

Registered pharmacy inspection report

Pharmacy Name: Townhead Pharmacy Ltd., Phase 1, Glasgow Royal Infirmary, Alexandra Parade, GLASGOW, Lanarkshire, G31 3AA

Pharmacy reference: 1042262

Type of pharmacy: Community

Date of inspection: 23/11/2022

Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs).

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

Pharmacy team members follow documented working practices. And they manage dispensing risks to keep services safe. Pharmacy team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's private information and keep the records they need to by law. Team members make records of mistakes and use this information to review the pharmacy's processes and procedures. They learn from mistakes and take the opportunity to improve the safety of services.

Inspector's evidence

The pharmacy had control measures to manage the risks and help prevent the spread of coronavirus. This included a plastic screen at the counter. It also included hand sanitizer at the entrance and throughout the dispensary for visitors and team members to use. The pharmacy used 'standard operating procedures' (SOPs) to define its working practices. And team members annotated records when they had read and understood them. The 'superintendent pharmacist' (SI) who worked at the pharmacy, was in the process of reviewing and updating the SOPs to provide assurance that working practices were safe and effective. SOPs included the 'responsible pharmacist' (RP) and 'controlled drug' (CD) procedures. 'Accuracy checking technicians' (ACTs) had signed to confirm they followed the 'final accuracy check' SOP. This included only checking prescriptions that a pharmacist had annotated to show they had clinically checked and approved supplies.

Pharmacy team members signed dispensing labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacy had an audit trail for dispensing. It also helped the pharmacists, and the ACTs identify dispensers to help them learn from their dispensing mistakes. The pharmacists and the ACTs kept some records of near miss errors. And they reviewed the records at the end of the month to identify the need for improvements. Team members provided a few examples of changes following reviews. This included attaching shelf edge caution labels to highlight selection risks, such as for 'look alike and sound alike' (LASA) items. They had also discussed items that were not suitable to be dispensed into multi-compartment compliance packs, such as alendronic acid. Team members knew to record dispensing mistakes which had been identified after the person received their medicine, on an electronic template which they shared with the SI. The template included a section to record information about the root cause and any mitigations to improve safety arrangements. The pharmacy provided a complaints policy for team members to refer to. And they knew how to manage complaints effectively. A few people had taken the opportunity to provide feedback using a new suggestions box in the waiting room. And this had been positive with no suggestions for improvement that team members could act on.

The pharmacy maintained the records it needed to by law. And it had public liability and professional indemnity insurances in place which were valid until 30/04/2023. The pharmacist displayed a 'responsible pharmacist' (RP) notice, and it was visible from the waiting area. The RP record showed the time the pharmacist took charge of the pharmacy and the time they finished. The pharmacy had introduced new electronic 'controlled drug' (CD) registers in August 2022. Team members checked and verified stock balances at the time of dispensing. And they were re-introducing monthly checks for all stock. People returned controlled drugs they no longer needed for safe disposal. And a register showed the pharmacist signed to confirm that destructions had taken place. Team members filed prescriptions

so they could easily retrieve them. And they kept up-to-date records of supplies against private prescriptions and supplies of unlicensed 'specials'. The pharmacy trained team members to safeguard confidential information and to keep it safe and secure. And they used a shredder to safely dispose of information that they no longer needed to keep. Team members had completed training so they could recognise and manage safeguarding concerns relating to vulnerable people. And they provided examples of referrals to relevant agencies. This included sharing information when people missed three or more days' worth of some medication.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to suitably manage its workload. And they have the necessary qualifications and skills for their roles and the services they provide. The pharmacy supports its team members ongoing learning and development needs. And team proactively suggest improvements to keep pharmacy services safe and effective.

Inspector's evidence

The pharmacy's dispensing workload had decreased significantly at the start of the coronavirus pandemic. But it was gradually increasing to previous levels as more people visited the health centre for appointments. The owner had not made any changes to the pharmacy team, with team members well-established and experienced in their roles. The 'superintendent pharmacist' (SI) worked in the pharmacy part-time. And a second full-time pharmacist also worked there. They provided cover for each other, and this meant they did not have to arrange locum pharmacists to provide cover. Two part-time 'accuracy checking technicians' (ACTs) supported the pharmacists with checking activities. And two part-time and one full-time dispenser carried out dispensing tasks. A part-time driver provided deliveries to help vulnerable people at home. They had worked at the pharmacy for around five years and were experienced in their roles and responsibilities. Team members worked on weekdays and the pharmacy closed on a Saturday along with the health centre. Team members worked together to support each other. And they covered for each other's leave. A new dispenser had been in post since July 2022. And they had met the requirements of the pharmacy's induction procedure which included health and safety training and reading the relevant pharmacy SOPs. The dispenser had experience of using an electronic 'controlled drug' (CD) register which they had gained in their previous role. And they had supported colleagues at the time the pharmacy had introduced the new system in August 2022.

