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: 14/08/2020

Pharmacy context

This is a community pharmacy next to a medical 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 dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. The pharmacy was inspected during the Covid-19 pandemic.

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 updates its working instructions to keep its processes and procedures safe and effective. The team members read and sign the instructions to show they follow them. They record their dispensing mistakes, and review the information to learn and help them manage risks in the pharmacy. The team members keep the records they need to by law up to date. They protect people's private information and prevent sensitive information being seen by people who are not authorised to do so. And they know the importance of their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had been carrying out risk assessments throughout the Covid-19 pandemic to manage the risk of virus transmission. Notices in the window provided public health information about the virus and how to protect against it. This included social distancing and the wearing of masks. The waiting area was large in size, and the team members had created a one-way system with arrows showing people the direction of travel. A side entrance had been locked, and the number of people in the waiting room was restricted to two at a time. A Perspex screen at the medicines counter created a barrier between the team members and people that visited the pharmacy. And a basket was used for people to leave their prescriptions in to maintain a safe distance from the team members. The dispensary had hand sanitiser, and it was used on a regular basis by the team members. They also wore appropriate face masks as personal protective equipment (PPE). They observed social distancing as far as possible while working in the dispensary.

The pharmacy displayed the responsible pharmacist notice, and it showed the name and registration number of the pharmacist in charge. The pharmacy had been inspected in January 2020, and an action plan had been issued to make improvements. The Superintendent pharmacist had made progress with the action plan and the necessary improvements were seen. The team members had read and signed the pharmacy's current working instructions. This ensured their learning was up to date and services were safe and effective. An extra work instruction had been introduced for multi-compartment compliance pack dispensing. This meant the team members could easily refer to instructions whenever they needed to refresh their knowledge, for example whenever they returned from a period of leave.

The team members signed dispensing labels to show they had completed a dispensing task. This allowed the pharmacist to support individual team members to learn and improve their accuracy in dispensing. And it acted as an audit trail of who had been involved in the dispensing process. The pharmacy's workload had fallen at the start of the Covid-19 pandemic. This had released extra time for dispensing. It also had provided more time to review and improve upon near miss errors and the recording of them. For example, the team members had discussed the need for a 'no-blame' culture in the pharmacy and to focus instead on learning from the mistakes they made. The team members had an increased awareness of the dispensing risks in the pharmacy. And they had introduced a few changes to help manage them. For example, separating the different formulations of co-codamol to manage selection errors.

The team members knew to handle complaints in a sensitive manner. But the pharmacy did not use a complaint notice to tell people how to complain about the service they received when they needed to. This may prevent the pharmacy from putting things right or improving the services it provided. The

team members followed the pharmacy's complaints procedure and they knew to refer dispensing incidents to the pharmacist. The Superintendent pharmacist had introduced a new incident reporting template since the last inspection. But there had been no incidents and the form had not been used. The team members had been dealing with people's frustrations at their prescriptions not being ready for collection. But the nearby GP practice had closed, and people's prescriptions were being sent to other pharmacies for dispensing instead. The team members had been liaising with the other pharmacies so that people received their prescriptions on time. The Superintendent pharmacist had registered with a mystery shopper initiative to review the pharmacy's service. The survey assessed how well the pharmacy team was delivering its service against several measures. And a survey in June 2020 had graded the pharmacy team's performance 93.3% against the measures that were used. The Superintendent had discussed the results with the team so they could improve, such as telling people where their nearest GP was located.

The pharmacy maintained the records it needed to by law. The pharmacist in charge kept the responsible pharmacist record up to date. And public liability and professional indemnity insurances were in place, and valid until June 2021. The pharmacy recorded private prescriptions and records met legal requirements. Specials records were kept up to date with details of each person who had received a supply. The pharmacy did not display information about its data protection arrangements. So people did not have the reassurance about how the pharmacy safeguarded personal information according to the Data Protection regulations. The pharmacy kept personal information such as people's names and addresses well away from the waiting area, and they used a shredder to dispose of sensitive data.

The pharmacists had 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 them. For example, the team members had identified people who were not collecting their multi-compartment compliance packs on time. They had discussed this with them. And had offered to deliver their packs to them at home.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the required skills and knowledge for their roles and the services they provide. The pharmacy supports trainees to develop their knowledge and skills. It also provides them with protected time in the workplace to complete their training. The pharmacist updates the pharmacy team about changes to pharmacy services when they arise. But the pharmacy does not provide formal ongoing training so that individual team members continue to develop in their roles. The team members support each other in their day-to-day work. They are enthusiastic and knowledgeable, and they suggest improvements to make services safer and more effective.

Inspector's evidence

The pharmacy's workload, and the number of people visiting the pharmacy had fallen since the start of the pandemic. This had created more time to carry out dispensing tasks and the team members had taken more time to discuss the safety culture in the pharmacy. The pharmacy team was well-established, and the team members were experienced and knowledgeable in their roles and responsibilities. Following the last inspection, the Superintendent had enrolled two assistants onto the medicines counter assistant training course. The assistants had completed the course, and were accredited to carry out their roles and responsibilities. This also ensured they followed safe systems of work on the medicines counter. The pharmacist supported trainees to develop their knowledge and skills. They also provided protected learning time in the workplace so they made satisfactory progress with training courses.

