General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Docherty Pharmacy, 224 Kilmarnock Road, GLASGOW, Lanarkshire, G43 1TY

Pharmacy reference: 1042394

Type of pharmacy: Community

Date of inspection: 03/03/2022

Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy also 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). The inspection was completed during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 satisfactory working practices. But the pharmacy does not review its documented procedures to keep them up to date. It can show how it manages some of its dispensing risks. But it does not document most of its near miss errors and dispensing incidents so it can learn from its mistakes. It keeps the records it needs to by law, and it suitably protects people's private information.

Inspector's evidence

The pharmacy had introduced new processes to manage the risks and help prevent the spread of coronavirus. Team members had been limiting the number of people in the waiting area to two at a time. They had recently relaxed this restriction due to falling infection rates. And they continued to monitor the waiting area to manage the risk of congestion. This ensured people kept a safe distance from each other. Hand sanitizer was not available for people to use on arrival at the pharmacy. They had to ask team members who pumped a supply onto people’s hands. Team members each had their own bottle of sanitizer and they applied it to their hands throughout the day. The responsible pharmacist, who was also the superintendent, and the pharmacy technician were not wearing face masks. They each donned a face mask at the request of the inspector. A plastic screen was in place at the medicines counter. This acted as a protective barrier between team members and members of the public. The pharmacy used documented working instructions to define the pharmacy's processes and procedures. Sampling showed it had not produced an ‘assembly and labelling’ procedure for team members to refer to. The pharmacist had annotated most of the procedures with a review date of May 2019, but the review was overdue. Team members had not recorded their signatures to show they had read and understood most of the procedures. The pharmacy kept the procedures in a folder which also contained some expired ‘patient group directions’ (PGDs). The headers for urinary tract infection treatments stated NHS Grampian and NHS Lanarkshire. The pharmacist later produced several PGDs that were in date. Those included, aciclovir which was valid until 2023 and flucloxacillin which also expired in 2023.

Pharmacy team members signed medicine labels to show who had ‘dispensed’ and who had ‘checked’ each prescription. This meant that the pharmacist could identify dispensers to help them learn from their dispensing mistakes. Team members had recorded one near miss error since the start of the year. This meant they were unable to identify patterns and trends in dispensing errors. Team members had taken some action to manage the risk of errors recurring. This included separating atorvastatin/esomeprazole, mirtazapine tablets/orodispersible tablets and lamotrigine 100mg/200mg. The pharmacist could not recall any recent dispensing incidents. And they were unable to produce any records to show they were documenting dispensing incidents, the learnings, and any mitigations to manage the risk of the same error happening again. The pharmacy trained its team members to handle complaints. It had defined the complaints process in a procedure for team members to refer to. The procedure had expired in May 2019. The pharmacy did not display a notice in the waiting area to provide information about how to complain. People had been mostly satisfied with the services they received with no areas highlighted for improvement.

The pharmacy maintained the records it needed to by law. It had public liability and professional

indemnity insurances in place which were valid until 30 April 2022. The pharmacist displayed a responsible pharmacist notice. The notice was not visible from the waiting area and did not reflect the pharmacist on duty. The responsible pharmacist kept the RP record up to date to show who had been on duty. The pharmacy had introduced an electronic controlled drug register in July 2021. Team members had checked and verified the controlled drug balances at the same time. They maintained the register and kept it up to date and checked and verified the balances at the time of dispensing. This meant that slow-moving stock was not checked on a regular basis. People returned controlled drugs they no longer needed for safe disposal. Team members kept records of the destructions of these, and the pharmacist had also authorised the pharmacy technician to sign the records to confirm that destructions had taken place. Team members kept prescription forms in good order. They kept records of supplies against private prescriptions and supplies of 'specials' and kept the records up-to-date. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. Team members used a shredder to dispose of confidential waste. The pharmacy displayed a notice to inform people about how it used and processed their information. This was in relation to the NHS Pharmacy First service. The pharmacy trained its team members to manage safeguarding concerns. It had not introduced a policy for them to refer to but kept an up-to-date list of contact details for key agencies. Team members knew to speak to the pharmacist whenever they had cause for concern. This included concerns about failed deliveries or collections of multi-compartment compliance packs. Team members monitored packs that were due for collection. This helped them identify potential concerns which they followed up. The dispenser on duty provided a few examples of when she had needed to contact family members and the GP practice due to concerns. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. This helped to protect children and vulnerable adults.