The SI supported team members to learn and develop in their roles. They had arranged for them to access relevant training on 'Turas', which was NHS Education for Scotland's (NES) single, unified learning platform for registered professionals. The SI kept records that listed the learning that each team member had completed. This included 'adult and child protection' which they had completed in August 2022, 'fire and health and safety' in August 2022, and 'medicines: care and review' service (MCR) training in March 2021. The pharmacists and the ACTs reviewed near miss errors at the end of the month. And they shared their findings with the pharmacy team. This included information about any patterns and trends so the team could make improvements to manage dispensing risks. Team members were aware of their responsibilities. And they felt empowered to speak up if they had any concerns.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises adequately support the safe delivery of services. And the pharmacy suitably manages the space for the storage of its medicines. It has appropriate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean and well maintained. And it provided adequate space for dispensing and the storage of medicines. Team members used designated areas for dispensing tasks. They used a dedicated bench in a separate area of the pharmacy to assemble multi-compartment compliance packs. This provided them with ample space to safely dispense four packs at a time. They used a bench for carrying out final accuracy checks. And the pharmacist supervised the counter from the dispensary so they could intervene and provide advice when necessary. Team members used a sound-proofed room to provide a confidential environment for private consultations. And they supervised the consumption of some medications from the consultation room through an integrated hatch from the dispensary. Team members used the dispensary sink for hand washing and the preparation of medicines. And health centre employed staff cleaned and sanitised the pharmacy on a regular basis. This was during working hours when the pharmacy was open. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. It has arrangements in place to identify and remove medicines that are no longer fit for purpose. This ensures that its medicines are suitable to supply.

Inspector's evidence

The pharmacy had a step-free entrance that provided unrestricted access for people with mobility difficulties. Team members kept stock neat and tidy on a series of shelves. And they kept the controlled drug cabinets well organised with items safely segregated. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members carried out date checking activities which they recorded to keep track of when checks were next due. They attached labels to highlight short-dated stock. And sampling showed that items were within their expiry date. The pharmacy had a large glass-fronted fridge to keep medicines at the manufacturer's recommended temperature. And team members monitored and recorded the temperatures every day. This provided assurance that the fridges were operating within the acceptable temperature range. Team members accepted unwanted medicines from people for disposal. And the pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste.

Team members printed, annotated, and retained drug alerts and recall notices to show the action they had taken and what the outcome had been. For example, team members evidenced they had recently checked for hyoscine medication in November 2022 with none found. Team members knew about valproate medication and the Pregnancy Prevention Programme for people at risk. And the pharmacist knew to speak to people in the at-risk group about the associated risks. Team members knew to supply patient information leaflets and to provide patient cards with every supply.

Team members used dispensing baskets to safely hold medicines and prescriptions during dispensing. This managed the risk of items becoming mixed-up. They stored prescription items for collection in totes on a series of shelves. And they segregated male and female names to help them select the correct prescription at the time of hand out. The pharmacy supplied medicines in multi-compartment compliance packs to help people with their medicines. And team members followed a documented 'standard operating procedure' (SOP) which defined the assembly and dispensing process. They referred to supplementary records that provided a list of each person's current medication and dose times. And the pharmacist contacted prescribers to confirm any changes before dispensing. Team members provided descriptions of medicines on dispensing labels. And they supplied patient information leaflets for people to refer to.

The pharmacists supervised the consumption of some medicines in the pharmacy. They dispensed doses in advance, and they obtained accuracy checks before making a supply. The pharmacy dispensed serial prescriptions for a significant number of people that had registered with the 'medicines: care and review' service (MCR). And it had a system in place for managing dispensing. People knew to contact the pharmacy a few days before their next supply was due. And this enabled team members to order and dispense items in advance of the due date. Most people collected their medication on time. And

team members referred people when they had concerns about compliance and whether they were suitable for the scheme. The pharmacy provided a prescription delivery service to help vulnerable people stay at home. And the delivery driver kept an audit trail of deliveries to help them resolve queries.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for substance misuse medicines. They kept the measures separate, so they were used exclusively for this purpose. The pharmacy stored prescriptions for collection out of view of the waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. A portable phone allowed team members to carry out conversations in private if needed. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks.

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.