General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Willis Pharmacy, 142 Duntocher Road, CLYDEBANK, Dumbartonshire, G81 3NQ

Pharmacy reference: 1041971

Type of pharmacy: Community

Date of inspection: 28/08/2020

Pharmacy context

During the Covid-19 pandemic the pharmacy is mainly dispensing NHS prescriptions and delivering medicines to people at home. It supplies some medicines in multi-compartment compliance packs. 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.

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 has working instructions to help manage the risks to its services. The pharmacy keeps records about dispensing mistakes that happen. And its team members learn and make improvements to keep services safe and effective. The pharmacy mostly keeps the records it needs to by law, and the pharmacy team keeps them up to date. Members of the team protect people's personal information. And they prevent people from seeing sensitive information they are not allowed to see. They know the importance of their role in protecting vulnerable people.

Inspector's evidence

The company issued guidance about the necessary new practices to protect against the Covid-19 virus. It also issued safety updates to keep its team members informed. The pharmacy had been carrying out risk assessments throughout the pandemic and its team members had introduced changes to manage the risk of virus transmission. Notices in the window provided public health information about the virus and how to protect against it. This included social distancing and the wearing of masks. The size of the waiting area was big enough to allow two people to keep two metres apart. Team members monitored the area to confirm only two people were there at the one time. A Perspex screen at the medicines counter created a barrier between the people visiting the pharmacy and the pharmacy team. The dispensary had hand sanitiser, and it was used on a regular basis by team members. They also checked their temperature each morning to ensure it was in the safe range. Appropriate face masks were worn as personal protective equipment (PPE) and they observed social distancing as far as possible throughout the day.

The pharmacy displayed the responsible pharmacist notice, and it showed the name and registration number of the pharmacist in charge. The pharmacy had been inspected in October 2019, and an action plan had been issued to make improvements. The action plan had been updated and improvements were seen. The pharmacy had purchased a new set of working instructions that defined the pharmacy processes and procedures. But there was no documented evidence to show they had been authorised for use or read by the team members. The pharmacist said they were working their way through it. Team members signed dispensing labels to show they had completed a dispensing task. This allowed the pharmacist to support individual team members to learn and improve their accuracy in dispensing. It also acted as an audit trail of who had been involved in the dispensing process. The pharmacy's team members had been recording near miss errors since the beginning of January 2020. But formal reviews of the errors had not been carried out. Team members had improved their understanding of the risks in the pharmacy, and this had allowed them to make some improvements. For example, they no longer attached address labels to dispensing baskets. This managed the risk of address labels attaching to the wrong basket and the wrong prescription bags and resulting in a dispensing error. Team members knew to handle complaints in a sensitive manner. The pharmacy did not use a complaint notice to tell people how to complain about the service they received if they needed to. This could prevent the pharmacy from receiving feedback or improving the services it provided. The team members followed the pharmacy’s complaints procedure and they knew to refer dispensing incidents to the pharmacist. The pharmacy kept some information about dispensing incidents, but they did not record full details of the investigation, such as the root cause and any changes that were made to prevent a similar incident in the future.

The pharmacy mostly maintained the records it needed to by law. But the pharmacist in charge had not been updating the responsible pharmacist record to show when they had finished for the day. This meant they couldn't always show when they stopped being in charge of the pharmacy. Public liability and professional indemnity insurances were in place, and valid until 31 January 2021. The pharmacy recorded private prescriptions and records met legal requirements. Specials records were kept up to date with details of each person who had received a supply. The pharmacy displayed information about its data protection arrangements. And people were reassured about how the pharmacy safeguarded personal information according to the Data Protection regulations. The pharmacy kept personal information such as people's names and addresses well away from the waiting area, and they used a shredder to dispose of confidential information. The pharmacists had registered with the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The company provided a ‘safeguarding vulnerable adults and children’ policy. This included contact details for the relevant Scottish agencies. Team members knew to refer serious concerns to the pharmacist so they could investigate and take the necessary action if necessary. For example, speaking to the ‘community addictions team’ (CAT) when people did not arrive for medication that was due. The pharmacy displayed a notice about a ‘Safe Space’ initiative. This informed people that it supported individuals that were experiencing domestic abuse.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the required skills and knowledge for their roles and the services they provide. The pharmacy supports its trainees in developing their knowledge and skills. And it provides them with protected learning time in the workplace to complete their training. The pharmacist updates the pharmacy team about changes to pharmacy services when they arise. But the pharmacy does not provide formal ongoing training so that individual team members continue to develop in their roles. Team members support each other in their day-to-day work. They are enthusiastic and knowledgeable, and they suggest improvements to make services safer and more effective.