Principle 2 - Staffing ✔ Standards met

Summary findings

Most of the pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. They complete training as and when required. And they learn from the pharmacist to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's workload had increased since the start of the coronavirus pandemic. The company had maintained the number of regular team members it employed. It also employed two pharmacy students to work every Saturday and to provide weekday cover when needed, such as for annual leave. A regular relief pharmacist worked every Friday and Saturday and sometimes provided extra cover. The pharmacist also arranged locum pharmacist cover when they needed to. Most of the team members were long-serving and experienced in their roles and responsibilities. One of the assistants had been in post for one year. The pharmacist had not yet enrolled them onto the necessary training course so they were eligible to work on the medicines counter. Also, there was no evidence to show they had read the procedures that were relevant to their role. The pharmacy team included one full-time pharmacist, one full-time pharmacy technician, one full-time dispenser, two full-time medicines counter assistants, one full-time assistant, two student pharmacists and one full-time delivery driver.

The pharmacist kept the pharmacy team up to date with service developments. Recent topics had included a new 'Hospital at Home Service'. Team members knew they sometimes needed to contact the Hospital at Home Team instead of the GP practice to arrange new prescriptions for multi-compartmental compliance packs. One of the medicines counter assistants provided an example of a recent POM to P change for fexofenadine. The pharmacist encouraged team members to provide feedback and suggest areas for improvements. The dispenser had changed the way the pharmacy ordered repeat prescriptions. Instead of ordering prescriptions over the telephone they co-ordinated with the delivery driver's schedule. The driver took the repeat prescription slips and handed them into the GP practice instead. This had been beneficial and had saved team members time waiting on the phone.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises adequately support the safe delivery of services. And pharmacy team members manage 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

The dispensary was small and team members had arranged the dispensing benches and storage areas to make the best use of the available space. The dispensing benches were organised and mostly clutter free. Workstations were at least two metres apart and team members kept a safe distance from each other for most of the day. A rear area provided extra storage for excess stock and other items. It also included a small kitchen area. One team member at a time used the area for comfort breaks. This allowed them to remove their face masks without being at risk of infection. The pharmacist supervised the medicines counter from the checking bench. They were able to intervene and provide advice when necessary. The consultation booth was not being used to see people. It was being used for dispensed prescriptions that were awaiting collection or delivery. The pharmacist invited people to the rear storage room for consultations. This allowed them to be carried out in private. The pharmacy kept some multi-compartment compliance packs in the room, but they were mostly kept out of sight. A sink in the dispensary was available for hand washing and the preparation of medicines. Team members cleaned and sanitised the pharmacy on a regular basis to reduce the risk of spreading infection. Lighting provided good visibility throughout. The ambient temperature provided a suitable environment to store medicines and to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

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. The pharmacy provides services which are easily accessible. And it generally manages its services well to help people receive appropriate care.

Inspector's evidence

The pharmacy advertised its services and opening hours in the windows at the front of the pharmacy. A step-free entrance provided unrestricted access for people with mobility difficulties. Team members used dispensing baskets to manage the risk of items becoming mixed-up. They kept stock neat and tidy on a series of shelves. The pharmacy had two, controlled drug cabinets. One of the cabinets was becoming congested, but there was still adequate space to segregate expired stock and items awaiting destruction. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members confirmed that the pharmacy students carried out date-checking at the weekend. They were unable to produce records to confirm that date checking was up-to-date. Sampling showed that items were within the manufacturer's expiry date. Two medicines fridges were used to keep stock at the required temperature. Team members had organised the fridges so that one contained stock and the other items that had been dispensed and awaiting collection or delivery. Team members monitored and documented the temperature of the fridges to show they were operating within the accepted range of 2 to 8 degrees Celsius. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. The pharmacist knew to contact prescribers if they received new prescriptions for people in the at-risk group. Team members knew to supply patient information leaflets and to provide warning cards.

The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people. This had remained at the same level over the course of the pandemic. The pharmacy had defined the assembly and dispensing process in a documented procedure for team members to refer to. The procedure was not up-to-date and had passed its expiry date. A separate bench was used to assemble the packs. Team members ordered new prescriptions after they removed the third pack of the four-week cycle for supply. This ensured they had sufficient time to process subsequent supplies. Team members retained previous prescriptions and checked new prescriptions for accuracy before they started dispensing packs. Queries were discussed with the relevant prescriber. Team members produced a list of deliveries for the driver and the driver signed to confirm deliveries had been completed. The driver had supplies of face masks, gloves, and hand sanitizer for personal protection and to protect others. Team members accepted unwanted medicines from people for disposal. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Drug alerts were prioritised, and the pharmacist checked for affected stock so that it could be removed and quarantined straight away. The day before the inspection they had checked for isosorbide stock. The MHRA had issued the alert on 2 March 2022. The pharmacist retained the drug alerts in an electronic folder. They were unable to show they had acted on the alert or what the outcome of the checks had been.

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). It used crown-stamped measuring equipment. Team members cleaned them after use and kept them on a rack above the sink. The pharmacy stored prescriptions for collection out of view of the waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy used a cordless phone. This meant that team members could carry out conversations in private if needed. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks and gloves.

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.