services, including for weight loss, such as ensuring consultations were completed in the pharmacy face-to-face with people. And monitoring people's BMI to ensure they were suitable for ongoing treatment. Whilst they had considered the risks associated with the prescribing services, they did not document them, and this was discussed during the inspection. Risk assessments for the ear wax removal service, administration of influenza vaccinations, weight loss management and blood screening were produced after the inspection. The risk assessments described some of the risks and mitigating factors for the services. For example, for the weight loss management service, it documented a risk reduction measure of gaining consent from people to share the information about the medicines prescribed with their GP. But this was not usually given by people accessing the service. A discussion about informing people of the risks of not sharing information about the medicines prescribed was had.

The pharmacy had a process for electronically recording mistakes identified and rectified during the dispensing process known as near misses. Team members scanned a QR code which linked to an online reporting system to capture details about the mistakes. Records showed that the last near misses were three recorded in August 2024. Team members showed that medicines previously identified as being involved in near misses had been separated on the shelves where they were kept. These included separating different strengths of prednisolone tablets from each other and separating different forms of metformin from each other. The pharmacist completed a monthly patient safety review to identify

trends in near misses, but the last one was completed in February 2024. The pharmacy had a process for recording errors identified after a person had received their medicines, known as dispensing incidents. The pharmacist manager confirmed that reporting of dispensing incidents was not always completed. Some analysis was completed for the pharmacy's most recent incident, such as who was involved in the dispensing and checking of the medicine, but no further learnings were identified which means that team members may miss opportunities to help prevent a similar mistake from occurring again.

The pharmacy had current professional indemnity insurance. And the PIP had separate indemnity insurance for their prescribing services. The pharmacy had a complaints procedure to follow which involved resolving complaints or concerns informally in the first instance. And escalating any that could not be resolved to the SI. The pharmacy received mostly verbal feedback from people accessing its services. And the pharmacist confirmed that following a complaint and feedback about delivering medicines with owed medication, they had changed their procedures to ensure people were delivered the medicine that was available, instead of waiting for the full supply. Team members described their roles and responsibilities. They knew what tasks could and could not be completed in the absence of the RP. The RP notice was prominently displayed in the retail area of the pharmacy and reflected the correct details of the RP. The RP record was mostly completed correctly, with occasional entries missing the time the RP ceased duty. The pharmacy recorded the receipt and supply of its CDs electronically, with some minor errors in the recording of the supplying wholesaler's address. Team members checked the physical stock levels matched those in the CD register running balance, when a supply was recorded. The pharmacy recorded details about CD medicines returned by people who no longer needed them at the point of receipt. And they were destroyed in the presence of two team members, one of whom was sometimes a registrant. The pharmacy retained certificates of conformity for unlicensed medicines known as "specials". And it captured the details of who the medicine was supplied to, to provide an audit trail. The pharmacy recorded the supply of medicines against private prescriptions and records showed these were completed correctly. And associated prescriptions were retained. The PIP documented the consultations they provided for both the NHS Pharmacy First Plus service and for private prescribing services. The consultation notes included a summary of findings and any medication that was prescribed. And they were shared with the person's GP surgery if consent was given.

Team members were aware of their responsibility to keep people's private information secure. A privacy notice was displayed in the retail area informing people of how their data was used. Team members separated confidential waste which was uplifted for secure destruction by a third-party company. They were also aware of their responsibility to safeguard vulnerable adults and children and knew signs to look out for. Team members, including the delivery drivers, would report any concerns to the pharmacist. The pharmacist gave an example of an intervention they had made regarding a vulnerable adult. The pharmacist manager had completed online training about safeguarding. And the RP on duty was registered with the protecting vulnerable groups (PVG) scheme. The pharmacy displayed a chaperone policy in its consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled and competent team members to deliver the services safely and manage the workload. Team members in training receive appropriate support to complete their training. And team members give suitable advice and assistance to support people with their healthcare needs.

