General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: S H Mehta Pharmacy, 34 Admiral Street, GLASGOW, Lanarkshire, G41 1HU

Pharmacy reference: 1042272

Type of pharmacy: Community

Date of inspection: 17/01/2020

Pharmacy context

This is a community pharmacy next to a health centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also 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. It offers a smoking cessation service and diabetes testing.

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	1.1	Standard not met	The pharmacy doesn't have working instructions in place to support the team members in their roles. And it does not have procedures in place for high-risk activities such as dispensing multi-compartment packs. This means that team members may not be following effective practices to keep services safe.
		1.2	Standard not met	The pharmacy keeps some information about near misses. But it had documented only six near-misses in 2019. The pharmacy keeps some information about dispensing incidents. But, it does not show the root cause or what it has done to manage the risk of the same thing happening again. There is little evidence that pharmacy team members learn from the mistakes or make changes to stop similar errors in the future.
2. Staff	Standards not all met	2.2	Standard not met	Not all pharmacy team members have a recognised training qualification. Neither are they on a recognised training course relevant to their role. This is not in accordance with GPhC

Principle	Principle finding	Exception standard reference	Notable practice	Why
				minimum training requirements.
3. Premises	Standards not all met	3.1	Standard not met	There is excessive clutter and waste materials at two of the pharmacy's exit routes. And this presents significant health and safety risks for those that work there.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy does not provide working instructions. And it does not define its processes and procedures. It does not provide the pharmacy team with information about how to safely provide high-risk services such as multi-compartment compliance device dispensing. And it puts its services at risk of safety incidents.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

