General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tollcross Pharmacy, 229 Tollcross Road, GLASGOW, Lanarkshire, G31 4UN

Pharmacy reference: 1042519

Type of pharmacy: Community

Date of inspection: 25/11/2021

Pharmacy context

This is a community pharmacy on a parade of shops. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it offers a medicines' delivery service to vulnerable people. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines' use. And they supply a range of over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs). This was a follow-up inspection and was completed 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 acts to keep members of the public and team members safe during the Covid-19 pandemic. It has policies and procedures in place and team members follow them. The pharmacy team discuss dispensing mistakes and make some improvements to avoid the same errors happening again. The pharmacy keeps the records it needs to by law, and it keeps confidential information safe. Team members securely dispose of personal information when it is no longer required.

Inspector's evidence

The pharmacy had introduced new processes to manage the risks and help prevent the spread of coronavirus. Posters on the entrance door reminded people visiting the pharmacy to wear a face covering as required by law. And informed them the waiting area could only accommodate a maximum of three people to allow them to maintain a safe two-metre distance from each other. People were seen to be following the guidelines without any instruction from the pharmacy team members. Hand sanitizer was available in the waiting area and throughout the dispensary. A plastic screen was in place along the entire length of the medicines counter. This acted as a protective barrier between team members and members of the public. Pharmacy team members were wearing face masks throughout the inspection. The pharmacy used working instructions to define the pharmacy's processes and procedures. The previous owner had authorised the procedures for use and sampling showed they had gone beyond their review dates. This included a procedure for the management of controlled drugs which was due to be reviewed in April 2019, and a procedure for dispensing multi-compartment compliance packs which was due to be reviewed in June 2016. The procedure for prescription deliveries had last been updated in September 2018, and it did not reflect a new electronic recording system for deliveries. Most of the team members had recorded their signatures to show they understood and followed the procedures. Team members signed medicine labels to show who had ‘dispensed’ and who had ‘checked’ each prescription and team members recorded their near miss errors. The pharmacist provided dispensers with feedback about their errors. This helped them to reflect and learn to identify the cause of mistakes to avoid them happening again in the future. A list of ‘look alike and sound alike’ medicines was being displayed above the dispensing bench. It highlighted the risk of common selection errors, such as, amitriptyline/amlodipine and trazadone/tramadol. The list had not been updated since its introduction two years ago. The pharmacy had access to an incident reporting template. The pharmacist knew to record information about the incident, including the root cause and any improvements made to manage the risk of the same incident happening again. The pharmacist confirmed there had been no incidents since the last inspection in April 2021. The pharmacy trained its team members to handle complaints. It had not defined the complaints process in a documented procedure for team members to refer to. And it did not display contact details to inform people how to submit a complaint.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurance in place, and they were valid until 30 April 2022. The pharmacist in charge displayed a responsible pharmacist (RP) notice and kept the RP record up to date. Team members kept private prescription forms in good order, and they kept a record of the supplies they made. The pharmacy had introduced an electronic controlled drug register since the last inspection. At the time, team members had intended carrying out the checks on a weekly basis. But due to annual leave they

had last checked and verified the balances at the start of October 2021. Controlled drug stock awaiting destruction had been placed in a labelled bag and segregated at the bottom of the controlled drug cabinet well away from other stock. The back of the private prescription register was being used to record controlled drugs that people returned for destruction. At the time of the inspection, a small quantity was being held in the cabinet, but it had not been documented in the register. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. The pharmacy did not display a notice or inform people about how it used or processed their information. A separate identifiable bag was used to dispose of confidential waste and spent records. A company specialising in confidential waste disposal collected the bag and disposed of it securely. The previous owner had introduced a safeguarding policy, a chaperone policy and a whistle blowing policy in 2016. Team members knew to speak to the pharmacist whenever they had cause for concern, and they knew how to protect children and vulnerable adults. The pharmacist was registered with the protecting vulnerable group (PVG) scheme, which also 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. Pharmacy team members speak-up and make suggestions to help improve pharmacy services.

Inspector's evidence

The pharmacy's workload had remained stable since its last inspection in April 2021, and the pharmacist had not needed to make any changes to the pharmacy team. The following team members were in post; one full-time pharmacist, one full-time dispenser (pharmacy manager), one full-time dispenser, two full-time trainee dispensers, one part time trainee pharmacy technician and one part-time delivery driver. The pharmacist supported the trainees with their courses, and they provided protected learning time in the workplace, so they made satisfactory progress.
Another team member worked as a dispenser, but the RP could not confirm if they had completed the necessary training.

