General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gordons Chemists, 16 Douglas Street, MILNGAVIE, Dumbartonshire, G62 6PB

Pharmacy reference: 1041993

Type of pharmacy: Community

Date of inspection: 10/03/2020

Pharmacy context

The pharmacy is in a shopping precinct in the centre of Milngavie. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It offers a repeat prescription collection service and a medicines delivery service. And it provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and the use of medicines. And supplies a range of over-the-counter medicines. It also offers a smoking cessation service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.2	Standard not met	The pharmacy does not have a system in place to learn from things that go wrong. It does not support the pharmacy team to record errors. And it does not support them to learn from their mistakes. This means that it does not routinely assess the safety and quality of services provided.
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 not all met	4.3	Standard not met	The safety of medicines and medical devices is compromised by inadequate management arrangements.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy uses working instructions to help it provide safe services. And the pharmacy team members discuss mistakes that happen when dispensing. But as they don't record the details it is difficult for the team to identify patterns in the mistakes. So, they may miss opportunities to improve and reduce the risk of further errors. People using the pharmacy can raise concerns. But the pharmacy does not tell people how they can complain about the services they receive. And this means it may not be able to put things right when it needs to. The pharmacy does not always keep the records it needs to. And the responsible pharmacist record does not always show the identity of the pharmacist in charge each day. The pharmacy trains the team members to keep confidential information safe. It understands its role in protecting vulnerable people. And team members know to refer concerns to the pharmacist for immediate action.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. And the team members had read and signed the documents to keep services safe and effective. The pharmacist displayed the responsible pharmacist notice. And people in the waiting area could identify the pharmacist in charge. The pharmacy used dispensing labels which included boxes for the team members to sign when they had dispensed or checked a prescription. But on sampling several labels it was found that the practice was not fully embedded with some audit trails incomplete. And this created a barrier to learning from mistakes. The pharmacist provided individual feedback about near-misses when they were able to. And this helped them to manage the risk of the same errors happening again in the future. The pharmacy produced a document for near-misses. But the team members had only recorded two near-miss errors in 2019 and none in 2020. And they had not improved the practice of recording near-misses since their last inspection in September 2019. This prevented the team members from effectively learning about their weaknesses and taking the necessary action to manage them.

The regular pharmacist was off-duty at the time of the inspection. And a locum pharmacist was providing cover. The pharmacist was responsible for managing the incident reporting process. And the team members could not recall any incidents happening since the last inspection. The team members knew to apologise for any upset. And they knew to refer to the pharmacist who spoke to the person making the complaint. The company provided a complaints policy to help the team members handle complaints in a consistent manner. But it did not provide information to help people to complain if they needed to. The pharmacy encouraged people to provide feedback about the services they received. And this had been mostly positive with no suggestions for improvement. The pharmacy was aware of the number of people wishing to wait on their prescriptions being dispensed. And the dispensers knew to prioritise these prescriptions and provide assistance at the medicines counter when queues formed.

The pharmacist had not kept the responsible pharmacist record up to date. And they had not recorded information between 18 February to 10 March 2020. The pharmacy had public liability and professional indemnity insurance in place. And it was valid until 30 September 2020. The pharmacy team members kept the controlled drug registers up to date. And they carried out monthly balance checks to confirm that the actual stock matched the registered stock. The pharmacy team recorded controlled drugs that

people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. And a sample showed that the NHS Greater Glasgow & Clyde Seasonal Influenza vaccination PGD was valid until August 2020.

The pharmacy did not display a notice to inform people about its data protection arrangements. And it did not inform people about how it kept their personal information safe. The pharmacy had trained the team members about data protection procedures since its last inspection. And this was due to them disposing of confidential waste along-side the general waste. The pharmacy used working instructions to train the team members. But this was different to the process they followed in practice. The pharmacy had trained the team members to shred confidential waste. And to sign to confirm they had done so. But the procedure instructed them to place the waste in a sealed box to be collected for off-site shredding. The dispensary had restricted space due to the increased demand for dispensing services. And the team members had recently started using two upstairs areas for excess stock and labelled multi-compartment compliance packs awaiting collection or delivery. But the rooms were unlocked at the time of the inspection due to problems operating the keypads. And there was a risk of unrestricted access by people waiting to see the on-site chiropodist. The team members followed the advice of the inspector and locked the rooms at the time of the inspection.

The pharmacy used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The pharmacy team members knew to refer concerns to the pharmacist. And they knew where to find the child protection flow-chart with contact details of the local agencies. The team members knew to monitor supplies of multi-compartment compliance packs. And they identified people who had not collected their packs on time or people who were not at home when they expected them to be. The team members spoke to the pharmacist when they had concerns. And they contacted carers or the surgery to make further enquiries when needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete ad-hoc training. And, they learn from the pharmacist to keep their knowledge and skills up to date. The pharmacist encourages the team members to learn. And they provide protected learning time so that trainees are supported. The pharmacy team members support each other in their day-to-day work. And they can speak up and make suggestions to improve how they work.

Inspector's evidence

The pharmacy's workload had almost doubled in two years. But not in the last six months since its last inspection. The company had recently appointed a new area manager to support its branches. And they had authorised the pharmacy to recruit a new team member to ensure the pharmacy continued to have the capacity and capability to manage the extra demand. The new team member was working on the medicines counter. And the rest of the pharmacy team was supporting them. The pharmacy team members were well-established. And they were experienced and knowledgeable in their roles and responsibilities. The following team members were in post: one full-time pharmacist, one part-time pharmacist providing double cover on a Wednesday, three full-time trainee dispensers, one part-time trainee dispenser, one full-time medicines counter assistant and two pharmacy student working on a Saturday. The pharmacy managed annual leave requests. And it maintained minimum levels by authorising only one team member to be off at the same time. The team members covered for each other. And they prioritised tasks to reduce the work-load.

