

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: 21/08/2024

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

The pharmacy has relevant written procedures for the services it provides. And team members mostly follow these to help them provide services safely. They discuss mistakes that happen when dispensing. And they keep some records to identify patterns in the mistakes and reduce the risk of errors. The pharmacy keeps accurate records as required by law, and it protects people's confidential information to keep it safe and secure. Team members understand their roles in protecting vulnerable people.

Inspector's evidence

The pharmacy defined its working practices in a range of relevant standard operating procedures (SOPs) and team members had access to them whenever they needed to refresh their knowledge. The superintendent pharmacist (SI) had approved and issued new pharmacy SOPs since the last inspection in January 2024. Team members had read and signed them to confirm their understanding and ongoing compliance. The folder containing the SOPs showed a range of documented procedures, such as for controlled drugs (CDs) and responsible pharmacist (RP) regulations. It also included a procedure for carrying out final accuracy checks for the pharmacist, accuracy checking dispenser (ACD) and accuracy checking pharmacy technician (ACPT) to follow. The SI and the RP knew to use a checking stamp and to annotate prescriptions they deemed suitable for the ACD and the ACPTs to accuracy check. And the procedure instructed the ACDs and the ACPTs to accuracy check only those prescriptions that the pharmacist had annotated. But they had checked prescriptions that had not been annotated and had left them in a separate area for the SI and the RP to check retrospectively which was not inline with the SOP. The RP explained this had been a temporary measure and confirmed that going forward they would ensure ACDs and ACPTs complied with the SOP.

A signature audit trail on medicine labels showed who was responsible for dispensing each prescription. This helped the SI, the RP, the ACD and the ACPTs identify and help team members learn from their dispensing mistakes. The pharmacy had defined the process for team members to follow to report errors identified before they reached people, known as near miss errors. The RP kept records of errors, but the other team members responsible for carrying out final accuracy checks had not been keeping records. This meant the pharmacy did not always take the opportunity to identify patterns and trends to make the necessary safety improvements. Team members provided some examples of improvement action to manage dispensing risks. This included the separation of the different pack sizes of the most used analgesia medications, such as the 112 and 224 packs of co-codamol. The pharmacy used shelf-edged caution labels to highlight look-alike, sound-alike (LASA) medicines to manage the risk of selection errors, such as ropinirole and risperidone. Team members knew to escalate dispensing mistakes, which were errors that were identified after a person had received their medicine. The pharmacist discussed the incidents with team members, so they learned how to manage risks to keep dispensing safe. The pharmacy defined its complaints procedure in a documented SOP and team members knew to handle any concerns that people raised in a calm and sensitive manner. Team members maintained 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 and the RP record was up to date.

Team members maintained controlled drug (CD) registers and they checked the balance recorded in the

register matched the physical stock, once a week. The pharmacy kept records of CDs that people returned for disposal which contained signatures to provide an audit trail when destructions had taken place. Team members filed prescriptions so they could easily retrieve them if needed and they kept records of supplies of unlicensed medicines and private prescriptions that were up to date. The pharmacy trained its team members to safeguard sensitive information. This included using a shredder to dispose of confidential waste safely and securely. The pharmacy defined its safeguarding of vulnerable people procedure in a documented SOP and team members knew when to escalate concerns and discuss them with the pharmacist to protect people. For example, when the driver was unable to complete deliveries that had been previously arranged.

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 supports team members to learn and develop.

Inspector's evidence

The following team members were in post; a full-time superintendent pharmacist (SI), a regular full-time responsible pharmacist (RP), one full-time pharmacy technician, one part-time pharmacy technician, one part-time accuracy checking pharmacy technician (ACPT), two part-time accuracy checking dispensers (ACDs), one full-time dispenser and one full-time delivery driver. Most team members had worked at the pharmacy for a considerable length of time. And the SI had appointed an extra team member in the last few months to help manage the increasing workload. The pharmacy had minimum staffing levels in place with only one team member permitted to take leave at the one-time unless there were exceptional circumstances. And a nearby branch in the same company provided cover when required. The SI arranged locum pharmacists to provide cover and they had also arranged backfill to support the regular RP to undergo qualification training to become an independent prescriber. There was adequate team members present to manage the workload and keep up to date.

