General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 18 Quarry Street, JOHNSTONE, Renfrewshire, PA5 8DZ

Pharmacy reference: 1042906

Type of pharmacy: Community

Date of inspection: 23/03/2023

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 company used 'standard operating procedures' (SOPs) to define the pharmacy's working practices. And it issued new and updated procedures via its online operating system. Relevant SOPs were available in each individual team member's online file for them to read and follow. This was dependent on their roles and responsibilities. The company alerted team members when it issued new or updated SOPs. And they annotated the relevant record to show they had read and understood them. This was reflected in their individual training record. A sample of SOPs showed they were up to date. This included the 'responsible pharmacist' and 'controlled drug' SOPs that had been reviewed in May 2021. A sample of training records showed a dispenser had read the SOPs that were relevant to their role. This included a 'central fulfilment' SOP for off-site dispensing. Team members 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. Following feedback team members knew to record their near miss errors on the pharmacy's online operating system. This also allowed the non-pharmacist manager to carry out near-miss reviews. The online system produced an info graphic to show any patterns and trends for team members to consider. And an 'incorrect quantity' category accounted for most of the near misses in February 2023. The non-pharmacist manager discussed the findings with the rest of the team who agreed to take extra care and highlight part-packs before placing them on the dispensary shelves. The entire pharmacy team had changed around December 2022. And two new team members were about to be enrolled onto dispenser qualification training. Another team member had recently qualified and was accredited to carry out dispensary tasks. The near-miss error reviews helped the new team members to learn and to identify and manage risks in the pharmacy. For example, they obtained a pre-assembly accuracy check for all insulins and inhalers whilst they learned about the different formulations. One of the trainees had recently learned about 'look alike and sound alike' (LASAs) errors involving gabapentin and pregabalin and knew to take extra care.

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. Team members knew to record dispensing incidents on an electronic template which they sent to the superintendent's office to review. The template included a section to record information about the root cause and any mitigations to improve safety arrangements. The company carried out internal audits against professional standards to highlight areas for improvement and to ensure the pharmacy was operating safely. An audit on 22 March 2023 had highlighted some areas for improvement with a re-audit date agreed for approximately six months' time. An action included keeping the responsible pharmacist (RP) record up to date and recording the time the RP finished each day. The missing entries were due to the company recently changing from a paper-based record to an electronic record.

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 an RP 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 CD registers and kept them up to date. And they showed they mostly checked the balance at least once a month. People returned CDs they no longer needed for safe disposal. And the pharmacy had an electronic CD destruction register to record all the items it received. An audit trail showed that team members had conducted a witnessed destruction. The pharmacy filed prescriptions so they could be easily retrieved if needed. And 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 communicated with relevant agencies to discuss 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 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 decreased over the past year. And the company was in the process of reducing the pharmacy's opening hours to reflect the reduction in footfall. A new pharmacy team had taken up post in January 2023 to replace the team that had left. And a new pharmacist manager from another branch was due to assume a temporary position to review the services the pharmacy was offering. This meant the non-pharmacist manager who had been providing cover would be returning to their base branch. The pharmacy had been supporting its new team members to learn and develop. And they had completed the company's mandatory induction process. This included completing health and safety training. And reading the pharmacy's policies and procedures. One new team member had recently completed dispenser qualification training. And the other two team members had recently enrolled on the same training course. The non-pharmacist manager had allocated protected learning time in the workplace to support their training.

The following staff were in post; one full-time pharmacist, one part-time dispenser (non-pharmacist manager) and three full-time trainee dispensers. The pharmacy provided access to ongoing training for team members to complete. And they were required to log onto the company's online system to access the learning. The qualified dispenser provided examples of some training they had completed over the past six months. This included fever in children, sexual health, cold and nasal viruses, eye care and hay fever. They had also read the company's 'culture code' which included raising concerns and whistleblowing.

The non-pharmacist manager kept the pharmacy team up to date with any new initiatives and procedural changes. They discussed progress against performance standards and targets which was illustrated on a large tracker on the dispensary wall. This included registering people with the services the pharmacy was offering, such as a text service to notify people about their prescriptions and when they were ready for collection. Team members had agreed to review prescriptions to identify those that could be sent to an offsite hub for dispensing to increase the pharmacy's workload capacity. Team members discussed the findings from the monthly near miss review to discuss safety improvements. This included LASA medications to manage the risk of selection errors. Team members were proactive at suggesting changes. For example, changing the way they managed serial prescriptions for people that had registered with the 'medicines: care and review' service (MCR). They had recently alphabetised the prescriptions for ease of access to make dispensing more effective.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises support 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 in large premises with ample storage and dispensing benches. A sound-proofed consultation room provided a confidential environment for private consultations. The room was clearly marked, and team members used a keypad code to prevent unauthorised access. It had a sink with hot and cold running water, and it provided a clinical environment for the delivery of professional services.

The 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 daily, and this ensured it remained hygienic for its services. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate room provided adequate space for team members to take breaks.

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 conducts 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 access services. The pharmacy was in the process of reducing its opening hours. And the team members had placed a notice in the window to inform people of its intentions. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were safe to supply. This included date-checking activities and attaching ‘use this pack first’ stickers to highlight short-dated medicines. Team members were catching up with date checking as they had fallen behind and a sample of stock showed that items were within their expiry date. The pharmacy used two fridges to keep medicines at the manufacturers recommended temperature. And team members monitored and recorded the temperatures every day. This provided assurance that the fridge was operating within the accepted range of two and eight degrees Celsius. They used one fridge for insulin products and the other fridge for everything else including items they had dispensed. They placed the dispensed items in clear bags to easily identify the contents. Team members kept stock neat and tidy on a series of shelves. And they used secure controlled drug cabinets and 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 pholcodine medication which they had removed from stock. Team members followed the company’s procedure which included updating the relevant online form to inform the superintendent’s office they had taken the necessary actions. 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 as not to cover-up the warning messages. The pharmacy supplied patient information leaflets and patient cards with every supply.

Team members used dispensing baskets to safely hold medicines and prescriptions during dispensing. And this managed the risk of items becoming mixed-up. 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. 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 provided descriptions of medicines on the dispensing labels. And they supplied patient information leaflets for people to refer to. Packs were placed in clear bags for improved visibility and stored in alphabetical order on a series of shelves until

they were supplied in paper prescription bags.

The pharmacy supervised the consumption of some medicines. And team members dispensed some doses using an automated dispensing machine. They obtained a clinical and accuracy check at the time of registering new prescriptions on the system. And they obtained an accuracy check at the time of supply. The pharmacy dispensed serial prescriptions for a considerable number of people that had registered with the 'medicines: care and review' service (MCR). The pharmacy had a system 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 more than half of the prescriptions it received. These were mostly for people who took the same medicines with little or no changes to their prescriptions. The pharmacist checked the 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 into sealed prescription bags and into separate totes for delivery to the pharmacy. The pharmacist opened one prescription bag each day for checking. This provided assurance that the offsite hubs 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 confidential 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 used an automated dispensing system to dispense methadone doses. The dispenser calibrated the system each morning to ensure accuracy of doses. And they documented the calibrations to provide an audit trail. The pharmacy kept two blood pressure monitors, but a February 2023 label showed that a calibration was overdue. This meant the pharmacy could not provide assurance that the monitors were 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. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the sink was clean and suitable for dispensing purposes.

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.