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: 07/09/2020

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 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

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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 updates its working instructions to keep its processes and procedures safe and effective. The pharmacy's team members sign the instructions to show they follow safe systems of work. They record and discuss their dispensing mistakes and then review the information to learn from them and manage risks. The pharmacy satisfactorily protects people's personal information and prevents sensitive information being seen by people who are not allowed to do so. Team members know the importance of their role in protecting vulnerable people. They also keep their legal records up to date.

Inspector's evidence

The company had been issuing regular safety updates since the start of the Covid-19 pandemic. The updates supported its team members in introducing new working practices. An area manager had been providing team members with support to keep them safe. This included confirming they had been wearing appropriate face masks as personal protective equipment (PPE). It also included carrying out a risk assessment to identify team members that were disproportionately affected by the coronavirus. One team member had been shielding since the start of the pandemic and had only recently returned to work. A Perspex screen at the medicines counter created a barrier between team members and people visiting the pharmacy. Arrows on the waiting-room floor directed people around a one-way queuing system to keep them apart. Notices in the window instructed people to keep moving and to keep browsing to a minimum so the queue kept moving. Posters in the window provided public health information about virus transmission and how to protect against it. This included social distancing and the wearing of masks. Hand sanitiser was available at the entrance to the pharmacy and at various locations in the dispensary. Team members used it on a regular basis as well as washing their hands.

The pharmacy had been inspected in March 2020, and an action plan had been issued to make improvements. The action plan had been updated and improvements were seen. The company kept its working instructions up to date, and team members had read and signed them. This ensured their learning was up to date, and that services were safe and effective. The pharmacy displayed the responsible pharmacist notice. It showed the name and registration number of the pharmacist in charge. The pharmacist in charge also kept the responsible pharmacist record up to date. Team members mostly signed dispensing labels to show they had completed a dispensing task. This helped the pharmacist support individual team members to improve their accuracy and manage dispensing risks. It also acted as an audit trail of who had been involved in the dispensing process. Team members had been keeping records of their near miss errors throughout the pandemic. They had an awareness of the risks in the pharmacy, and had separated products to manage selection errors. For example, shelf-edge warning labels had been attached to highlight mix-ups with levothyroxine and losartan. The pharmacist managed the incident reporting process, and they used the company's standardised report form to document the root cause and the improvement action taken. The pharmacy had introduced a complaints leaflet since the last inspection, but it was not on display for people to see or to select from themselves. Team members knew to handle complaints in a sensitive manner, and they referred dispensing incidents to the pharmacist for them to investigate and correct.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurances in place, and they were valid until 30 September 2020. Team members recorded

private prescriptions and those records met legal requirements. Specials records were kept up to date with details of each person who had received a supply. The company trained its team members to protect confidential information, and it displayed information about its data protection arrangements in the window. This provided people with the assurance that their information was safe and secure. Team members kept prescriptions for collection well-away from the waiting area so that people's names and addresses could not be read by others. They used a shredder to safely dispose of confidential information. The pharmacists registered with the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The company did not formally train its team members to identify vulnerable adults and children. But they knew to refer concerns to the pharmacist so they could take the necessary actions to protect people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are qualified for their roles and the services they provide. The pharmacy supports its trainees in developing their skills. It also provides them with some protected learning time in the workplace to complete training courses. The pharmacy updates the team members about changes to pharmacy services when they arise. But it doesn't provide structured training so that team members continue to develop in their roles after they qualify. Team members support each other in their day-to-day work. They are enthusiastic and knowledgeable in their roles, and they suggest improvements to make services more effective.

Inspector's evidence

The pharmacy's workload had increased at the start of the Covid-19 pandemic, but it had since returned to its previous level. The pharmacy's team members had remained the same since the last inspection. Some had completed the pharmacy training courses they were on, and had achieved the necessary qualifications. The pharmacist provided protected learning time in the workplace to support trainees. This ensured they made satisfactory progress with their training courses. One of the trainees had been encouraged to enrol on further training. They had recently registered with pharmacy technician training after completing their dispensing course. The pharmacist usually carried out individual performance reviews once a year to ensure all the team members were competent for the services they provided. But the reviews had been delayed due to the pandemic.

The pharmacy did not provide ongoing structured training for all team members to continue to develop in their roles. They had learned about the new arrangements that were needed to manage the risk of virus transmission. They had also learned about the new 'NHS Pharmacy First' service that had launched at the end of July 2020. The pharmacy's team members felt empowered to raise concerns and to provide suggestions for improvement. For example, the trainee pharmacy technician had been manually checking stock levels due to delayed wholesaler deliveries. This ensured they had sufficient stock levels for the prescriptions they dispensed.

The pharmacist kept copies of qualifications and training certificates on-site. The following team members were in post; one full-time pharmacist, one part-time pharmacist providing double cover every Wednesday , one full-time trainee pharmacy technician, two full-time trainee dispensers, one part-time trainee dispenser, one full-time medicines counter assistant, one part-time trainee medicines counter assistant and one pharmacy student who worked on a Saturday. The pharmacy student was working at the time of the inspection to provide extra cover for someone who was on leave.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and hygienic and has suitable infection control arrangements in place. It has appropriate consultation facilities to meet the needs of the services it provides so that people can speak in private.