The Superintendent pharmacist had recently appointed a student pharmacist to work in the pharmacy. They would provide backfill for two dispensers who were in the process of reducing their working hours. The following team members were in post; one full-time pharmacist, two part-time dispensers, one part-time trainee dispenser and two part-time trainee medicines counter assistants (MCAs). The pharmacy team members submitted holiday requests in advance with only one person permitted leave at the one time. This ensured that minimum levels were maintained. The dispensers worked part-time, and they worked extra to cover annual leave and unplanned absences.

The pharmacy did not use formal performance reviews to develop the team members. And it did not provide ongoing training for team members to continue to develop in their roles. The pharmacist updated the team members whenever there were changes or new initiatives. This ensured the pharmacy team members stayed up to date in their roles. For example, they had learned about the new 'NHS Pharmacy First' service that launched at the end of July 2020, and they had read industry guidance about the necessary safety measures during a pandemic. For example, effective hand-washing techniques.

The company did not use numerical targets to grow the services it provided. The team members promoted the services that would benefit people. For example, the new 'NHS Pharmacy First' service. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, one of the dispensers had organised new storage arrangements for the growing number of serial prescriptions for ease of access.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and has appropriate infection control arrangements in place. It has consultation facilities to meet the needs of the services it provides, and people can speak with team members in private.

Inspector's evidence

The pharmacy was a large purpose-built building. It had ample storage facilities to the rear of the dispensary. It also had a large retail area with two separate entrances. Following the previous inspection, the superintendent had cleared a significant amount of waste that had built-up over time and also removed the waste that had been blocking the fire exits. There was unrestricted access to a safe exit route in an emergency. The Superintendent had segregated the remaining waste and confirmed they would continue to clear the rest of the waste as a priority.

The pharmacist had reviewed the cleaning arrangements at the start of the pandemic. They had instructed the medicines counter assistants to clean the door handles at the front of the pharmacy throughout the day. The dispensers cleaned the work-benches at least twice a day. The dispensary had hand sanitiser, and it was used on a regular basis by the team members.

The pharmacy had designated areas for dispensing tasks. The pharmacist had a separate bench area to carry-out checking activities. And they were able supervise the medicines counter from their work bench and intervene if they needed to. The dispensers used separate benches for dispensing and these were organised and clutter-free. The pharmacy was well-lit, and the ambient temperature provided a suitable environment from which to provide services. The consultation room was not being used due to the coronavirus pandemic, and the waiting area was large enough to take people to the side and speak to them in private.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays information about its services and opening times so people can easily see them. It provides public health information and it keeps people up to date with safety messages. The pharmacy reviews its working arrangements when there are changes, this helps keep its processes safe and effective. The pharmacy sources, stores and manages its medicines appropriately. It receives safety information about medicines. And it updates team members so they know to only supply medicines that are safe to use.

Inspector's evidence

The pharmacy had step-free access to the waiting area. It displayed information about the services it provided and promoted its opening hours in the window. The pharmacy displayed public health notices to help protect people from the coronavirus. It also provided a delivery service to vulnerable people at home and those shielding from the virus. The superintendent delivered the medication. They placed the items on the doorstep to keep a safe two metre distance away from the other person. They also waited until the person took the items inside. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. They had printed the new 'NHS Pharmacy First' PGDs for ease of access.

The pharmacy team members knew about 'high-risk' medicines. They knew to look for information stickers on prescriptions bags and to act accordingly. For example, a ‘pharmacist’ sticker meant calling on the pharmacist to provide extra advice, such as for new medicines. A ‘fridge’ sticker meant they had to retrieve extra items from the fridge. The team members used dispensing baskets, and they kept prescriptions and medicines contained throughout the dispensing process.

The pharmacy provided multi-compartment compliance packs to around 25 people. The team members provided descriptions of medicines on the labels to identify the medicines inside. It also supplied patient information with the packs so that people had all the information they needed to take their medicines safely. The team members used a separate section of bench to assemble and check the packs. And they used a filing cabinet to store the packs until they were supplied. The pharmacy used a tracker to help them manage dispensing. This helped the team members to order prescriptions from the surgeries well before the medication was needed. It also helped them to manage supplies and to put packs out for the delivery driver on the day they were due.

The pharmacy purchased medicines and medical devices from recognised suppliers. The team members carried out regular stock management activities. They highlighted short-dated stock and split packs during regular checks. This helped them to supply medication that was within its expiry date, and to manage the risk of quantity errors. They monitored and recorded the fridge temperature and they showed that medicines had been kept between two and eight degrees Celsius.

The team members knew about the valproate pregnancy protection programme. They knew to issue information leaflets and cards to keep people safe. The pharmacy had implemented the necessary resources to follow the ‘falsified medicines directive’ (FMD). The team members were scanning products to confirm they were of the quality expected. They followed the process that the superintendent pharmacist had defined in a working instruction. The 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 digoxin tablets in August 2020 with no affected stock found.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. It keeps its equipment clean and well-maintained.

Inspector's evidence

The pharmacy kept cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes and the team members kept the measuring equipment clean and ready to use. The team members were wearing face masks and they washed and sanitised their hands on a regular basis. The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). The team members kept computer screens out of sight of people in the waiting area. They used a portable phone to speak to people in private.

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.