General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 171-177 Baillieston Road, GLASGOW, Lanarkshire, G32 0TN

Pharmacy reference: 1042283

Type of pharmacy: Community

Date of inspection: 31/10/2022

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 good 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 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 the placing of hand sanitizer at the entrance and throughout the dispensary for visitors and team members to use. The company used 'standard operating procedures' (SOPs) to define the pharmacy's working practices. The company issued new SOPs via an online operating system. And it notified team members about the new SOPs when it released them. This meant they knew to log into the system and to annotate records once they had read and understood them. This was reflected in individual training records. At the time of the inspection, team members accessed their training records to show the SOPs they had read. But the list did not provide a description of the working practices they related to, such as 'assembly and dispensing' procedures. They had to open each of the documents to find what they were looking for, which was time-consuming.

Dispensers signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist was able to help individuals learn from their dispensing mistakes. The company expected team members to record near miss errors on its online operating system. This allowed the responsible pharmacist (RP), the team leader and the superintendent's office to review them. The RP recorded errors on paper records before entering them onto the system. And this helped with record keeping when the pharmacy was busy. The online system produced an info graphic of all the near miss errors to show patterns and trends. Team members had access to bar-code scanning technology. But this had not been installed onto all the 'patient medication record' (PMR) computers. This meant that team members did not always use the facility to help them manage dispensing risks. Sampling of previous reviews showed more errors occurred on certain days of the week. And this linked to lower staffing levels on these days. The pharmacy was in the process of recruiting another full-time team member. Team members were proactive. And they had recently reorganised the pharmacy shelves. This involved arranging stock so that 'look alike and sound alike' (LASAs) medicines, such as pregabalin and gabapentin were separated due to selection errors. They had also agreed to obtain an accuracy check before de-blistering medicines and placing them into multi-compartment compliance packs due to some errors.

Team members knew to record dispensing incidents on an electronic template which they sent to the superintendent's office. The template included a section to record information about the root cause and any mitigations to improve safety arrangements. The area manager visited the pharmacy on a weekly basis. They conducted 'one to one' meetings with the team leader, who was a dispenser, to discuss the pharmacy's performance. And they carried out audits against professional standards to highlight areas for improvement to ensure the pharmacy was operating safely. For example, team members were focussing on overdue expiry date checks due to staff absences. Some team members

were learning about the pharmacy's texting service. This was used to notify people when their prescriptions were ready. The pharmacy provided information about its complaints process on a notice in the waiting area. And it encouraged people to provide feedback about the services they received. The pharmacy had contingency arrangements in place. And team members knew the actions to take if there was a disruption to service provision.

Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place. The pharmacist displayed a responsible pharmacist notice which was visible from the waiting area. And the RP record showed the name and registration details of the pharmacist in charge. Team members maintained the electronic controlled drug registers and kept them up to date. And they showed that they mostly carried out balance checks every week. People returned controlled drugs (CDs) they no longer needed for safe disposal. And the pharmacy had an electronic CD destruction register to record all the items it received. Team members filed prescriptions so they could be easily retrieved if needed. They kept records of supplies against private prescriptions and supplies of 'specials' that were up to date. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. And they used a designated container to dispose of confidential waste. An approved provider collected the waste for off-site destruction. The pharmacy trained its team members to manage safeguarding concerns. And it provided a protocol for them to refer to. This included contact details for local agencies. Team members knew to speak to the pharmacist whenever they had cause for concern. And they provided examples of speaking to relevant agencies due to concerns about vulnerable people. A chaperone notice at the entrance to the consultation room advised that people could be accompanied during consultations.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members mostly have the necessary qualifications and skills for their roles and the services they provide. And they work together well to manage the workload. Pharmacy team members continue to learn to keep their knowledge and skills up to date. And the pharmacy supports new team members to learn during their induction.

Inspector's evidence

The pharmacy's prescription workload had increased slightly over the past year. And the pharmacy was in the process of recruiting a new team member to replace someone that had left. The pharmacy had been operating with a regular responsible pharmacist (RP) since January 2022. And they were supported by a team leader who was a full-time dispenser. An area manager visited the pharmacy on a regular basis. And they carried out checks to confirm the pharmacy was running safely and effectively. The RP notified the relevant person at head office to arrange cover when necessary. And regular locum pharmacists usually provided this. The pharmacy had arrangements in place with other branches in the area. And they worked together to provide support and cover when needed. This had been arranged the previous week to cover for two dispensers. Team members knew to contact the area manager when they were unable to arrange cover. And they provided the necessary support.

The company recognised the pharmacy as a training branch. And support staff regularly worked there whilst they underwent training. A new dispenser was currently training to take up a relief dispenser role for the area once qualified. The pharmacy provided student pharmacists with work experience opportunities. And two pharmacy students had recently worked there for a period of six weeks. The following staff were in post; one full-time pharmacist, one full-time dispenser (team leader), two part-time trainee dispensers that had taken up post around June 2022 and one part-time delivery driver who had been in post for around one year. The driver had completed induction training and training modules relevant to their role. The team leader carried out a skills assessment for new team members. And this identified individual learning needs which they addressed through training.

