

Registered pharmacy inspection report

Pharmacy Name: Rightdose Pharmacy, 584 Alexandra Parade,
Glasgow, Lanarkshire, G31 3BS

Pharmacy reference: 1042271

Type of pharmacy: Community

Date of inspection: 06/08/2024

Pharmacy context

This is a busy community pharmacy within a parade of shops in the city of Glasgow. Its main services include dispensing NHS prescriptions, including serial prescriptions and selling over-the-counter medicines. The pharmacy provides medicines in multi-compartment compliance packs for people who need help to take their medicines at the right times. And it provides a smoking cessation service and substance misuse service. Pharmacy team members provide advice on minor ailments and medicines' use.

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 adequately identifies and manages the risks with the services it provides. Team members understand their role in helping to protect vulnerable people and they suitably protect people's confidential information. The pharmacy keeps the records required by law. Team members discuss ways to reduce dispensing mistakes and mitigate risk.

Inspector's evidence

The pharmacy had a set of paper-based standard operating procedures (SOPs) available to its team members designed to help them work safely and effectively. They were stored neatly in a folder that could be easily accessed and included SOPs such as Responsible Pharmacist (RP), receipt of prescriptions and temperature monitoring. Team members mostly followed SOPs although records showed fridge temperatures were not consistently recorded. SOPs were reviewed by the Superintendent Pharmacist (SI) every two years and team members signed a record of competence to show they had read and understood them. Team members described their roles and responsibilities within the pharmacy and accurately described what activities they could and couldn't undertake in the absence of the RP. Team members were not aware of a business continuity plan in place to address disruptions to services or unexpected closure. The RP regularly reviewed ways of working with the SI. They would then undertake a risk assessment together. For example, pharmacy sundries were stored at height in two separate spaces within the pharmacy, including in part of the roof space. A risk assessment was completed to identify any potential safety issues such as, electricity and heat, the maximum weight load the roof space could hold, maintenance of equipment and the health and safety of team members. Following the risk assessment and before stock was stored in the roof space, new light bulbs were fitted as a way of managing heat within the space. A second risk assessment was carried out recently on the set of ladders used to access the space. Following this risk assessment, new ladders were purchased.

The pharmacy had a process for reporting mistakes identified during the dispensing process, known as near misses on an online system. But they had not been consistent with the recording of near misses and the RP acknowledged this. The lack of regular monitoring of near misses meant team members may miss opportunities to share learning and reduce the risk of dispensing errors happening again. Mistakes identified after a prescription had reached a person, known as dispensing incidents, were recorded on an online system, and then reviewed by the SI. Team members described how they had taken steps to reduce the risks of near misses occurring, by separating stock of medicines with similar packaging or similar sounding names to avoid selection errors. And team members used an online messaging service to highlight useful information such as medicines being received that had changed packaging or had similar packaging to another medicine. And this ensured information was shared with all team members, including those who worked part-time. The pharmacy had a complaints procedure and welcomed feedback. Team members were trained to manage complaints and aimed to do so informally. However, if they could not resolve the complaint, they would refer to the RP or provide contact details for the SI.

The pharmacy had current professional indemnity and liability insurance. And it displayed an RP notice that was visible from the retail area and reflected the correct details of the pharmacist on duty. The RP log held electronically was mostly up to date with some omissions of the time the RP ceased duties at

the end of the day. Team members maintained complete electronic controlled drug (CD) registers and they checked the physical quantity in stock matched the balance recorded in the registers every two weeks. Team members had assigned certain electronic CD registers to a specific colour, this colour matched the colour of physical box of medicines. This acted as a safety prompt to help ensure accuracy when completing entries in the CD registers. A random balance check of the quantities of two CDs were correct against the balances recorded in the registers. The pharmacy had records of CDs people had returned for safe disposal. Private prescription records held electronically were up to date and records related to unlicensed medicines were complete. The process for dispensing substance misuse liquid medicines meant CD registers showed prescriptions had been collected at the point at which the pharmacy had prepared these in advance, which was inaccurate. The RP explained at the end of the day medicine that had not been collected was added back to stock, and records were adjusted accordingly to reflect the correct balance held in stock. The inspector highlighted the need for registers to accurately reflect when medicines had been collected.