Inspector's evidence

The pharmacy's workload had increased by around 20% since the start of the pandemic. The superintendent had authorised the pharmacist to recruit another dispenser. And a new full-time dispenser had recently taken up post to meet the increased demand for services. A new pharmacist manager had taken up post in January 2020. They had made significant changes to the way the pharmacy operated, such as introducing rotas for team members to follow and ensuring their knowledge and skills were up-to-date. This had resulted in efficiency gains and had freed-up extra time for other duties. It also meant that team members could easily cover for each other in the event of unexpected absence. The pharmacist was supporting a trainee pharmacy technician to develop their knowledge and skills. This included providing protected learning time in the workplace. The following team members were in post; one full-time pharmacist, four full-time dispensers, one full-time trainee medicines counter assistants (MCAs) and two full-time delivery drivers. An accuracy checking technician (ACT) from another branch provided extra cover when the pharmacy was busy. And the area pharmacist manager and other pharmacists provided extra support at peak times of the day.

The pharmacy did not use formal performance reviews to develop its team members. And it did not provide formal ongoing training for team members to continue to develop in their roles. The pharmacist updated the team members whenever there were changes or new initiatives. This ensured the pharmacy team members were competent to deliver the pharmacy services. For example, the pharmacist updated the team members about the 'specials' process when they identified knowledge gaps. This ensured they followed the correct procedure. Team members had also spent time learning about new safety measures to protect against Covid-19. The company did not use numerical targets to grow the services it provided. Team members promoted the services that would benefit people. For example, the new 'NHS Pharmacy First' service. The pharmacy's team members felt empowered to raise concerns and provide suggestions for improvement. For example, the medicines counter assistant had reviewed the new NHS Pharmacy First approved list of products that could be supplied to people using the service. They created a separate area to keep the products together, so they could be easily accessed and replenished when needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and has appropriate infection control arrangements in place. It has consultation facilities to meet the needs of the services it provides, and people can speak with team members in private.

Inspector's evidence

The pharmacy displays safety information in the window to help protect people from Covid-19. The pharmacist had reviewed the pharmacy's cleaning arrangements at the start of the pandemic. They had implemented a new cleaning regime with team members cleaning the dispensing benches and door handles twice a day. A Perspex screen at the medicines counter created a barrier between the team members and people visiting the pharmacy. A bottle of sanitiser was available at the medicines counter for people to use, and team members used it throughout the day. They also wore appropriate face masks as personal protective equipment (PPE). The team members had created four separate workstations in each corner of the dispensary. This helped them to observe social distancing and to keep as far apart from each other as often as they could. The benches were organised and clutter-free. The pharmacist used a separate bench to carryout checking activities. The location of the bench also allowed them to supervise the medicines counter and intervene if they needed to. The pharmacy was well-lit, and the ambient temperature provided a suitable environment from which to provide services.

The consultation room was out of use due to the pandemic. The pharmacist described the pharmacy's new arrangements to people when they wanted to speak to them in private. Some people agreed to speak to the pharmacist when they were the only person in the waiting area at the time. Others preferred to leave the pharmacy and call the pharmacist from a private place of their choice. This ensured people's privacy and dignity was respected and protected. The pharmacist had undergone training to provide the seasonal flu vaccination. The consultation room was congested with excess stock, and team members were about to clear it of excess stock. This would ensure it presented a professional environment for people to be seen in. The pharmacist was mindful of the need for social distancing. And they were able to leave one of the consultation room doors open and step back into the dispensary to create a two metre distance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy mostly stores and manages its medicines appropriately. And the team members act on safety notices and remove faulty medicines from use. They know the importance of making additional checks with people about their high-risk medicines. And when to speak with people about their medicines to help keep them safe. The pharmacy has satisfactory working instructions for most of its services. But it did not provide instructions for multi-compartment compliance packs. This would support its team members and help to ensure the process was safe and effective.