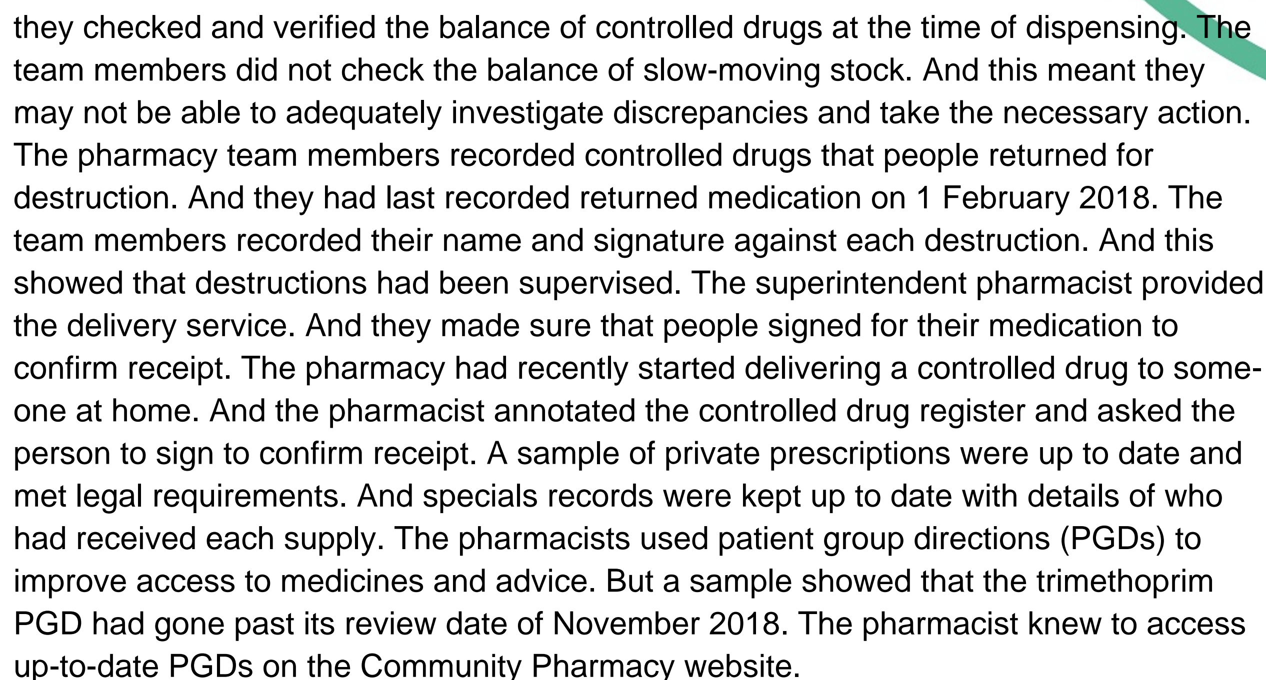
Summary findings

The pharmacy does not have the necessary arrangements in place to help it manage the risks to its services. It does not provide working instructions for the team members to follow. So, they may be unclear about the safest and most effective way to carry out their duties. Pharmacy team members do not record all mistakes that happen. They do not analyse the information they collect to spot any patterns to the mistakes. And, they do not always make changes to help prevent mistakes happening again. So, they may miss opportunities to improve and make services safer. The pharmacy does not have a complaints policy in place. And it does not tell people how to complain. This means that the pharmacy team may be inconsistent in the way they deal with complaints. And people are discouraged from highlighting areas that need to be improved. The pharmacy keeps the records required by law. It protects people's privacy and confidentiality. And, pharmacy team members generally know how to safeguard the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy did not have working instructions on-site. And the team members did not have access to information about the pharmacy's processes and procedures. The pharmacy team members signed the 'dispensed by' and 'checked by' boxes on the dispensing labels. And the pharmacist gave feedback about near-misses when dispensers failed to identify their errors. The pharmacy team had recorded six near-misses in 2019. But this didn't provide them with sufficient information to spot patterns and trends to identify risks and make safety improvements. The team members provided a few examples of changes they had made to manage risks. Such as separating atenolol/allopurinol products. And adding shelf-edge caution labels to the shelves used to keep mirtazapine and methotrexate to manage the risk of selection errors. The pharmacist managed the incident reporting process. But they did not always document incidents to show what the root cause had been. For example, they had recorded a recent incident on the near-miss record form. But this did not show the learnings, and any improvement action they had taken. The pharmacy provided training during induction so that team members knew how to handle complaints and how to manage conflict. The pharmacy team members did not have access to a complaints policy. And it did not promote its complaints handling arrangements so that people knew how to complain.

The pharmacy maintained the pharmacy records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity insurance in place. And it was valid until 31 March 2020. The pharmacy team kept the controlled drug registers up to date. And



they checked and verified the balance of controlled drugs at the time of dispensing. The team members did not check the balance of slow-moving stock. And this meant they may not be able to adequately investigate discrepancies and take the necessary action. The pharmacy team members recorded controlled drugs that people returned for destruction. And they had last recorded returned medication on 1 February 2018. The team members recorded their name and signature against each destruction. And this showed that destructions had been supervised. The superintendent pharmacist provided the delivery service. And they made sure that people signed for their medication to confirm receipt. The pharmacy had recently started delivering a controlled drug to some-one at home. And the pharmacist annotated the controlled drug register and asked the person to sign to confirm receipt. 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. But a sample showed that the trimethoprim PGD had gone past its review date of November 2018. The pharmacist knew to access up-to-date PGDs on the Community Pharmacy website.

The pharmacy trained its team members during induction to comply with data protection arrangements. And they knew how to protect people's privacy and confidentiality. The pharmacy did not promote its data protection arrangements. And it did not inform people that it protected their personal information. The team members separated waste. And they used a shredder to dispose of confidential waste. The pharmacy archived its spent records. And it retained them for the standard retention period.

The pharmacy used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. But it did not provide training to raise awareness of safeguarding. The team members knew to discuss any concerns they had with the pharmacist. And made referrals when they needed to.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy does not always enrol team members on formal training courses. And some team members are not qualified for the roles they are carrying out. This means they may not be aware of the safety risks. And there is a risk that services may not be as safe as they need to be. The team members support each other in their day-to-day work. And the pharmacy provides the team with some opportunities to complete ongoing training. But it does not give team members feedback on their performance. So, they miss opportunities to improve and suggest ideas to help the safe and effective delivery of services.

Inspector's evidence

The workload had remained stable over the past year. And the number of pharmacy team members had remained the same. The pharmacy had not trained and accredited all team members. And this meant they were not qualified for the roles they were carrying out. A team member of four years had been working in the dispensary for the past year. And two team members of two years and one year respectively had not been enrolled on the medicines counter course to enable them to carry out the tasks they were expected to.

The superintendent pharmacist did not work on-site. And the same locum had been working as the responsible pharmacist for the past ten years. The locum was aware of some of the decisions taken by the superintendent. For example, they were aware of a reduction in the number of available working hours due to long-term leave and changes to working arrangements. But they did not know if the superintendent planned to address the short-fall. The superintendent cascaded some information, such as a medicine supply alert in January for phenytoin, and a reminder from the Health Board in January about NEO submissions.

The team members were experienced and knowledgeable in their roles. And the pharmacy kept qualifications on-site when team members had achieved qualifications. The following team members were in post; one full-time pharmacist, one full-time dispenser, one part-time dispenser (on long-term leave), one full-time medicines counter assistant (working in the dispensary) and two part-time team members (working on the medicines counter).

