General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Domkell Ltd, Castlemilk Health Centre, Dougrie Drive, Castlemilk, GLASGOW, Lanarkshire, G45 9AW

Pharmacy reference: 1042333

Type of pharmacy: Community

Date of inspection: 18/01/2024

Pharmacy context

This is a community pharmacy in a health centre 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 prescription only medicines via patient group directions (PGDs).

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	Team members do not always follow the pharmacy's written procedures creating risk of errors. And they do not adequately manage all risks when carrying out dispensing activities.
		1.6	Standard not met	The responsible pharmacist record is incomplete. It has missing entries for two months and so does not meet all of its legal obligations for record keeping.
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 not all met**

Summary findings

Team members do not always follow the pharmacy's written procedures to keep services safe and effective. And they do not always adequately manage risks when carrying out dispensing activities. The pharmacy does not keep all the records it needs to by law. And this means it does not have a complete legal record of who is responsible for the safe running of the pharmacy. Overall, team members understand their roles in protecting people's personal information. And they know when to raise safeguarding concerns to protect vulnerable people.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define the pharmacy's working practices. The SOPs had last been reviewed in February 2018 and last read in 2016 and by only two team members. There was evidence to show team members did not always follow SOPs. For example, when carrying out final accuracy checks. Pharmacists were responsible for annotating prescriptions to confirm a clinical check had taken place before a prescription had been assembled. This authorised the accuracy checking pharmacy technicians (ACPTs) and the accuracy checking dispenser (ACD) to complete the final accuracy check. But they were completing the accuracy checks before the pharmacists had carried out and annotated the clinical checks. And there was a risk that prescribing mistakes were not identified and resolved by the pharmacist before supplies were made.

Team members did not always sign medicine labels to show who had dispensed them. For example, when dispensing multi-compartment compliance packs. A regular team member usually dispensed the packs but other team members sometimes dispensed them when they provided cover. This meant the pharmacists, the ACPT and ACD were not always able to identify which team member had dispensed each pack. And they couldn't always help individuals learn from their dispensing mistakes to avoid future errors. A SOP defined the process for near miss reporting, and team members knew to document their own errors on the pharmacy's digital record. But they had not been keeping records and this meant they were not always able to identify patterns and trends. Team members were aware of some of the common dispensing risks of error in the pharmacy such as incorrect selection of amitriptyline and amlodipine. And a few years previously they had attached shelf-edge warning labels to highlight some medicines that look-alike or sound-alike (LASA). The SI encouraged the pharmacy team to suggest improvements to the pharmacy's working arrangements. A team member had highlighted similarities between mercaptopurine and medroxyprogesterone and they had separated them to avoid selection errors. Team members knew how to manage complaints and knew to report dispensing mistakes that people reported after they left the pharmacy. These were reviewed by the superintendent pharmacist (SI) who worked onsite at the pharmacy.

Team members maintained most of the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed a responsible pharmacist (RP) notice which was visible from the waiting area. But there was a gap in the RP record and there were no entries between 16 November 2023 and 18 January 2024. The pharmacist used an Application (App) to manage staff attendance. And they were able to show which staff were on duty. But this did not show who had been legally in charge of the pharmacy on these dates as two pharmacists at a time worked at

the pharmacy. Team members maintained controlled drug (CD) registers and kept them up to date. The pharmacy team recorded CDs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. Team members filed prescriptions so they could easily retrieve them if needed. And they kept records of supplies against private prescriptions that were up to date. Team members knew to protect people's privacy and they used a shredder to dispose of confidential waste. Team members discussed safeguarding concerns with the pharmacists so that vulnerable people were protected. They provided several examples of when they had raised concerns with family members and people's GP practice. For example, when people did not collect their medication on time. They had a list of relevant contact information for ease of access.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy reviews its staffing levels to ensure it has the right number of suitably skilled pharmacy team members working when it needs them. Team members have the right qualifications and skills for their roles and the services they provide. And the pharmacy provides some support to help team members develop.

Inspector's evidence

The pharmacy's prescription workload had increased significantly over the past year. And the SI had carried out a staffing review to identify any gaps or shortfalls in the pharmacy team. They had appointed a full-time pharmacist which meant that two pharmacists worked in the pharmacy most of the time. And they had increased the working hours of some team members to help with the extra workload. Most of the pharmacy team members had worked at the pharmacy long term and were experienced and competent in their roles. There were two full-time and one part-time pharmacy technicians, one part-time accuracy checking dispenser (ACD) and one full-time dispenser. Two of the pharmacy technicians were accredited to carry out final accuracy checks.

The pharmacy did not plan and deliver formal training for its team members to complete. But the SI supported the pharmacy professionals that worked there to meet their regulatory obligations and to evidence ongoing development in their roles. The pharmacy technicians provided examples of their learnings. This included learning about real-time glucose monitoring using mobile phone technology and learning about a new patient group direction (PGD) to treat hayfever, which the NHS had introduced in 2023. The ACD submitted a portfolio of evidence every two years for reaccreditation which showed they had learned and developed in their role. But the pharmacy did use the information to learn and to identify new and emerging risks in the pharmacy.