Inspector's evidence

The RP at the time of the inspection was a regular locum pharmacist who had worked previously in the pharmacy. They were supported by a trainee pharmacist, an accuracy checking dispensing assistant (ACDA), and four dispensers, one of whom was recently employed. The pharmacist manager was a PIP and worked in the pharmacy full-time. Team members who were not present during the inspection included two dispensers, one of whom was a pharmacy student. And there were three delivery drivers. The trainee pharmacist was supported in their training by the pharmacist manager who acted as their tutor. And they received protected learning time each week. The PIP assessed their competency to prescribe, and this included peer discussions with other PIPs for services such as weight loss management. And they had completed additional training to provide services such as the ear wax removal service. Annual leave was managed by the pharmacist manager who ensured that there were sufficient team members to support periods of absence. And pharmacist absence was managed between the pharmacist manager and SI and locum pharmacists were used to support periods of absence.

Team members were observed working well together and were managing the workload. There was an open and honest culture amongst the team, and they were able to make suggestions for changes and supported each other with queries. They knew how to raise professional concerns and felt comfortable raising them with the RP or SI if necessary. The pharmacy gave performance reviews to its newer team members at the end of their probation period. And for other team members, in the moment feedback about performance was given by the pharmacist. The pharmacy did not set its team members targets.

Team members asked appropriate questions when selling medicines over the counter to help people with their healthcare needs. And they knew to be vigilant to repeated requests for medicine liable to misuse. Some team members felt comfortable to have supportive conversations with people directly and others referred to the RP to have the conversations and refer to the person’s GP where appropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and suitable for the services it provides. It has appropriate facilities for people requiring privacy when accessing services. The premises are generally tidy but there are some areas of clutter which may present a trip hazard to team members.

Inspector's evidence

The pharmacy comprised of a small retail area to the front of the premises and a dispensary behind. A room to the rear of the premises was used for the preparation of multi-compartment compliance packs. The room was spacious and housed a recently installed automated robot to assist with dispensing the packs. The medicines counter helped to act as a barrier and prevented unauthorised access to the dispensary. The dispensary had different bench spaces for the completion of different tasks. There was some clutter in the dispensary and boxes containing some completed prescriptions were stored on the floor which reduced the available floor space and could cause a trip hazard. The pharmacist's checking bench was situated centrally so they could supervise the dispensary and medicines counter accordingly. The dispensary had a sink with hot and cold water. And toilet facilities and a staffing area were clean and provided separate hand washing facilities. Lighting provided good visibility throughout and the temperature was comfortable.

The pharmacy's website had inaccurate links to a private hospital and clinic. The pharmacist manager explained the website was in the process of being updated by a new website provider. The pharmacy had two consultation rooms, with one in use. The consultation rooms had a desk and chairs for consultations to be completed comfortably. The main consultation room had a doctor's bed. Both consultation rooms had sinks for handwashing.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. And it makes them accessible to people. Team members complete checks on medicines to ensure they remain fit for supply. They generally provide people with the necessary information to take their medicines safely. And they respond appropriately to alerts about the safety of medicines.

Inspector's evidence

The pharmacy had level access from the street which allowed access to those with limited mobility and those using pushchairs. Team members ensured that they did not cover braille on manufacturer's packaging for those with visual difficulties. And they communicated using mobile phones with people who had difficulty communicating verbally.

Team members used baskets to keep people's prescriptions and medicines together and reduce the risk of errors. They used stickers to highlight the inclusion of a CD or fridge line on a prescription. And "speak to pharmacist" stickers were used to highlight that referral to the pharmacist was required when handing out the prescriptions. Team members signed dispensing labels to confirm who had dispensed and who had checked the prescriptions so there was an audit trail of those involved in each stage of the process. Team members were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicines safely. They supplied some people with their valproate outwith the manufacturer's original pack. They had completed risk assessments for these people and provided them with information cards. Team members informed people either verbally or with a note if they were unable to be supplied with the full quantity of medicines on their prescription. They reviewed owed medication twice daily. For any medicines that could not be supplied, team members gave people options such as sourcing the medicine from another pharmacy or referring them back to their GP.

