General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Apple Pharmacy, 11 Mossvale Crescent, GLASGOW, Lanarkshire, G33 5NZ

Pharmacy reference: 1089756

Type of pharmacy: Community

Date of inspection: 05/04/2023

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 satisfactory 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 pharmacy used 'standard operating procedures' (SOPs) to define most of the pharmacy's working practices. And it reviewed and updated them on a regular basis. Team members read the SOPs and annotated them to confirm they understood and followed them. A sample of SOPs showed they had been reviewed in September 2022. These included the 'responsible pharmacist' and controlled drug' procedures. An 'accuracy checking technician' (ACT), carried out final accuracy checks on prescriptions that had been clinically checked and approved by a pharmacist. But the pharmacy had not documented the process in a SOP. This meant that team members may not be aware of all the risks and the necessary mitigations to keep dispensing safe. This included the need for pharmacists to annotate prescriptions to show they had clinically approved them. The ACT produced a 'stamp' and confirmed the pharmacist used it to annotate prescriptions. This meant the ACT could identify the prescriptions they were authorised to check. Team members signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist and the ACT were able to help individuals learn from their dispensing mistakes. Team members recorded their own near miss errors. And the pharmacy technician and the operations manager carried out near-miss reviews at the end of the month. They discussed patterns and trends but they did not document their findings. They provided examples of recent changes to manage the risk of dispensing mistakes. This included separating olmesartan and olanzapine and amitriptyline and amlodipine due to selection risks. The pharmacy trained its team members to follow its complaints process. And a labelled box at the medicines counter invited people to provide feedback about the services they received. The absence of feedback meant there had been no opportunity to make improvements. Team members responded to complaints, and they knew to record dispensing incidents on a form which they sent to the superintendent's office to review. The form included a section to record information about the root cause and any mitigations 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 expired in August 2023. The pharmacist displayed a 'responsible pharmacist' (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 controlled drug (CD) registers and kept them up to date. And they evidenced they checked the balance once a month. They also checked that doses supplied via multi-compartment compliance packs had been entered into the registers at the end of the day once they had been supplied. This helped them to ensure that balances were accurate. People returned CDs they no longer needed for safe disposal. And the pharmacy had a CD destruction register to record all the items it received for safe disposal. The pharmacy filed prescriptions so they could easily be retrieved if needed. And records of supplies against private prescriptions and supplies of 'specials' were up to date. Team members understood data

protection requirements and how to protect people's privacy. And they used a shredder to dispose of confidential waste. The pharmacy was reviewing its safeguarding arrangements. This was due to the removal of a partition in the waiting area which had been used to display relevant safeguarding notices and information. It was also due to the trainee pharmacy technician's feedback following completion of course work and learning. Pharmacy team members knew to refer safeguarding concerns to the pharmacist. And they communicated with relevant agencies to discuss concerns about vulnerable people.

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.

Inspector's evidence

The pharmacy's prescription workload had increased over the past year. And this was mostly due to an increase in the number of multi-compartment compliance packs it dispensed. A trainee pharmacy technician was employed as an operations manager across all eight branches, and they worked at the pharmacy three days a week. They were supporting the pharmacy team until a newly recruited responsible pharmacist took up their post in the following weeks. A pharmacy technician worked at the branch, and they covered for the operations manager. A regular locum pharmacist worked every Saturday, and the 'superintendent pharmacist' (SI) and another pharmacist manager provided cover when needed. This meant they did not have to rely on locum pharmacists. Only one team member at a time was permitted leave. This meant that team members could cover each other's leave. Team members were well-established in their roles and the following staff were in post; one full-time pharmacist, one full-time pharmacy technician, one part-time trainee pharmacy technician, one full-time dispenser, three part-time dispensers, two part-time trainee dispensers, one full-time delivery driver and one part-time delivery driver. Two pharmacy students worked alongside other team members on a Saturday. The pharmacy knew that demand for services was highest around 3pm when schools finished for the day. And it had organised cover so that more team members were on duty to help manage workload demand at this time. The pharmacy technician and the operations manager supported the pharmacy team. They reviewed the workload each morning and held a briefing meeting to prioritise and allocate tasks.