The SI used an Application to manage holiday requests, and this helped with contingency arrangements so there was service continuity. For example, when more than one person was off at the one time team members from a nearby pharmacy owned by the same company could be called on to provide extra support when required. Team members understood their obligations to raise whistleblowing concerns, and they knew when to refer concerns to the pharmacist. The SI encouraged the pharmacy team to suggest improvements to the pharmacy's working arrangements. One of them had highlighted similarities between mercaptopurine and medroxyprogesterone and they had separated them to avoid selection errors.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean, and hygienic. The pharmacy has adequate facilities for people to have private conversations with team members.

Inspector's evidence

The pharmacy team managed the available workspace well to ensure dispensing procedures were carried out safely and effectively. The pharmacy did not have a separate dedicated consultation room and a private booth at the side of the waiting area was available for use. This helped people speak freely with the pharmacist and other team members during private consultations. Team members cleaned and sanitised all areas of the pharmacy on a regular basis. This ensured the pharmacy remained hygienic for its services. 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 people can easily access. And overall it provides its services in accordance with safe working practices. The pharmacy obtains its medicines from reputable sources and it carries out some checks to make sure it stores its medicines appropriately and that they are fit for purpose.

Inspector's evidence

People accessed the pharmacy via the health centre. And a step-free entrance provided access which helped people with mobility difficulties. The pharmacy opened on weekdays but not weekends. It purchased medicines and medical devices from recognised suppliers. And team members knew to conduct monitoring activities to confirm that medicines were fit for purpose. They checked expiry dates at the time of dispensing to ensure that items were in date and suitable to supply. But they had not been carrying out routine checks on a regular basis and sampling showed that some of the items on the pharmacy shelves were out of date. The pharmacy used two fridges to keep medicines at the manufacturers' recommended temperature. At the time of the inspection the fridges showed satisfactory temperatures of 3.1 degrees Celsius, and 5.6 degrees Celsius. The SI confirmed they had read the temperature every day, but they had not recorded them. This meant they were unable to provide an audit trail to show that fridges had remained within the accepted range of between two and eight degrees Celsius. The fridges were organised with items safely segregated. This helped team members manage the risk of selection errors.

Team members used four secure cabinets for some of its items. Medicines were well-organised and items awaiting destruction were kept segregated from other stock. The pharmacy had medical waste bins and denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy received drug alert and recall notifications. Team members checked the notifications and acted when necessary. For example, they had recently acted on a notification for the recall of a baby milk. But they did not record the actions they had taken to maintain an audit trail. 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 knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so people were able to read the relevant information. They also knew about legislative changes which required them to provide supplies in the original manufacturer's packs. The pharmacy dispensed valproate into multi-compartment compliance packs for a very small number of people and the pharmacist had considered the risks. They had authorised team members to continue to dispense their valproate doses in this way but did not have a documented risk assessment to provide assurance that supplying medication in this way remained in the best interest for these people.

The pharmacy used an automated dispensing machine for some medicines to help with the pharmacy's prescription workload. And team members obtained an accuracy check at the time of entering new prescription data onto the system. This managed the risk of errors when entering information and dispensing incidents. The pharmacy used containers to keep individual prescriptions and medicines together during the dispensing process. This helped them to manage the risk of items

becoming mixed-up. The pharmacy had introduced bar-code scanning for completed prescriptions to ensure that multiple prescriptions were identified at the time people arrived to collected them.

Team members used a separate rear bench to dispense multi-compartment compliance packs to help people with their medicines. A team member was responsible for managing the dispensing of the packs. And they referred to records that provided a list of people's current medication and the time of the day it was due. They checked new prescriptions for accuracy and kept records up to date. Team members worked closely with the practice pharmacists who helped to resolve queries. Team members provided descriptions of medicines on the medicines label on the pack. But they only provided patient information leaflets (PILs) following changes to people's medicines. The driver delivered most of the packs, but some people arranged collection either by themselves or by a representative. Team members monitored the packs to confirm they had been collected on time and they contacted the surgery when people failed to collect them.

The pharmacy dispensed serial prescriptions for people that had registered with the Medicines: Care and Review service (MCR). The pharmacy had a procedure to manage and record the dispensing of these prescriptions. And a team member was responsible for ensuring compliance with the pharmacy's arrangements. This included annotating a record to show when supplies were next due and informing the surgery when a new prescription was due. They shared concerns with the surgery such as when people were requesting inappropriate supplies of some medicines.

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 had highlighted the measures, so they were used exclusively for this purpose. Team members used a dispensing machine to measure doses for some medication. They calibrated the machine each morning to confirm it was measuring accurately. 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 conduct conversations in private if needed, using portable telephone handsets.

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.