The pharmacy had informal arrangements for new team members training. This included the reading and signing of SOPs to confirm adherence to the pharmacy's safe working practices. The new ACD had spent time learning about the pharmacy's patient medication record (PMR) which was different to the system they were used to in the pharmacy they previously worked in. The SI and the RP supported team members to develop their knowledge and skills to keep up-to-date in their roles and responsibilities. They had recently discussed topiramate and the introduction of new safety measures, including a Pregnancy Prevention Programme. And they discussed NHS pharmacy first formulary changes when they received notifications from the health board. The pharmacy technicians also kept their own knowledge and skills up-to-date for example, one of the pharmacy technicians had read about changes to a glucose monitoring system that sent real-time readings to people's smartphones.

The pharmacist encouraged team members to provide feedback and suggest service improvements and they provided examples of recent changes, such as using coloured labels on the storage boxes used for multi-compartment compliance packs. This helped them to accurately select the correct pack and to manage the risk of hand-out errors. The pharmacy had a documented SOP that defined the process for raising whistleblowing concerns and it trained team members, so they understood their obligations to do so. This ensured they knew when to refer concerns to the pharmacist or another team member.

Principle 3 - Premises ✓ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was in a purpose-built premises and team members managed the available workspace well to ensure dispensing procedures were conducted safely and effectively. They had designated workstations depending on the various tasks they conducted. This included separate areas for the checks that were carried out by the pharmacist and the ACDs. Rear benches were used to assemble and label multi-compartment compliance packs. This ensured sufficient space for the prescriptions and the relevant documentation to carry out the necessary checks and keep dispensing safe. The pharmacist had good visibility of the medicines counter and could intervene when necessary.

The pharmacy had a consultation room, but this was mostly used to store ancillary stock. It also had a private booth that helped people speak with the pharmacist and other team members in private. A clean, well-maintained sink in the dispensary was used for medicines preparation. And team members cleaned 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 to store medicines and to provide services.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it provides its services safely. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team conducts checks to make sure medicines are in good condition and suitable to supply. And they identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy was in a health centre and provided its services five days a week from Monday to Friday. People accessed the premises via a ramped entrance which helped with mobility difficulties. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were fit for purpose. This included regular date-checking which was documented so that team members knew when checks were next due. Team members highlighted short-dated items to manage the risk of near miss errors and a random check of dispensary stock found no out-of-date medicines.

The pharmacy used two fridges to keep medicines at the manufacturers' recommended temperature. And team members read and recorded the temperature every day to show that fridges remained within the accepted range of between two and eight degrees Celsius. The fridges were organised with items safely segregated which helped team members manage the risk of selection errors. The pharmacy received drug safety alerts and medicine recall notifications. The SI and the RP checked the notifications, and maintained an audit trail to show they had conducted the necessary checks. The pharmacy had medical waste bins and denaturing kits available to support the team in managing pharmaceutical waste.

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 safety information. They also knew about recent legislative changes which required them to provide supplies in the original manufacturer's pack unless in exceptional circumstances.

The pharmacy used containers to keep individual prescriptions and medicines together during the dispensing process. This helped team members manage the risk of items becoming mixed-up. It also helped them prioritise prescriptions, for example, they used a red basket for people that wished to wait on their medication. Team members dispensed a considerable number of medicines in multi-compartment compliance packs over a four-week cycle. The pharmacist carried out a clinical check on all the prescriptions and they used a stamp to annotate their signature, so the ACD knew when they were authorised to accuracy check them. Team members used supplementary pharmacy records to document the person's current medicines and administration times. This allowed them to carry out checks and identify any changes that they queried with the GP surgery. Team members also kept a schedule to show when people's compliance packs were due for delivery. They retrieved the packs from the storage shelf, and these were checked against the schedule to ensure they were correct. Team members supplied patient information leaflets (PILs) whenever there were prescription changes, but not on each dispensing, and they provided descriptions on the packs of to help people identify their medicines.

The pharmacy used an automated dispensing machine to dispense substance misuse medicines. And team members knew to obtain an accuracy check from the pharmacist at the time they inputted the prescription information onto the machine. This managed the risk of dispensing mistakes and people being supplied incorrect supplies.

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. 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. The pharmacy used an automated dispensing machine to dispense a high-risk medicine. And team members calibrated the machine to confirm it was measuring accurately.

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.