There was a data protection notice on display and a General Data Protection Regulation (GDPR) policy. And team members knew how to protect people's confidential information. A recent increase in prescription volume meant the storage area for prescriptions awaiting collection had to be increased in size. Team members discussed the best way to implement this while still protecting people's confidential information from unauthorised view. Confidential waste was segregated and collected by a third-party contactor to be securely destroyed off-site. Team members understood their roles in protecting vulnerable people. And they provided examples of signs that would raise concerns and of interventions they had made to protect people. The pharmacy manager was a member of the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members have the necessary skills and knowledge they need for their roles and the services they provide. They work well together in a busy environment and provide support to each other as they work. And they feel comfortable raising concerns and discussing improvements to provide a more effective service.

Inspector's evidence

The pharmacy employed two part-time pharmacists, one of whom had the role as the pharmacy manager, one full-time dispenser, three part-time dispensers, one part-time pharmacy technician, two part-time trainee dispensers, one part-time medicines counter assistant and a delivery driver who worked every day. Most team members had worked with the pharmacy for several years and were very experienced in their roles. They were observed managing the busy workload well and they provided support to each other as they worked. There was a staff task rota to manage skill-mix arrangements to ensure team members rotated tasks and provided continuity of work. The pharmacy manager managed annual leave requests to ensure staffing levels remained sufficient to manage the workload safely. And part-time team members increased their hours to provide contingency cover during periods of absence.

Team members received protected learning time when undertaking accredited courses. And for continued learning and development. For example, the pharmacy provided a smoking cessation service. And team members attended face-to-face refresher training to continue to provide the service safely. Team members spoken to at the time of inspection undertaking accredited courses felt well supported throughout their training. Team members received annual performance reviews by the pharmacy manager and SI to review progress and identify any individual learning needs. They asked appropriate questions when selling over-the-counter medicines. And explained how they would handle repeated requests for medicines liable to misuse, such as codeine-containing medicines, by referring to the RP or the persons GP for supportive discussions. The pharmacy manager had a close working relationship with pharmacy teams within local GP practices. They described a recent telephone conversation in which the RP and practice pharmacist discussed how they could improve their ways of working. The practice shared a direct line telephone number as a way of more efficient communication between the practice team and the pharmacy team.

Team members were encouraged to make suggestions to improve their ways of working. They were aware of a whistle blowing policy although a team member explained they were not sure of the information contained within it, they would feel comfortable raising concerns with the pharmacy manager or the SI. The pharmacy manager was in regular contact with the SI and felt supported in their role. There were no targets set for team members by the company.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean, secure and provides a professional image suitable for the services it provides. And people can access a private area to have confidential conversations with a team member.

Inspector's evidence

The pharmacy premises were secure, clean and provided a professional image. There was a small well-presented retail area which led to a healthcare counter and then dispensary. Pharmacy-only medicines were stored in shelves to the side of the healthcare counter and in a glass cabinet underneath the healthcare counter. The retail area had been made smaller with the introduction of a second healthcare counter. The original healthcare counter was used as further work bench space for team members to complete different tasks. There was a tape used to act as a barrier to prevent unauthorised access. The dispensary was screened in a way which allowed the pharmacist to supervise the sale of medicines and intervene in a sale where necessary. But also allowed for privacy to prevent distractions during the dispensing process.

The dispensary was small, and the work benches were busy with prescriptions awaiting a final accuracy check. But the team managed the space well. Medicines were stored around the perimeter of the dispensary and in drawers. There was a sink with access to cold water for professional use and hand washing. Staff facilities were clean and hygienic and included a second sink with access to hot water and separate toilet facilities. Non-medicinal stock was stored in a roof space that had been created which provided the team with more space to work. The pharmacy had a consultation room that was currently used for further storage and also accommodated the pharmacy fridge for medicines requiring cold storage. There was a second private area which was used for specialist services such as substance misuse supervision. And it provided a space for private conversations with people.

Principle 4 - Services ✓ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely and effectively. The pharmacy sources its medicines from recognised suppliers. Team members generally store medicines appropriately and complete the required checks to demonstrate they are suitable to supply.

Inspector's evidence

The pharmacy had access via a small step at the front door. There was always a team member working on the healthcare counter to help people who required assistance to access the pharmacy. There was a range of healthcare leaflets available for people to read or take away such as information on the NHS Pharmacy First Service. And they advertised services available in the local community such as cancer support groups. Team members knew how to access details for a translator service to communicate with people who did not use English as their first language. And they had the facilities to provide large-print labels to help people with visual impairments take their medicines safely.

