General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Mount Florida Pharmacy, 1047 Cathcart Road, GLASGOW, Lanarkshire, G42 9AF

Pharmacy reference: 1086527

Type of pharmacy: Community

Date of inspection: 09/06/2023

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 safe working practices. And they manage dispensing risks to keep services safe. 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 these 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. The pharmacy usually kept hard copies onsite for team members to refer to. But these were not available at the time of the inspection. This was due to the company removing them temporarily to support new team members in two new branches it had recently acquired. Following the inspection, the RP provided evidence of core SOPs and the associated training records to show that team members had confirmed they had read, understood, and would adhere to them. The 'responsible pharmacist' (RP) and the 'controlled drug' (CD) SOPs showed a review date of 10 May 2025. Dispensers signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist and the 'accuracy checking technician' (ACT) were able to help individuals learn from their dispensing mistakes. The RP annotated prescriptions to show they had conducted a clinical check. And the ACT knew only to check prescriptions with annotations which showed they had been authorised to conduct accuracy checks.

Team members evidenced they had recorded a few near miss errors every month, and there was some evidence of near miss reviews to identify patterns and trends. This had helped the team to agree upon improvements to maintain the safe dispensing arrangements at the pharmacy. The 'responsible pharmacist' (RP) had delegated the near miss reviews to the trainee pharmacist. And the last review they had conducted was at the start of 2023. Most of the errors had fallen under the 'incorrect quantity' category, and team members had agreed to remind themselves to highlight split packs before placing them back on the storage shelves. The pharmacy used bar-code scanning technology which helped to manage the risk of selection errors. And team members used pink coloured baskets for dispensing and they attached pink labels to prescriptions when the bar-code reader failed to scan items. This provided extra information for the RP and the ACT to conduct accuracy checks on dispensed items.

The pharmacy trained its team members to manage complaints. And they knew to provide the contact details for the SI's office if people wished to complain. Team members knew to report dispensing mistakes that people reported after they left the pharmacy. And the RP produced an incident report using an electronic template which they sent to the SIs office. The template included a section to record information about the root cause and any mitigations they introduced to improve safety arrangements.

Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place which were valid until 25 March 2024. The RP 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. But it did not always show the time the RP finished for

the day. Team members maintained the electronic controlled drug (CD) registers and kept them up to date. They evidenced that they conducted a balance check for most of the items every two weeks and they conducted a visual check of methadone balances. But they did not use measuring cylinders and this meant they had not corroborated the balances with the registers for a significant length of time. People returned CDs they no longer needed for safe disposal. And team members used a CD destruction register to document items which the pharmacist signed to confirm destructions had taken place.

Team members completed regular data protection training and they understood data protection requirements and how to protect people's privacy. For example, they used a shredder to dispose of confidential waste. A notice was on display in the waiting area to inform people about its data protection arrangements. Team members had completed an online training module and knew how to manage safeguarding concerns. They discussed concerns with the pharmacist which included sales of codeine containing medications when they were concerned about misuse or abuse. They also communicated with relevant agencies to discuss concerns about vulnerable people, and they kept context details up to date for ease of access.

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. Team members continue to learn to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's prescription workload had increased over the previous year. And the pharmacy team was changing at the time of the inspection due to experienced team members leaving. An area manager visited the pharmacy on a regular basis. And this was an opportunity for team members to discuss the pharmacy operations, such as staffing resources. The pharmacy had replaced one team member, and a qualified dispenser was about to take up a new position. It was also about to recruit another new team member to replace someone who was about to leave. The 'responsible pharmacist' (RP) had worked at the pharmacy for around two years. And the company's head office arranged locum pharmacist cover when required. The pharmacy team consisted of long-serving experienced team members and included; one full-time RP, one full-time trainee pharmacist, one full-time pharmacy technician who was an accredited 'accuracy checking technician' (ACT), one full-time dispenser, one full-time trainee dispenser, one full-time 'medicines counter assistant' (MCA) and one full-time delivery driver.

The company enrolled new team members on qualification training once they had completed induction training. And the pharmacy was providing protected learning time in the workplace for the trainee dispenser. The company provided team members with access to an online training platform. And they completed two or three mandatory modules every year. They also had the option to complete another five or six modules of their choice. This was linked to the company's bonus scheme, and team members received a bonus when they completed eight modules in total.

The pharmacy supported team members to learn and develop and keep up to date with changes and new initiatives. For example, changes to the NHS pharmacy first scheme. The RP had completed 'pharmacist independent prescriber' (PIP) training. And they were in the process of reflecting on how the pharmacy service could develop. The RP supported the trainee pharmacist and encouraged them to undertake consultations which they discussed prior to providing treatments. The trainee pharmacist assisted the RP in supporting team members to learn and develop. And they had recently discussed some of the pharmacy's SOPs to ensure compliance with safe working practices. This had included the recording of near miss errors.

