General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 10-12 Kilblain Street, GREENOCK, Renfrewshire, PA15 1SR

Pharmacy reference: 1089022

Type of pharmacy: Community

Date of inspection: 01/11/2024

Pharmacy context

This is a community pharmacy in Greenock. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy dispenses private prescriptions and pharmacy team members advise on minor ailments and medicines use. They provide 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 follow safe working practices. Team members discuss mistakes that happen when dispensing. And they keep records to identify patterns in the mistakes to make safety improvements 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 standard operating procedures (SOPs). The superintendent pharmacist's (SIs) office reviewed and updated current SOPs and produced new SOPs in response to changes. It notified team members when they had uploaded digital copies of the SOPs. And they knew to access their training record where they were able to read them. Once they correctly answered the relevant test questions their training record was updated to show they understood and were able to follow the SOP. A sample training record showed that one of the experienced dispensers had only read around 80% of the SOPs that were relevant to their role. And the remaining team members were new to their posts and in the process of reading the SOPs. The pharmacy was operating with different locum pharmacists. An experienced dispenser who had recently taken on a team leader role was supporting the locum pharmacists and the rest of the pharmacy team. They encouraged them to read the SOPs, but they were unable to view the team members training records so they could monitor compliance with the company's requirements.

Team members were seen to be following safe working practices at the time of the inspection. An area manager visited the pharmacy on a regular basis, and they conducted audits to monitor the pharmacy's performance against the company's governance requirements. For example, they had recently confirmed that the pharmacy complied with the management of some higher risk medicines with no improvement action required.

A signature audit trail on medicine labels showed who was responsible for dispensing each prescription. This meant the pharmacist was able to identify and help team members learn from their dispensing mistakes. The pharmacy kept records of near miss errors and the team leader produced a monthly report that highlighted any patterns and trends. This helped the pharmacy team identify and manage dispensing risks. Team members provided examples of improvement action that had helped them to manage near miss errors. This included moving amitriptyline to a separate area. It also included taking extra care when selecting medicines that were available in different strengths.

Team members knew to escalate dispensing errors, which were mistakes that were identified after a person had received their medicine. The team leader knew to complete an incident report which they shared with the SI's office so they could intervene and implement extra improvements if necessary. The pharmacy defined its complaints procedure in a documented SOP and team members knew to manage 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 an RP notice which was visible from the waiting area and the RP record was up to date. Team members maintained 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, and they annotated the records to provide an audit trail to show when destructions had taken place.

Team members filed prescriptions so they could easily retrieve them if needed. They kept records of supplies of private prescriptions which were up to date. The pharmacy trained its team members to safeguard sensitive information. This included managing the safe and secure disposal of confidential waste. A notice at the medicines counter advised people that the pharmacy kept their personal information safe and secure.

The pharmacy defined its safeguarding procedure in a documented SOP and team members knew to escalate any safeguarding concerns and discuss them with the pharmacist to protect people. For example, when some people failed to collect their medication on time so that alternative arrangements could be arranged if necessary. A chaperone notice was displayed at the medicines counter and advised people they could be accompanied whilst speaking to team members during a private consultation.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy reviews its staffing levels to ensure it has the right number of qualified pharmacy team members working when it needs them. It regularly reviews pharmacy team members performance so they can improve and develop in their roles. And it encourages team members to provide feedback and suggest improvements to improve working practices.

Inspector's evidence

The pharmacy changed ownership in August 2023 and the company had been monitoring the pharmacy's dispensing workload. It had not made any changes to the pharmacy's staffing levels even though the workload had fallen over the previous year. The company had appointed new team members to replace those that had left, and the following team members were in post; one responsible pharmacist (RP), one full-time dispenser team leader, one full-time trainee dispenser, two part-time trainee dispensers and one part-time delivery driver. The pharmacy had a vacant post and was in the process of recruiting a new dispenser. One of the experienced dispensers had been appointed to the post of team leader in March 2024. They managed annual leave according to the minimum staffing levels that were in place with only one team member permitted to take leave at the one time. The company arranged locum pharmacist cover well in advance to provide back fill for the regular pharmacist who was on leave. And cover was in place until the end of 2024. The team leader had produced a list of tasks to remind colleagues of necessary daily and weekly tasks whilst they were on leave. And they were in the process of training an experienced dispenser on how to produce the pharmacy's monthly safety briefing in their absence.

