General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Toryglen Pharmacy, 18 Glenmore Avenue, GLASGOW, Lanarkshire, G42 0EH

**Pharmacy reference:** 1089080

**Type of pharmacy:** Community

**Date of inspection:** 02/02/2022

## Pharmacy context

This is a community pharmacy next to a medical centre in Toryglen. 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). The inspection 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

Pharmacy team members follow good working practices. And they show that they are managing dispensing risks to keep services safe. The pharmacy documents its near miss errors, and it learns 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 limited the number of people in the waiting area to two at a time to help them keep a safe distance from each other. Sometimes people queued outside, and they 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 at the medicines counter. This acted as a protective barrier between team members and members of the public. Pharmacy team members were not wearing face masks at the start of the inspection. They each donned one at the request of the inspector. The pharmacy used working instructions to define the pharmacy's processes and procedures. The responsible pharmacist had worked at the pharmacy since 2018. They had been carrying out formal reviews and updating the procedures since they took up their post. Sampling showed they had reviewed and updated a significant number of procedures in March 2021. Some had not been formally reviewed since September 2018 due to time constraints caused by the pandemic. The responsible pharmacist was satisfied they continued to reflect the safe working practices at the pharmacy. Team members had recorded their signatures to show they had read and understood them. This included the trainee pharmacist who had taken up their post in August 2021. The pharmacy employed an ‘accuracy checking dispenser’ and the responsible pharmacist had defined the process in a documented procedure. This was past its review date of September 2018. It continued to reflect the safe checking procedure being followed by the accuracy checking dispenser. They mostly checked multi-compartmental compliance packs and the responsible pharmacist annotated the prescriptions using a stamp to indicate they had carried out a clinical check. Dispensing of packs was carried out by experienced dispensers. They followed safe dispensing practices which involved checking prescriptions against the pharmacy's supplementary records. This reduced the risk of dispensing errors when carrying out the final accuracy check.

Pharmacy team members signed medicine labels to show who had ‘dispensed’ and who had ‘checked’ each prescription. The pharmacists and the accuracy checking dispenser spoke to team members to help them learn from their dispensing mistakes. They were consistent in recording near miss errors to identify patterns and trends which they acted on. This included separating gabapentin and pregabalin when there was an unacceptable number of near misses. The responsible pharmacist recorded dispensing incidents. This included a root cause analysis and any mitigations to improve patient safety. A recent incident involved a prescription written by a nurse prescriber which was processed against the wrong PMR. The root cause analysis showed the dispenser had been interrupted and this had contributed to the error. The responsible pharmacist had not followed the checking procedure, and this had also contributed to the error. Team members had discussed the incident and had agreed to always re- start the dispensing process from the beginning following interruptions. The pharmacy trained its team members to handle complaints and had defined the complaints process in an up-to-date

procedure for team members to refer to. It did not display contact details to advise 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 notice and kept the RP record mostly up to date. Team members maintained the electronic controlled drug registers and kept them up to date. The trainee pharmacist had produced a stock balance record which was attached to the controlled drug cabinet. They were responsible for checking and verifying the balances. The record provided evidence they were checking the balances at least once a month. Team members kept records of destructions of controlled drugs that people returned for disposal. The responsible pharmacist signed the records to confirm that destructions had taken place. They had last witnessed a destruction in January 2022. Team members kept prescription forms in good order. For example, they kept records of supplies against private prescriptions and any supplies of 'specials' they had made. 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 or processed their information as part of the NHS Pharmacy First service. The pharmacy trained its team members to manage safeguarding concerns, but it had not introduced a policy for them to refer to. They 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, or concerns about other vulnerable groups that used the pharmacy. Team members retrieved packs that were due to be collected and put them at the medicines counter for collection by people or their carers. They checked the shelf at the end of the week, and this helped them identify potential concerns which they followed up. The responsible 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