Inspector's evidence

The pharmacy displays service information in the window and keeps people up to date with changes. It provides public health information and safety information to help protect people from Covid-19. 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 return home or to their cars and speak to the pharmacist on the phone. This ensured people's privacy and dignity was respected and protected. The pharmacist supervised the medicines counter from the checking bench. This meant they could make interventions when necessary. The pharmacy had effective lighting, and the ambient temperature provided a suitable environment from which to provide its services. A cleaning rota had been introduced to ensure that work surfaces and public areas were cleaned on a regular basis.

The pharmacy's team members were unable to maintain a two-metre distance from each other throughout the day. And they had organised the dispensary to help them maintain as safe a distance as possible. This included placing markers on the floor at each of the workstations. There was restricted space within the dispensary, and two upstairs rooms provided extra storage space. Multi-compartment compliance packs were assembled on a rear bench in the main dispensary once all the other prescriptions had been dispensed. This reduced the risk of the benches becoming congested. Once checked by the pharmacist the packs were placed in an upstairs stock room for safe storage. The team members always kept the room locked.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy stores and manages its medicines appropriately. And its team members act appropriately on receipt of 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 them about their medicines to help keep them safe. The pharmacy has satisfactory working instructions for team members to follow which helps them to deliver services in a safe and effective way.

Inspector's evidence

The pharmacy had step-free access and it provided unrestricted access for people with mobility difficulties. It displayed information in the window about the services it provided, and it promoted public health information to help protect people from the coronavirus. The pharmacy employed a podiatrist who had recently re-introduced their services in line with government requirements. They used a dedicated upstairs room away from the pharmacy. It was at the opposite end of the corridor where two pharmacy stock rooms were located. People arrived just in time for their appointment and the pharmacy's team members showed them to the room upstairs. They ensured the person wore a mask and used hand sanitiser and maintained social distancing at all times. The podiatrist cleaned the room between appointments. They also had professional indemnity insurance arrangements in place. These were regularly checked by the superintendent's office to ensure they were renewed and up to date. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. They were familiar with the PGDs they used on a regular basis and did not keep hard copies of them in the pharmacy. NHS Greater Glasgow and Clyde kept PGDs on its website, and the pharmacist referred to them when they needed to check for information.

The pharmacy provided a delivery service and the driver knew to keep a safe two metres distance away from people. They placed items at the person's door until they were taken inside and kept an audit trail of the deliveries they made. Team members knew about 'high-risk' medicines. They knew to check prescription bags for messages or extra information and to act accordingly. For example, to add fridge items, and to call on the pharmacist to counsel people and to support them to take their medicines correctly. Team members knew about the valproate pregnancy protection programme. They knew where to find the safety leaflets and cards and when to issue them to people. The pharmacy's team members used dispensing baskets. They used these to keep prescriptions and medicines safely contained throughout the dispensing process.

Multi-compartment compliance pack dispensing was provided for around 200 people. The level of dispensing had stayed the same since the last inspection. The pharmacist had introduced working instructions since the last inspection. This helped team members to assemble and dispense the packs safely and effectively. The instructions had been read and signed by team members to show they would follow the safe practices. Team members dispensed packs on a four-weekly cycle. They used supplementary records to keep track of when packs were due, and these were kept in four folders that corresponded to each week of the cycle. Team members updated the records following prescription changes. This kept a robust audit trail of changes should it be needed. They did not always record their signature to show who had dispensed and checked the packs. This created a barrier to learning and improvement action so that errors could be prevented in the future. Team members provided

descriptions of medicines on the labels. This supported the person or their carer to identify the medicines inside. They supplied patient information with the packs. This helped people to take their medicines safely.

The pharmacy purchased medicines and medical devices from recognised suppliers. Team members carried out regular stock management activities and highlighted short-dated stock and split packs during regular checks. A new medicines fridge had been installed since the last inspection. Team members carried out temperature checks every day. Records showed that the temperatures had remained in the safe range of between 2 and 8 degrees Celsius. Medicines had been kept according to the manufacturer's storage instructions. Team members acted on drug alerts and recalls. They recorded the date they checked for affected stock and what the outcome had been. For example, they had checked for Oxylan tablets in August 2020 with no affected stock found. Team members knew about the Falsified Medicines Directive (FMD). But the company had not provided the necessary resources to implement the system.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

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 methadone was highlighted, so it was used exclusively for this purpose. The pharmacy kept cleaning materials for hard surface and equipment cleaning. Members of the team kept the pharmacy sink clean and suitable for dispensing purposes. They kept computer screens out of sight of people in the waiting area and used a portable phone to keep personal conversations private. Team members wore face masks throughout the day, and they washed and sanitised their hands on a regular basis.

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.