The pharmacy provided a delivery service, taking medicines to people in their homes. Prescriptions to be delivered were scanned to an electronic device which tracked the prescription's progress whilst out on delivery. Information about the inclusion of a CD or fridge line was highlighted on the prescription bags for the drivers. For any failed deliveries, the drivers left a note of failed delivery and returned the medicine to the pharmacy. And they informed the pharmacist of any failed deliveries, so they were aware.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. The pharmacy had recently installed an automated machine to assemble these packs. And a trainer from the company supported team members in its use. With the new automated machine, people were provided with pictures printed on the packs of their medicines along with directions so they could be easily identified. The pharmacy did not generally provide people with patient information leaflets (PILs). The pharmacy sent people a PIL if they were issued with a new medication. A discussion was had about ensuring people had the necessary information to take their medicines. While the pharmacy team was learning how to use the new automated machine, the pharmacist confirmed that packs produced by the machine were double checked for accuracy. And they had decided to check a months' packs for each person.

The PIP provided a range of prescribing services, including the NHS Pharmacy First Plus service and private services including weight loss management. Team members were aware of the differences between NHS Pharmacy First and NHS Pharmacy First Plus and triaged people. The PIP had informed the local GP surgeries of the therapeutic conditions that they were able to prescribe for and how people could make an appointment. The PIP saw people face to face for their appointments. For the weight loss service, people filled in a form which was reviewed by the PIP at the face-to-face appointment with height and weight and medical history checked. When counselling people about their weight loss injections, the PIP ensured they knew the process for administration by injecting the first dose for the person. The PIP provided other services such as ear wax removal, administration of influenza vaccinations under private group direction (PGD) and taking blood samples from people and sending them to a known laboratory for analysis. There were medical conditions that made people ineligible to have their ears suctioned, such as a perforated ear drum. A questionnaire was completed before treatment and reviewed by the PIP to ensure treatment was suitable. And the PIP could liaise with audiologists and doctors at the healthcare company who provided the equipment for advice if necessary. The PIP had initial discussions with people as to why they wanted to have their bloods taken for analysis. And the blood results that could be analysed included a full blood count, diabetes health and thyroid health checks. The PIP discussed the results with the person and prescribed for acute conditions where indicated. They did not prescribe for any chronic conditions and referred the person to their GP. A summary of the results and any medication prescribed was shared with the person's GP.

The pharmacy stored medicines on shelves in the dispensary. Team members had a process for checking the expiry date of medicines. And records had been completed up to July 2024. Team members highlighted medicines that were going out of date for use first. And they marked liquid medicines with a shortened expiry date on opening with the date of opening. A random selection of medicines found none past their expiry date. Team members confirmed they checked the expiry dates when dispensing. The pharmacy had a fridge to store medicines that required cold storage. Team members recorded the temperatures daily, which a few omissions of records on Saturdays. Records showed the fridge was operating between the required two and eight degrees Celsius. The pharmacy received notifications about drug alerts and recalls via an online platform and email. They actioned drug alerts directly on the electronic platform and they were marked as actioned once complete.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to paper copies of the British National Formulary (BNF) and British National Formulary for children (BNFc). And it has access to electronic reference resources including medicines complete. The pharmacy had equipment used to provide the NHS Pharmacy First service. This included a blood pressure monitor which was replaced every six months, a manual otoscope and a video assisted otoscope used in the ear wax microsuction service, a pulse oximeter and sharps bins. The pharmacist cleaned the equipment with alcohol wipes. The pharmacy had an adrenaline pen for influenza vaccination services available in the consultation room which was in date. It had glass measuring cylinders which were marked to identify which were for liquid medicines and which were for water.

The pharmacy had portable telephones so that conversations could be taken in a private area. And it stored medicines awaiting collection in the dispensary in a way that ensured people's private information was secured. Confidential information was secured on computers and laptops using passwords. Computers were positioned within the dispensary so that only authorised people could see the information on the screens.

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.