General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Westwood Square Pharmacy, 16 Westwood Square, EAST KILBRIDE, Lanarkshire, G75 8JQ

Pharmacy reference: 1042251

Type of pharmacy: Community

Date of inspection: 09/09/2020

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 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's team members sometimes record and discuss their dispensing mistakes. They 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. The pharmacy does not show that it adequately reviews its working instructions and keeps them up to date. And it is unable to adequately show that its processes and procedures are as safe and effective as they need to be. The pharmacy's team members do not always sign the working instructions, and they can't show they follow safe systems of work.

Inspector's evidence

The superintendent pharmacist had been carrying out risk assessments since the start of the pandemic. They had identified the need to introduce social distancing measures in the pharmacy. And to provide personal protective equipment (PPE) for their team members. They had not documented the outcomes from the risk assessments, but they had spoken to their team members about any new arrangements that were needed. A few notices in the window instructed people to keep two metres apart and to use the hand sanitiser that was freely available at the front of the pharmacy. But the pharmacy was not displaying the government’s public health information in the window about the coronavirus and what to do if they were experiencing symptoms. Hand sanitiser was also available in the dispensary for team members to use. They used it on a regular basis as well as washing their hands. A small Perspex screen at the till-point created a barrier between team members and people visiting the pharmacy. Most of the people visiting the pharmacy wore face masks. But there was no barrier or other measures in place at the medicines counter to maintain the safe two metre distance at all times. The medicines counter assistant and a trainee dispenser were wearing masks at the time of the inspection. But the superintendent pharmacist and a locum dispenser were not and said they donned a face mask before speaking to people at the medicines counter. They both donned a face mask when asked to by the inspector and kept them on for the duration of the inspection. The inspector provided advice on the need to follow the government’s requirements to keep a safe two metres apart, and the wearing of PPE to reduce the risk of spreading the coronavirus infection.

The pharmacy had been inspected in December 2019, and an action plan had been issued to make improvements. The action plan had been updated and some improvements were seen. The superintendent pharmacist said they had reviewed the working instructions, but they had not updated the documents to show the date they completed the review. Team members had been instructed to re-read and sign the instructions, but the ‘assembly and dispensing’ document and others did not show the names of the pharmacy's team members. 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 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 some records of their near miss errors before the pandemic. But they had been unable to maintain records during the pandemic itself due to the increased workload. They had started keeping records again in May 2020,

but they had stopped doing so at the start of June 2020. Team members had some awareness of the risks in the pharmacy and they had separated products to manage selection errors. For example, attaching shelf-edge warning labels to shelves to highlight mix-ups with procyclidine and prochlorperazine. The pharmacist managed the incident reporting process. They used a standardised report form to record incidents. But they did not always show the root cause and the improvement action they had taken. This meant they were unable to show they had acted to avoid a similar incident in the future. The pharmacy had introduced a complaint notice since the last inspection, and people knew who to contact if they wished to complain. Team members followed the pharmacy's complaints policy. They knew to handle complaints in a sensitive manner and refer 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 1 July 2021. 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 at the medicines counter. 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 superintendent pharmacist checked that locum pharmacists were 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 suitably qualified for their roles and the services they provide. The pharmacy supports its trainees in developing their skills. It also provides them with regular 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 to help 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 by around 30% since the start of the Covid-19 pandemic. The number of team members had remained the same since the last inspection. But a part-time trainee dispenser had increased their hours to help manage the increased workload. A locum dispenser had been providing full-time cover for someone who was on long-term leave. And a new part-time assistant had been recently appointed and was within the three-month induction period. The superintendent pharmacist had planned to enrol the new team member onto the combined counter assistant and dispenser’s course. This would provide flexibility to cover the medicines counter and to help dispense multi-compartment compliance packs. The pharmacist provided some protected learning time in the workplace to support trainees. This ensured they made satisfactory progress with their training courses. The pharmacist kept copies of qualifications and training certificates on-site. The following team members were in post; one full-time superintendent pharmacist, one full-time locum dispenser, one part-time trainee dispenser, one full-time medicines counter assistant, two part-time trainee medicines counter assistants and one part-time driver.