The company did not provide structured training. But it cascaded briefings to the pharmacist and the team members. The pharmacist spoke to the team members to keep them up-to-date and current in their roles and responsibilities. For example, they had discussed the valproate pregnancy protection programme, the Falsified Medicines Directive (FMD), data protection and the COVID-19 virus. The pharmacist had also recently discussed changes to the minor ailments scheme. The new team member had been in post for three days. And they were able to describe the correct process to follow when people asked to buy codeine containing products.

The company used an annual appraisal to identify development needs. For example, one of the trainee dispensers was being encouraged to complete the course the company had enrolled them on. And to speak to the pharmacist if they needed more support. The pharmacist supported team members in training. And they allocated each of the trainee dispensers with protected learning time in the work-place every Wednesday when a second pharmacist was present.

The company did not use performance targets to grow the services it provided. And the team members did not feel undue pressure when carrying out tasks. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, one of the dispensers had suggested dispensing weekly prescriptions in advance instead of when they were due. The team members had also created a separate storage area. And they kept them in day order, so they were easier to find.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy has a consultation room. But it used the room for additional storage. And this meant it did not present a professional appearance for people to speak to the team members. The consultation room was used for privacy. And people could have conversations with pharmacy team members in private.

Inspector's evidence

A large well-kept waiting area presented a professional image to the public. And it provided seating and some patient information leaflets for self-selection. The dispensary provided restricted space for dispensing due to the workload increases. But the team members managed their workload to make the most of the space they had. For example, they dispensed multi-compartment compliance packs once they finished dispensing the other prescriptions.

The pharmacist supervised the medicines counter from the checking bench. And they could make interventions when necessary. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy had a consultation room. And it provided a private area for people to speak to the team members. But it used the room for additional storage. And it did not present a professional appearance in keeping with a health care premises.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy obtains its medicines from reputable sources. But a lack of audit arrangements mean it is unable to provide assurance that medicines are stored according to the manufacturer's instructions. The pharmacy stores controlled drugs in a poorly-lit area. And this makes it difficult for the team members to identify and select the correct medicines. The pharmacy has working instructions in place for most of its services. And this supports the pharmacy team to work in a safe and effective way. But it had not defined multi-compartment compliance pack dispensing. And the team members did not have a working instruction to refer to. The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know what services are available to them.

Inspector's evidence

The pharmacy had step-free access. And it displayed its opening hours in the window. The pharmacy displayed the NHS recommended public information about COVID-19 at the entrance to the pharmacy. And the pharmacist kept themselves up to date with the government's information about the spread of the virus. The pharmacist spoke to people about their medicines. And they marked prescription bags with 'see the pharmacist' instructions for those on high risk medication. The pharmacy employed a podiatrist who provided services in a dedicated room separate to the main pharmacy. And professional indemnity insurance arrangements were checked by the superintendent's office.

The pharmacy team members used dispensing baskets. And they kept prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 200 people. But the pharmacy had not developed or implemented a working instruction to support the pharmacy team. The pharmacist carried out clinical checks. And then passed the prescriptions to the pharmacy team for dispensing. The team members isolated packs when people's prescription needs had changed/were changing. For example, when they went into hospital. The team members used supplementary records to support the dispensing process. And they updated them following prescription changes with accuracy checks undertaken by the pharmacist to ensure they transcribed the correct information. The team members sometimes kept a signature audit trail to show who had dispensed, and who had checked the packs. The team members supplied patient information leaflets. And they provided descriptions of medicines to support people to take their medicines correctly. The pharmacy provided a delivery service to housebound and vulnerable people. And the delivery driver obtained signatures to confirm that people had received their medication. The team members supplied substance misuse services to one person. And they dispensed their doses in advance and secured them in the controlled drugs cabinet until needed.

The pharmacy purchased medicines and medical devices from recognised suppliers. And the team members carried out regular stock checks. The team members checked for short-dated stock. And sampling showed that stock was in date. But the last time they had documented date-checking was in April 2019. The last recorded fridge temperature check had been documented on 15 February 2020. With an actual reading of 4.2 degrees Celsius. And a maximum of 6.1 and a minimum of 2.8. The fridge temperature on the day of the inspection was 1 degree Celsius. But the pharmacy was unable to

provide the necessary assurance that medicines were being kept in accordance with the manufacturer's instructions. The team members kept controlled drugs in a cabinet in the hall next to the dispensary. The light in the hallway was not working. And it was difficult to identify stock which increased the risk of selection errors.

The team members acted on drug alerts and recalls. And they responded to head office requests to confirm they had checked for affected stock and what the outcome had been. For example, in February 2020 they had acted on an alert concerning ranitidine tablets. And they removed stock and returned it to head office. The pharmacist had briefed the team members about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards and when to issue them. The pharmacist monitored prescriptions for valproate. And they spoke to people that could be affected to confirm they knew about the risks. The team members knew about the Falsified Medicines Directive (FMD) and what it aimed to achieve. And the company had provided scanners to use in their day-to-day processes when they received packs with 2D data barcodes and anti-tamper devices. But the team members had not introduced the system. And they did not know when the system was due to be implemented.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

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. And the measure for controlled drug liquids was highlighted, so it was used exclusively for this purpose. The pharmacy kept cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes.

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. The pharmacy team members had access to a portable phone. And they were able to take calls in private when necessary.

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.