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 team members. Three student pharmacists provided extra cover at weekends and during the week when necessary. A recently qualified dispenser worked across two branches, and at the time of the inspection was providing cover for someone that was self-isolating due to coronavirus. Most team members were long-serving and experienced in their roles and responsibilities. The pharmacy team included one full-time pharmacist, one full-time accuracy checking dispenser, three part-time dispensers, two part-time medicines counter assistants, one trainee pharmacist, three part-time students and one delivery driver. The responsible pharmacist supervised the trainee pharmacist. They discussed progress at a weekly meeting and provided ongoing support throughout the week. The trainee had been supporting team members working at the medicines counter to identify medical conditions. For example, they intervened and identified someone who had presented with the signs and symptoms of impetigo. They made a referral to the pharmacist who provided the relevant treatment via a 'patient group direction' (PGD). The trainee was about to carry out a near miss review to identify patterns and trends. They knew to present the findings to the rest of the team and engage them in identifying any improvement actions. In September 2021, the accuracy checking dispenser had submitted the necessary documentation and evidence to demonstrate competency in final accuracy checking. The training provider had issued a revalidation certificate to confirm they had met the necessary standards. This was displayed on the dispensary wall alongside the other team members training certificates. The responsible pharmacist kept team members up to date with the relevant coronavirus initiatives. They had also provided training so that team members knew how to provide the NHS Pharmacy First service. This included a recent update to communicate formulary changes that had been introduced in January 2022. 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 premises adequately supports the safe delivery of its services. And it 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 dispensary had adequate storage space team members kept the dispensing benches organised and clutter free. They also kept workstations at least two metres apart. This kept them a safe distance from each other throughout the day. The pharmacist was able to supervise the main medicines counter from the checking bench and intervened and provided advice when necessary. A separate area was used to assemble multi-compartment compliance packs and team members kept the storage shelves, which were above the dispensing bench well-organised.

Team members had access to a small kitchen area and rest room. A sound-proofed consultation room and integrated hatch was in use. It provided a confidential environment to have private consultations. The consultation room was well-equipped with a sink and hot and cold running water. Another sink in the dispensary was available for hand washing and the preparation of medicines. Team members cleaned and sanitised the pharmacy twice a week to reduce the risk of spreading infection. 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 generally 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 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. A step-free entrance provided unrestricted access for people with mobility difficulties. The pharmacist had been responding to an increased demand for access to 'prescription only medicines' via 'patient group directions' (PGDs). This included emergency hormonal contraception. They had recently agreed to provide the NHS flu vaccination service and the responsible pharmacist was up to date with the necessary service requirements. Team members used dispensing baskets to manage the risk of items becoming mixed-up and they kept stock neat and tidy on a series of shelves. The pharmacy had two controlled drug cabinets and it had adequate space to segregate items, for example methadone, multi-compartment compliance packs and items awaiting destruction were kept separate from general stock. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members regularly checked stock to ensure it was in date. This was recorded on a date checking matrix to keep track of when checks were due. Sampling showed no out-of-date medicines. Two fridges were used to keep stock at the required temperatures. One was used for stock and the other was used for items that had been dispensed awaiting collection or delivery. Team members only monitored and documented the temperature of the fridge used for stock items. And they could not show that the second fridge kept items within the accepted range of 2 and 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 supplied patient information leaflets, but they did not always provide warning cards.

The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people. This had increased only slightly over the course of the pandemic. The responsible pharmacist had defined the assembly and dispensing process in a documented procedure for team members to refer to. A separate area was used to assemble and store the packs. An experienced dispenser was responsible for ordering the prescriptions to ensure that packs were assembled and supplied in good time. Supplementary records which contained a list of the person's current medication and dose times were kept up to date. Team members checked prescriptions against the master records for accuracy before they started dispensing packs. Queries were discussed with the relevant prescriber and they recorded changes on people's records. Team members supplied patient information leaflets with the first pack of the four-week cycle. They did not annotate descriptions of medicines on the packs. Team members used a pump to dispense methadone doses. They dispensed doses the day before they were due, and they placed them in the controlled drugs cabinet until they were needed. The pharmacist checked the doses against the prescription at the time of supply. 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

team members knew to check for affected stock so that it could be removed and quarantined straight away. The pharmacist retained the drug alerts in an electronic folder, but they did not record the outcome of the checks they carried out. The pharmacist produced documentation to show they had received an alert in January 2022 for Ikervis eye drops .

## 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. A separate measure had an elastic band wrapped around its base. Team members knew only to use it for measuring methadone. 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. |