Inspector's evidence

The pharmacy had step-free access to the waiting area. It displayed public health notices to help protect people from the coronavirus. But it didn't provide information about the pharmacy services it provided or its opening times. Two pharmacy drivers delivered prescriptions to people at home. This helped them to stay at home and protect against the virus. The drivers knew to place prescriptions on the doorstep and to keep a safe two metre distance away until the person took receipt of them. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. They had printed the PGDs and kept them in a folder for ease of access. The pharmacy team members knew about 'high-risk' medicines. They knew to look for information stickers on prescriptions bags and to act accordingly. For example, a 'pharmacist' sticker meant calling on the pharmacist to provide extra advice, such as showing people how to use their inhalers correctly. A 'fridge' sticker meant they had to retrieve extra items from the fridge. The team members also knew about the valproate pregnancy protection programme and to issue information leaflets and cards to keep people informed and keep them safe.

Team members used dispensing baskets, and they kept prescriptions and medicines contained throughout the dispensing process. The pharmacy supplied multi-compartment compliance packs to around 370 people. There had been no increase since the last inspection, and a Synmed robot at the company's hub pharmacy continued to dispense the packs as it had done before. The new pharmacist had carried out a risk assessment of the dispensing procedures when they started working in the pharmacy in January 2020. And they had introduced a new rota so that all team members were trained and competent to process the prescriptions before they were sent to the hub for dispensing. They also introduced new trackers and supplementary records to support the dispensing process, so it was safe and effective. The pharmacist clinically checked and endorsed the prescriptions before they were sent to the hub for dispensing. This authorised an accuracy checking technician at the hub to carry out a final accuracy check before returning the completed packs to the pharmacy. The team members checked the packs when the hub returned them. They knew to add medication when they saw labels attached to the front of the packs. This included alendronic acid and controlled drugs. The completed packs were immediately placed on shelves in a separate storage area. Regular prescription changes meant that packs needed to be changed after dispensing. The team members kept a diary of changes and used a section of a rear bench for the packs that needed to be changed. The pharmacy included photographs of the medicines on the backing sheets to identify the medicines inside. They did not supply patient information leaflets. This could mean that people don't have all the information they need to take their medicines safely. The pharmacy had not defined the dispensing process in a working instruction for the team members to follow. This could mean they were not dispensing packs in the safest way available to

them.

The pharmacy purchased medicines and medical devices from recognised suppliers. Team members carried out regular stock management activities. They highlighted short-dated stock and split packs during six-monthly checks. This helped them to supply medication that was within its expiry date, and to manage the risk of quantity errors. Several packs were checked at the time of the inspection and all were found to be safely within their expiry date. Both medicine fridges had an integrated thermometer for the team members to carry out temperature checks. On the day of the inspection the fridge temperatures were within the safe range between 2 and 8 degrees Celsius and the boxes were cold. But the team members could not produce fridge monitoring records. And they could not show that the temperature had remained with 2 and 8 degrees since the last inspection. The pharmacy did not have enough storage space in the main pharmacy. And the team members were using a unit next door for excess stock and to store multi-compartment compliance packs awaiting collection or delivery. The superintendent had not registered the unit with the GPhC, and the premises registration record was not up to date.

Team members knew about the Falsified Medicines Directive (FMD). But the company had not provided the necessary resources to implement the system. The company emailed drug alert and recall notifications for the branches to action. The pharmacist was able to show they had received and actioned drug alerts. But they were unable to show an audit trail for an alert for digoxin that the MHRA had issued in August 2020.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. It keeps its equipment clean and well-maintained. And it takes sensible precautions to help people use its facilities safely.

Inspector's evidence

The pharmacy kept cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes and the team members kept the measuring equipment clean and ready to use. Measures with elastic bands attached indicated they were only to be used for methadone. Team members wore face masks throughout the day, and they washed and sanitised their hands on a regular basis. The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members kept computer screens out of sight of people in the waiting area. They used a portable phone to speak to people in private.

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.