The pharmacy did not carry out performance reviews or provide ongoing structured training for all team members to continue to develop in their roles. They had learned about the new arrangements to manage the risk of virus transmission. They had also learned about the new 'NHS Pharmacy First' service that had been launched at the end of July 2020. The trainee dispenser had learned that nicorandil tablets were not suitable for multi-compartment compliance packs. And they knew to dispense the medication in its original foil packaging. The pharmacy's team members felt empowered to raise concerns and to provide suggestions for improvement. For example, one of the team members had started highlighting similar medicines on the supplementary records sheets they used when dispensing multi-compartment compliance packs. This included venlafaxine tablets and capsules that they dispensed for the same person. The superintendent had delegated responsibility to the locum dispenser to manage multi-compartment compliance pack dispensing. This ensured new prescriptions were ordered on time, and packs were dispensed a week in advance.

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 some public health information to help protect people from Covid-19. But it did not display the government's public health information about coronavirus symptoms and what to do if they were experiencing them. The consultation room was mostly out of use due to the pandemic. But the superintendent pharmacist had measured a few people's blood pressure when asked to do so. For example, before supplying oral contraception. The superintendent pharmacist had kept contact to a minimum and they had observed social distancing the rest of the time. The pharmacist described the pharmacy's new consultation arrangements to people when they wanted to speak in private. And they had agreed to speak to the pharmacist at a recessed area of the pharmacy that was well-away from the waiting area. This ensured people's privacy and dignity was respected and protected and they were able to keep two metres apart.

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. The superintendent pharmacist cleaned the dispensing benches with disinfectant every day. And the dispensers ensured they cleaned the door handles on a regular basis. The pharmacy's team members were unable to maintain a one-metre distance from each other throughout the day. There was restricted space within the dispensary, and a storeroom off to the side of the dispensary had been organised to provide a dedicated area for multi-compartment compliance pack dispensing. This provided a workstation for one of the team members to work in on their own for part of the day. It also reduced the risk of the benches in the dispensary becoming congested.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's team members 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 cannot show it keeps its working instructions up to date for the team members to follow. This means they may not be providing the pharmacy's services in the most safe and effective way. The pharmacy stores and manages its medicines appropriately. But it cannot show it receives all safety notices about faulty medicines so it can quickly remove them from use.

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 provided some public health information to help protect people from the coronavirus. The pharmacy had restricted the number of people in the pharmacy at the start of the pandemic to one at a time. But it had relaxed this measure as lock-down restrictions had eased. And people visiting the pharmacy queued outside if there were more than two or three people in the waiting area at the one time. The superintendent pharmacist 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 Lanarkshire 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 metre distance away from people. They placed items at the person's door until they were taken inside, and they 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 support them in taking 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 superintendent had counselled people about the risks of taking valproate. But they had not kept records of the discussions or checks. This meant it could be more difficult for the pharmacy to respond to a query relating to the supply of high-risk medicines should they be asked. Multi-compartment compliance pack dispensing was provided to 95 people. This was an increase of around 20 people since the last inspection. The superintendent pharmacist had not introduced written working instructions to define the dispensing process. And the team members did not have instructions to help them assemble and dispense the packs safely and effectively. 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 there be any queries. Team members did not always provide descriptions of medicines on the labels. This could make it harder for the person or their carer to identify the medicines inside. They did not always supply patient information leaflets with the packs. This could mean that people don’t have all the information they need 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. They attached stickers to packs within six months of their expiry dates. This allowed extra checks during dispensing so that out-of-date medicines were safely disposed of. The pharmacy used two fridges; one for insulin and the other for general stock and prescriptions awaiting collection. Team members monitored and recorded the fridge temperatures and they showed that medicines had been kept between two and eight degrees Celsius. Team members had kept records to show they had acted on drug alerts and recalls up until February 2020. But they had not kept records about recent alerts to provide assurance they had removed any faulty medicines and devices from stock. For example, a recent alert issued by the MHRA in August 2020 for Oxylan tablets. Team members knew about the Falsified Medicines Directive (FMD). But the pharmacy 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. The superintendent used a monitor they had purchased in January 2020 to measure blood pressure. But they did not keep records to show when they had first started using it or when it needed to be replaced. They kept computer screens out of sight of people in the waiting area and used a portable phone to keep personal conversations private. Not all the team members wore face masks. And they were unable to keep a one-metre distance from each other throughout the day to protect themselves from the coronavirus. 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.