The pharmacy had formal induction arrangements in place and new team members completed training to ensure they complied with the pharmacy's governance arrangements. This included topics such as GDPR, safeguarding vulnerable adults and children and reading pharmacy's SOPs. The team leader also briefed trainees about look alike, sound alike (LASA) medication so they took extra care when selecting medicines. The pharmacy supported team members to develop in their roles and provided protected learning time, so they made satisfactory progress. One of the dispensers was about to enrol on qualification training to conduct final accuracy checks on prescriptions that had been clinically checked and annotated by a pharmacist. The RP at a nearby sister branch was the trainee's mentor due to their experience of supervising a trainee accuracy checking pharmacy technician (ACPT) in the past. The trainee dispenser provided examples of learnings, which included reading about anti-depressants so they could identify the medicines they dispensed. The team leader supported team members and kept them up to date. This included enrolling them on smoking cessation training and learning about the NHS pharmacy first service and the medicines that were available via the health board's drug formulary.

The team leader discussed learnings that the company shared about dispensing mistakes in other branches. This included images of the packaging of LASA medicines, such as amitriptyline and trimethoprim. The company empowered team members to make suggestion for change. And they had discussed the benefits of continuing to keep records of supplies of some high-risk medicines on the patient medication record (PMR) as they had done so before in the previous organisation, and this had been agreed. This had helped with checks to confirm when supplies had commenced. The pharmacist encouraged team members to raise whistleblowing concerns to help to keep pharmacy services safe and effective.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was in a modern purpose-built premises that presented a professional appearance to the people that used it. The dispensary was well organised with separate dedicated areas for the dispensing and checking of prescription items. The pharmacist was able to intervene at the medicines counter when needed. Team members used dispensing baskets to help organise the workspace on the dispensing benches. And they organised the shelves and storage drawers and kept them tidy to manage the risk of medicines becoming mixed up. A separate area was used to assemble multi-compartment compliance packs. This ensured sufficient space for the prescriptions and the relevant documentation to conduct the necessary checks and keep dispensing safe.

The pharmacy had a consultation room with separate access from the dispensary and from the waiting area. It had a sink with hot and cold running water. A separate private booth was also available, and people could speak to the pharmacist and team members in private. A clean sink in the dispensary was used for medicines preparation and team members cleaned all areas of the pharmacy daily. 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 located next to a busy shopping centre, and it provided its services six days a week from Monday to Saturday. The premises had a step-free entrance and people with mobility issues were able to gain access without any restrictions.

The pharmacy purchased medicines and medical devices from recognised suppliers and team members conducted monitoring activities to confirm that medicines were fit for purpose. They regularly checked medicine expiry dates which they documented on a date checking matrix, so they knew when checks were next due. A random check of dispensary stock found no out-of-date medicines. The pharmacy used a large fridge to keep medicines at the manufacturers' recommended temperature. And team members monitored and recorded the temperature every day to show the fridge remained within the accepted range of between two and eight degrees Celsius. The fridge was organised with items safely segregated which helped team members manage the risk of selection errors. Team members used transparent plastic bags for refrigerated items such as insulin. This meant they could conduct extra checks, such as showing items to people so they could confirm they were as expected. The pharmacy used secure cabinets for some of its medicines and they were kept tidy and well-organised. Some items were quarantined in a separate cabinet whilst awaiting destruction. The pharmacy received drug safety alerts and medicine recall notifications. Team members checked the notifications and maintained an audit trail to show they had conducted the necessary checks. For example, they had checked for trandolapril in October 2024.

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. Team members were unable to provide the risk assessments that had been conducted for people that continued to receive sodium valproate in split packs alongside their multi-compartment compliance packs. Following the inspection, the team leader and a regular locum pharmacist contacted the SI's office to obtain the relevant risk assessment template which they sent to the inspector. They undertook to conduct a review and a documented risk assessment when necessary to identify any manage any relevant risks.

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, for people that wished to wait on their medication. Team members dispensed medicines in multi-compartment compliance packs over a four-week cycle

for some people. Team members used supplementary pharmacy records to document the person's current medicines and administration times. This allowed them to conduct checks and identify any changes that they queried with the GP surgery. The pharmacy used a form and a diary to document any changes that received over the telephone. This helped them reconcile prescriptions when they arrived in the pharmacy. Team members obtained accuracy checks before they de-blistered and placed medicines into the packs. They supplied patient information leaflets (PILs) with the first pack of the four-week schedule, and they provided descriptions on the packs of to help people identify their medicines.

An off-site dispensary hub dispensed prescriptions on behalf of the pharmacy. It dispensed multi-compartment compliance packs and original packs and once completed returned them to the pharmacy for team members to supply to people. Team members completed accuracy checks at the time of entering the prescription information onto the patient medication record (PMR). And the pharmacist conducted a final accuracy check which included a clinical check before transmitting the prescription information to the hub for processing. On receipt of the multi-compartment compliance packs, team members counted all the doses in all the compartments and confirmed this matched the number of prescribed doses.

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 access to the digital version of the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for substance misuse medicines. The pharmacy used an automated dispensing machine for one of its high risk-medicine. And team members cleaned and calibrated the machine daily. 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.

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.