The pharmacy supported trainees to learn and develop. And the pharmacist had signed a learning agreement with the learning provider for the trainee pharmacy technician. This meant they had agreed to provide 10% of the trainees working hours as protected learning time. Team members provided examples of ongoing learning. Following the introduction of a new 'patient medication record' (PMR) system in December 2023, the pharmacy technician and the operations manager had coached team members to be able to use it. The pharmacy technician had recently reminded the team on the use of the PC70 form for instalment prescription supplies. This was due to some team members forgetting to complete the forms and missing audit information. The pharmacy kept team members up to date with new initiatives and procedural changes. And it had arranged for two team members to attend off-site smoking cessation training. The team members knew they were expected to share the learning with the rest of the team on their return. Team members kept up to date with formulary changes and knew to refer to the new NHS pharmacy first formulary that had been updated in March 2023. They were proactive at making changes and improvements with the pharmacist's approval. And they had suggested creating a separate section at the medicines counter for medicines that were available via the formulary. This meant they were able to identify items for ease of access. Team members knew about 'patient group directions' (PGDs) and they knew about changes to the inclusion criteria for urinary tract infection treatments. They knew to refer people aged 65 years of age and over to the pharmacist. The pharmacy carried out an annual appraisal of performance. And team members knew

they had the opportunity to contribute to their development. For example, the ‘medicines counter assistant’ (MCA) had agreed to undertake dispensers training. Team members had also asked for a new style of uniform. This had been agreed with the SI who had purchased new uniforms.

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

These were average-sized premises with adequate storage facilities and dispensing benches. A consultation room with a counter and a glass partition was in use. The partition did not prevent team members in the dispensary from listening to private consultations if they were close by. And they knew to keep a safe distance away so that people’s privacy was protected. The shelves opposite the partition were used to store multi-compartment compliance packs. But there was a risk that some of the names and address could be seen, and this meant that personal information may not always be protected. The dispensary sink had 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 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 pharmacy cannot evidence it has a systematic approach to drug alerts. This means it cannot provide the necessary assurances that medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy had a step-free entrance, and this helped people with mobility difficulties to access services. The pharmacy was reviewing the information it displayed in the waiting area due to the recent removal of a partition. Currently it was only displaying its opening hours in the front window. The pharmacy provided access to 'prescription only medicine' (POM) treatments against 'patient group directions' (PGDs). And the PGD for treatments for urinary tract infections was valid until August 2024. The pharmacy offered a smoking cessation service. And it trained its team members to provide the service. 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. Team members did not keep an audit trail of activities to show when checks were next due. This meant that checks could be missed and short-dated stock supplied in error. The pharmacy used two fridges to keep medicines at the manufacturers recommended temperature. Team members used the main fridge to keep most of its stock. And they used the second fridge for items awaiting collection. Team members monitored and recorded the temperature of the main fridge. And this provided assurance that the fridge was operating within the accepted range of two and eight degrees Celsius. But team members did not record the temperature of the second fridge. This meant they could not provide assurance the second fridge was operating within the accepted range. Team members kept stock neat and tidy on a series of shelves. And they used secure controlled drug cabinets for some items and medicines were well-organised. The pharmacy had medical waste bins and 'controlled drug' (CD) denaturing kits available to support the team in managing pharmaceutical waste.

Team members produced an audit trail of drug alerts up until January 2023. This evidenced they had prioritised drug alerts and checked for affected stock so that it could be removed and quarantined straight away. But the dispenser could not confirm they knew about a recent drug alert for the withdrawal of pholcodine medication. And the pharmacy could not show they had a robust, systematic approach to the handling of drug alerts. 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 with every supply, but they did not have spare information cards and there was a risk that some supplies would be provided without them.

Team members used dispensing baskets to safely hold medicines and prescriptions during dispensing. And this helped to manage the risk of items becoming mixed-up. The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people to help them with their medication. The numbers had increased over the previous year as the pharmacy was the only provider of packs in the area. But the pharmacy had not introduced a dispensing SOP for packs for team

members to refer to. Trackers helped team members to plan pack dispensing. And this ensured that people received their medications when they were due. They used supplementary records that provided a list of each person's current medication and dose times which they kept up to date. And they checked new prescriptions against the records for accuracy. Team members obtained a pre-check of original packs before they de-blistered doses into the packs. And this helped to manage the risk of dispensing mistakes. But the team members only retained the flaps of the packs. And there was a risk of missing information, such as the expiry date to complete the final accuracy check. Team members did not provide descriptions of medicines on the dispensing labels. But they supplied patient information leaflets for people to refer to. People collected the packs either themselves or by a representative. And the team members monitored the collections to confirm they had been collected on time. The delivery driver followed a schedule to track deliveries of packs and they highlighted failed deliveries. Team members contacted family members or other relevant authorities to raise concerns and ensure that people were receiving support when necessary. The pharmacy supervised the consumption of some medicines for around the same number of people it had the previous year. 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 the pharmacist carried out a final accuracy check 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. They checked prescriptions every day to identify those that were due so they could order items and dispense 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.

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. And team members calibrated the system each morning to ensure accuracy of doses. The pharmacy stored most of its prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in such a way as 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.