The pharmacy did not carry out individual performance reviews. And it did not provide regular structured training. But the superintendent pharmacist updated the pharmacy team whenever there were service changes or new initiatives. For example, the team members had recently learned about the falsified medicines directive (FMD) and the

valproate pregnancy protection programme (PPP). And they had been trained to support the pharmacist to provide the smoking cessation service. The superintendent had authorised the team members to attend off-site training when relevant. And two team members were about to attend an event about changes to the pharmacy first service.

The pharmacy did not use numerical targets. And the team members were focussed on providing a professional service for the people that used the pharmacy. The team members felt empowered to raise concerns and provide suggestions for improvement. For example, the dispenser raised a concern about a prescription at the time of the inspection. And they highlighted the dosage which was in excess of the recommended daily intake for the age of the child. The pharmacist contacted the prescriber to query the dose.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy is cluttered with excessive waste. And it presents a significant health and safety risk for those that work there. The pharmacy has a consultation room that is professional in appearance. And it is an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

The pharmacy was set in a large purpose-built premises. It had large storage areas at the rear of the premises. But the superintendent used the rooms to keep large quantities of waste. This included cardboard boxes, files and some expired stock. The pharmacy team were unable to clean the storage areas. And this was due the amount of waste and how it was being kept. The pharmacy did not always provide a clear, safe route to exit the building. And this was due to the fire exit route being obstructed with waste.

The pharmacy had a well-kept waiting area. And it provided seating for people whilst they waited to be attended to. The pharmacy provided a consultation room. And people could talk in private with the pharmacy team about their health concerns. The team members had arranged benches for the different dispensing tasks. For example, the pharmacist observed and supervised the medicines counter from the checking bench. And they could make interventions and provide advice when needed. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services.

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

Summary findings

The pharmacy does not provide the team members with access to working instructions. And it does not provide information about how to carry out high-risk dispensing procedures. This means that team members are not supported to work in a safe and effective way. And it puts services at risk of safety incidents. The pharmacy sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information. The pharmacy displays service information for people to see. And it supports people to access services they might benefit from. The pharmacy team members do not always provide supplementary information for people on multi-compartment compliance packs. And this means that they are not fully supporting vulnerable people who need extra help to take their medicines.

Inspector's evidence

The pharmacy's main entrance was off the street at the front of the pharmacy. And it had a separate entrance for those using the surgery in the next building. The entrances were step free. And they provided unrestricted access for people with mobility difficulties. The pharmacy provided people with service information in the waiting area. And it displayed its opening hours in the window. The pharmacist spoke to people about their medicines. And they carried out reviews to identify if people were taking their medication correctly. And if not they provided extra support when needed. For example, the pharmacist had referred someone to ensure they received calcium supplements due to their health condition.

The dispensing benches were organised. And the pharmacy team used dispensing baskets to keep prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 25 people. And the team members used supplementary records to support safe systems of work. The pharmacist supervised multi-compartment compliance pack dispensing. And they carried out clinical checks before handing over prescriptions for dispensing. The dispensers obtained accuracy checks before they started dispensing. And this provided the opportunity to identify and correct selection errors. The team members isolated packs when they were notified about prescription changes. And they documented details of changes in the person’s records. The team members did not routinely supply patient information leaflets. But they annotated descriptions of medicines on the pack.

The team members kept the pharmacy shelves neat and tidy. And they kept controlled drugs in a well-organised cabinet with expired stock labelled and separated. The

pharmacy purchased medicines and medical devices from recognised suppliers. And the team members carried out regular stock management activities, highlighting short dated stock and part-packs during regular checks. The team members monitored and recorded the fridge temperature. And they demonstrated that the temperature had remained between two and eight degrees Celsius. The pharmacy accepted returned medicines from the public. And it used yellow containers to dispose of them. The health board collected the waste at regular intervals.

The pharmacist confirmed they responded to drug alerts and recalls. And they had removed ranitidine products as instructed in December 2019. The pharmacy did not retain an audit trail of drug alerts. And they were unable to provide assurance that all drug alerts were received and actioned. The pharmacy had introduced the necessary resources to meet the needs of the Falsified Medicines Directive (FMD). But it had not implemented the system. And the responsible pharmacist was waiting on authorisation from the superintendent pharmacist. The superintendent pharmacist had briefed the team members about the valproate pregnancy protection programme. And they knew about the initiative and when to supply patient information leaflets and cards. The team members confirmed they dispensed valproate prescriptions for two males. And they confirmed that the pharmacist carried out safety checks when females presented with prescriptions.

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 measures for methadone were highlighted and separated, so they were 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 had purchased a blood glucose monitor. And the supplier had provided training on how to use it. The pharmacist had not yet used the monitor. And they did not know how to carry out calibrations to confirm it was fit for purpose. 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 used a portable phone. And they took calls in private when necessary.

What do the summary findings for each principle mean?

✔ 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.