The pharmacy purchased medicines and medical devices from recognised suppliers. Medicines were mostly kept in their original containers and stored neatly on dispensary shelves. But at the time of inspection two different strengths of higher-risk medicines were stored in multiple clear bags on dispensary shelves. Hand-written labels attached to the outside of the bags showed the name and strength of the medicine, but batch number and expiry dates were not recorded. A team member provided assurances these were awaiting destruction and would not be used for prescriptions. However, the way in which they were stored meant there was still a risk of a mistake occurring when team members selected the medicine. And they could not safely identify batch numbers if they were indicated in Medicines Healthcare and Regulatory Agency (MHRA) patient safety alerts or product recalls. This was discussed at the time of inspection. The pharmacy received MHRA patient safety alerts and recalls via email and actioned them upon receipt. But they did not keep records to show actions they had taken for future reference. The pharmacy had a process for checking expiry dates of medicines. And paper-based records showed date checking was up to date. A random selection of 20 medicines showed none out of date. The pharmacy used one well-organised fridge to store medicines and prescriptions awaiting collection that required cold storage. Team members aimed to record fridge temperatures daily, although records showed several dates in the last three months where temperatures had not been recorded. The fridge was operating within the recommended limits of between 2 and 8 degrees Celsius. However, the fridge thermometer showed a maximum temperature that exceeded the recommended range. A team member checked the temperature of the fridge following the inspection, and the temperature showed it was operating within the recommended limits.

Team members used coloured baskets during the dispensing process to separate people's prescriptions and prevent medicines from becoming mixed-up. The coloured baskets helped team members prioritise workload, for example, green baskets were used for prescriptions to be delivered the next day. Team members highlighted the inclusion of a fridge line, CD and higher-risk medicines which required further counselling by attaching coloured stickers to the outside of the bags of the dispensed medicines. They were aware of the Pregnancy Prevention Programme and the risks associated with valproate-containing medicines. They always supplied valproate-containing medicines in the manufacturers original packaging, and they supplied patient information leaflets (PILs) and patient alert cards with each supply. Some people received serial prescriptions via the Medicines, Care and Review service (MCR).

Team members prepared prescriptions in advance of the expected collection dates and kept records of each supply. This allowed team members to plan their workload in advance. And allowed the pharmacist to identify any issues with people not taking their medicines as they should.

The pharmacy supplied medicines in multi-compartment compliance packs when requested to help people take their medicines properly. Team members worked on a four-week cycle, this allowed them sufficient time to resolve any queries with people's medication. They maintained a record of each person's current medicines on a master sheet. This was checked against prescriptions before dispensing. Team members recorded any changes to people's medicines on the master sheet, for example, if a medicines strength had been increased or decreased. And they recorded the date the change was communicated. Team members attached dispensing labels to each pack which included warning labels for each medicine, directions for use and a description of what each medicine looked like. They included patient information leaflets (PILs) every month to ensure people had up-to-date information relating to their medicines. A sample of three multi-compartment compliance packs seen during the inspection were missing an audit trail on dispensing labels to show who had dispensed and checked each medicine. Two other packs showed signatures on the label on the front of the pack. The absence of a robust audit trail may make it harder to investigate any future queries related to these medicines.

The pharmacy provided an NHS Smoking Cessation Service to people in the local community who required support to stop smoking. People could self-refer to the service directly at the community pharmacy or were referred by the local Quit Your Way Service. Team members were trained to ask appropriate questions and they worked to a service specification and health board formulary which listed medicines suitable to be supplied and when referral would be appropriate. They were supported by local health board colleagues and received training on how to monitor carbon monoxide levels. And they kept records electronically on the patient medication record (PMR). Pharmacy team members were trained to provide the NHS Pharmacy First Service. This included providing medicines to people for minor conditions such as urinary tract infections and skin infections under a Patient Group Direction (PGD). Paper records relating to PGDs were stored in folders. Team members asked appropriate questions before they referred to the pharmacist for treatment. The pharmacy maintained well-organised consultation records to record treatment or referral decisions. And team members communicated these to people's GPs to ensure their medical records were kept up to date.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Pharmacy team members have access to the appropriate equipment that is fit for purpose and safe to use. And team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had access to written resources such as the British National Formulary (BNF). And team members were able to access electronic resources to obtain up-to-date information and guidelines to support them in their roles.

The pharmacy used a range of clean CE-stamped measuring cylinders and tablet counters. And they had highlighted specific cylinders to be used solely for the purpose of measuring substance misuse liquids. The pharmacy used an automated dispensing pump to measure substance misuse liquids. It was calibrated by the RP at the beginning of the day to ensure it measured accurate doses. And it was cleaned at the end of each day.

Prescriptions awaiting collection were stored in a retrieval area behind the healthcare counter and confidential information was not visible to people in the retail area. Computers were password protected and positioned in a way that prevent unauthorised view. Cordless telephones were in use to allow for private conversations in a quieter area.

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.