The pharmacist was undergoing 'management and leadership' training. They provided individual feedback and coached team members to improve in their roles. The pharmacist kept the team members up to date with the relevant coronavirus initiatives. And they had recently provided re-fresher training following feedback about 'lateral flow test' submissions for payment due to some being incorrect. They had also provided re-fresher training so that information about serial prescription supplies was communicated to prescribers in good time. The pharmacist had completed the necessary training to provide a new flu vaccination service for the first time. Team members understood the need for whistleblowing and felt empowered to raise concerns when they needed to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, well-equipped, and professional in appearance. It has a large sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

Workstations were at least two metres apart and team members kept themselves as far apart as possible from each other throughout the day. Dispensary benches had been organised for different tasks, and a dedicated rear bench was being used to assemble and check multi-compartment compliance packs. A separate entrance provided access to an area that was being used to supply and supervise methadone doses. A security buzzer had been installed to restrict access to the area, but it was not working at the time of the inspection. Only one person at a time was being seen in the area at the time of the inspection. The pharmacist could observe and supervise the main medicines counter from the checking bench, and they could intervene and provide advice when necessary. A sound-proofed consultation room was in use. It was well-equipped and provided a confidential environment to have private consultations. A sink was available for hand washing and the preparation of medicines. The pharmacist was using the consultation room to administer flu vaccinations, and they cleaned the room and touch points in between sessions. Team members cleaned and sanitised the rest of the pharmacy on a regular basis to reduce the risk of spreading infection. 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 are easily accessible. And it generally manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and it stores them safely and securely. The team carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy advertised its services and opening hours in the windows at the front of the pharmacy. It had a step-free entrance which provided unrestricted access for people with mobility difficulties. Dispensing benches were organised and clutter-free, and team members used dispensing baskets to manage the risk of items becoming mixed-up. Stock was kept neat and tidy on a series of organised shelves, and three controlled drugs cabinets were well-organised for good visibility and to manage the risk of selection errors. The pharmacy purchased medicines and medical devices from recognised suppliers. Stock takers had conducted a full expiry date check on 1 April 2021. The pharmacy's date checking matrix had not been kept up to date and was blank. Two out-of-date medicines were found after a check of around 12 randomly selected medicines. Two medical fridges were in use. One was used mostly for insulin and the other for prescriptions that had been dispensed and awaiting collection or delivery. The responsible pharmacist monitored and recorded the fridge temperatures every morning. The records showed that the temperatures had remained between two and eight 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. The pharmacy did not have extra patient information leaflets for valproate, but the pharmacist confirmed that packs had extra warning cards that they could use if they split packs.

The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people. The storage area for the packs was well-organised. Team members attached repeat prescription slips to the third pack. This indicated that it was time to order a new prescription for the next four-week cycle. Team members checked the area regularly to ensure packs were being collected on time and contacted the relevant agency if they were not. Supplementary records which contained a list of the person's current medication and dose times were kept up to date. And team members checked prescriptions against the master records for accuracy before they started dispensing packs. Queries were discussed with the relevant prescriber. Team members supplied patient information leaflets with the first pack of the four-week cycle. They did not annotate descriptions of medicines on the backing sheet that was attached to the pack. The pharmacy provided a prescription delivery service. This helped vulnerable people and those that were shielding to stay at home. The driver used a handheld electronic device to record deliveries. They also used the device to record extra information such as failed deliveries when people were not at home. The driver wore a face mask and regularly sanitised their hands. They handed items directly to people at the time of delivery. This was mostly due to people not being able to bend down to pick them up if they were left at the door. Team members used a Methameasure system for measuring methadone doses. The pharmacist checked new prescriptions at the time they were entered onto the system, and they carried out an accuracy check at the time the doses were dispensed and supplied. Team members accepted unwanted medicines from people for

disposal. They put on disposable protective gloves before handling the packages and quarantined them for 72 hours before processing the waste for destruction. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Drug alerts were prioritised, and team members knew to check for affected stock so that it could be removed and quarantined. Team members produced a drug alert for Champix. They had removed the affected stock and placed it in quarantine in a separate store cupboard.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy’s equipment is clean and well-maintained. It uses equipment appropriately to protect people's confidentiality.

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. A separate measure was used for methadone and a Methameasure system was in use. Team members calibrated the system at least once a day to provide assurance it was measuring accurately. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team members. The pharmacy had a cordless phone, so that team members could have conversations with people in private. 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.