The RP empowered team members to suggest new ways of working to improve the pharmacy's safety and effectiveness. And team members provided examples of when they had implemented improvements. This included introducing a new supplementary record to help team members manage the risks associated with the dispensing of multi-compartment compliance packs at the company's hub dispensary. The company had recognised the benefits of the new record and had implemented its use in all of its branches. Team members understood their obligations to raise whistleblowing concerns if necessary. And they knew to refer concerns to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy 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

The pharmacy provided a modern, purpose-built environment from which to safely provide services. A sound-proofed consultation room with a sink was available for use. And it provided a clinical environment for the administration of vaccinations and other services. The consultation room provided a confidential environment. And people could speak freely with the pharmacist and other team members during private consultations.

A second consultation room with an integrated hatch provided a private counter for people that required access to supervised consumption services. Team members cleaned and sanitised the pharmacy and consultation room at the end of the day. This ensured the premises remained appropriately hygienic for the services the pharmacy provided. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment. A separate room provided adequate space for team members to take comfort 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

A step-free entrance and automatic door provided access to the pharmacy. This helped people with mobility difficulties access services. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were safe to supply. They checked expiry dates every six months and they applied labels to highlight when short-dated stock was due to expire. This helped team members conduct extra checks and remove items before they expired. This managed the risk of supplying short-dated items in error. The pharmacy used a large fridge to keep medicines at the manufacturers' recommended temperature. And team members monitored and recorded the temperature to provide assurance it was operating within the accepted range of two and eight degrees Celsius. Team members used clear bags so they could easily identify items. And only experienced dispensers were authorised to retrieve items and obtain accuracy checks before they could supply them. Team members kept stock neat and tidy on a series of shelves. And they used secure 'controlled drug' (CD) cabinets for some items. Medicines were well-organised and items awaiting destruction were well-segregated from other stock.

Team members produced an audit trail of drug alerts. And they evidenced they had checked for affected stock so they removed and quarantined items straight away. The pharmacy had medical waste bins. This helped the team to manage and dispose of 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 as not to cover-up the warning messages. The pharmacy mostly supplied original packs which contained patient information leaflets and information cards. And they had spare information leaflets in the event they needed to supply split packs. The pharmacy used dispensing baskets to safely hold medicines and prescriptions during the dispensing process. And this helped manage the risk of items becoming mixed-up.

The pharmacist conducted clinical checks and annotated prescriptions before team members processed them. This included prescriptions for multi-compartment compliance packs that the pharmacy sent to an offsite hub dispensary for dispensing. Trackers helped team members plan the dispensing of the packs. And this ensured that people received their medications at the right time. They also used supplementary records that 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 which ensured they queried any changes for accuracy. Team members provided descriptions of medicines. And they supplied patient information leaflets for people to refer to. Team members conducted accuracy checks before placing the prescriptions on the shelf for collection. This ensured they added items that the hub dispensary did not dispense, such as CDs. Some people collected the packs either themselves or by a

representative. And team members kept them segregated on separate shelves. This helped them identify packs that had not been collected so they could contact people or raise a concern about their wellbeing.

The pharmacy supervised the consumption of some medicines. And team members dispensed doses in advance, so they were available for people to collect. They obtained a clinical and accuracy check at the time of dispensing. And they placed them in separate baskets in the CD cabinet until they were needed. The pharmacist conducted a final accuracy check against the original prescription at the time they made the supply.

The pharmacy dispensed serial prescriptions for people that had registered with the 'medicines: care and review' service (MCR). The pharmacy had a system for managing dispensing. And team members checked a diary on a daily basis to identify those prescriptions that were due. They retrieved the prescriptions and placed them in yellow dispensing baskets. This ensured they were differentiated and visible for team members to dispense. 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 for compliance.

The pharmacy used a 24 hour collection point machine and team members sent text message to let people know their medication was ready for collection. People collected their prescriptions from the machine using a unique PIN code. This was at their own convenience even when the pharmacy was closed. The pharmacy excluded some medications such as CDs and items that required refrigeration. And team members regularly checked the machine for uncollected items which they removed and contacted people to let them know.

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 methadone. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy used a dispensing pump to dispense methadone doses and team members calibrated the pump each morning to ensure accuracy of doses.

The RP had recently purchased diagnostic equipment to carry out consultations due to recently qualifying as a 'pharmacist independent prescriber' (PIP). The pharmacy used a collection point that people had access to 24 hours a day. The collection point supplier was on hand to carry out repairs and support the pharmacy team whenever there were problems. And the helpline number was seen on the side of the machine for ease of access.

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 carry out 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.