The company required new team members to successfully complete an induction period. This included completing health and safety training. It also included reading and understanding the pharmacy's policies and procedures. Once completed the company enrolled new team members on a training course that led to a relevant qualification. The pharmacy supported team members to complete qualification training. And the team leader allocated some protected learning time to fit in with the pharmacy rota. The pharmacy provided mandatory training for team members to complete. And they logged onto the company's online system every day to check for new learning. In July 2022, the company had instructed team members to read specific policies such as those for complaints, data protection and Dementia Friends. The company supported team members to develop in their roles. And the team leader had taken the opportunity to carry out an area manager role for a short period of time.

The pharmacist had completed training and was accredited to provide the company's flu vaccination service. Team members kept up to date with NHS Pharmacy First Service formulary changes. And they highlighted the 'pharmacy only' (P) medicine treatments they could provide via the service. Team members participated in a monthly huddle. They discussed progress against performance standards

which was illustrated on a large tracker on the dispensary wall. And they discussed the findings from the monthly near miss review to discuss safety improvements. Team members had agreed to improve near miss recording to ensure they were identifying dispensing risks and implementing strategies to reduce them. The pharmacy encouraged team members to speak up and to provide suggestions for improvement. And they were proactive at testing each other's knowledge about medications and what they were used for. They had improved the process for dispensing prescriptions for people that had registered with the 'medicines: care and review' service (MCR). And they manually checked the due dates on records attached to the prescriptions and dispensed supplies the week before they were due.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises supports the safe delivery of its services. And it effectively manages the space for the storage of its medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

This was a modern, purpose-built pharmacy that had been refurbished around two years ago. It was in a large premises with ample storage space and dispensing benches. A sound-proofed consultation room provided a confidential environment for private consultations. It was clearly marked, and team members used a keypad code to prevent unauthorised access to the room. They also provided access to the room remotely by pressing a button in the dispensary. The room had a sink with hot and cold running water. And it provided a clinical environment for the administration of vaccines and other services. The pharmacist had access to two waste containers that they used to dispose of clinical waste.

The main dispensary had a sink with hot and cold running water. And team members used it for hand washing and the preparation of medicines. They cleaned and sanitised the pharmacy on a regular basis. And this reduced the risk of spreading infection. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate rest room provided the space for team members to remove their face masks without being at risk of spreading infection.

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. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy had a step-free entrance and an automatic door. This helped people with mobility difficulties to access services. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members carried out monitoring activities to confirm that medicines were safe to supply. This included monthly date checking activities and attaching 'short-dated' stickers to highlight medicines. Team members were catching up with checking the expiry dates of medicines as they had fallen behind with this task. Sampling showed that items were within their expiry date. The pharmacy used a large medical fridge to keep medicines at the manufacturers recommended temperature. And team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the accepted range of 2 and 8 degrees Celsius. Team members kept stock neat and tidy on a series of shelves. And they used secure controlled drug cabinets where medicines were safely segregated. The pharmacy had medical waste bins and 'controlled drug' (CD) denaturing kits available to support the team in managing pharmaceutical waste. Team members prioritised drug alerts and they knew to check for affected stock so that it could be removed and quarantined straight away. Records showed a recent drug alert for Saxenda medication. And team members had followed the company's procedure which included annotating and retaining the document to confirm they had completed the necessary action.

Team members used dispensing baskets to safely hold medicines and prescriptions during dispensing. And this managed the risk of items becoming mixed-up. Some of the pharmacy computers had bar-code scanning technology which validated or rejected packs that team members had selected during the dispensing process. But this facility could only be used when the computers were available. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They also knew to supply patient information leaflets and to provide patient cards with every supply.

The pharmacy supplied medicines in multi-compartment compliance packs to help people with their medication. And the company had defined the assembly and dispensing process in a documented procedure for team members to refer to. The pharmacy restricted the service due to available resources to keep it safe and effective. Trackers helped team members plan dispensing. And supplementary records provided a list of each person's current medication and dose times which they kept up to date. They checked new prescriptions against the records for accuracy. Team members sometimes provided descriptions of medicines on the dispensing labels but only when people asked them to. And they supplied patient information leaflets for people to refer to. Packs were stored in alphabetical order on a series of shelves until they were needed.

The pharmacy supervised the consumption of some medicines. And team members dispensed doses in advance, so they were ready for consumption when required. Once dispensed and checked by the pharmacist the doses were stored securely. The pharmacy dispensed serial prescriptions for a significant number of people that had registered with the ‘medicines: care and review’ service (MCR). The pharmacy had a system in place for managing dispensing. And they retrieved prescriptions a week before they were due so they could order items in advance. Most people collected their medication when it was due. And team members knew to refer people who arrived either too early or too late so the pharmacist could check compliance. The pharmacy used an offsite hub for dispensing around half of its prescriptions. These were mostly for people whose treatment was stable. The pharmacist checked prescriptions to make sure they were clinically appropriate. And they also checked that the prescription information had been inputted accurately before sending it to the hub for dispensing. Once assembled, the hub placed the medications in sealed prescription bags into separate totes and returned them to the pharmacy. The pharmacist carried out accuracy checks on some prescriptions as part of the company's quality assurance process to show the dispensing system was safe and effective.

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. But it doesn't always keep records of when equipment is due to be checked. And so, the pharmacy cannot be sure all measurements are accurate.

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 had highlighted the measures, so they were used exclusively for this purpose. The pharmacy kept a blood pressure monitor. But team members could not show when it was due to be calibrated to provide assurance it was accurate. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could carry out conversations in private if needed, using portable telephone handsets. The pharmacy used cleaning materials for hard surface and equipment cleaning. And 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.