

Registered pharmacy inspection report

Pharmacy Name: Hallglen Pharmacy, Unit 2 Hallglen centre, FALKIRK, Stirlingshire, FK1 2RB

Pharmacy reference: 1090493

Type of pharmacy: Community

Date of inspection: 09/10/2019

Pharmacy context

The pharmacy is on a parade of shops in the centre of Hallglen. It dispenses NHS prescriptions and provides a range of extra services. The pharmacy collects prescriptions from surgeries across the Falkirk area. And it delivers medicines to people at home. The pharmacy supplies medicines in multi-compartmental compliance packs. And it supports people that need extra help. A consultation room is available. And people can speak to the pharmacy team in private.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not routinely assess risks to patient safety from its activities and services. And it does not keep its working instructions up to date. The pharmacy does not confirm that team members are providing services according to its working practices. This means it cannot provide the necessary assurance that services are as safe and effective as they need to be.
		1.2	Standard not met	The pharmacy does not keep records of near-misses. And it does not keep adequate records when mistakes happen. The pharmacy is unable to show where it has improved its services when things have gone wrong. This means that risks are not managed. And services may not be as safe as they need to be.
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 not all met	4.3	Standard not met	The pharmacy has inadequate storage arrangements in place for some high-risk medicines. And those medicines are not kept in an orderly manner and are mixed together. This means that selection risks are not being managed. And the risk of dispensing the wrong medicine is increased.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy does not keep its written procedures up to date. And it does not always discuss and share information about mistakes when they happen. This prevents the pharmacy team from managing risks. And prevents it from keeping services as safe as they need to be. The pharmacy keeps most of the records it needs to by law. And it trains its team members to keep confidential information safe. The team members discuss their concerns with the pharmacist. And this helps to keep vulnerable people safe. The team members know to follow the company's complaints handling procedure. And this means that they listen to people and put things right when they can.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define safe ways of working. And these had been read and signed by the long-serving team members. But the newest team member was still to sign them. The SOPs were last reviewed in 2016. And the team members did not know when the next review was due. The team members explain that the regular pharmacist manager had left. And they expected a new manager to take up post in three months time. The pharmacy displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. The pharmacy team members signed dispensing labels to show they had completed a dispensing task. And the pharmacist checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The level of reporting did not reflect the level of near-misses. And the pharmacy team had recorded around a dozen or so errors since the start of 2019. The pharmacy team had occasionally made changes to manage dispensing risks. For example, they had separated felodipine/finasteride due to mix-ups. But this was not a routine activity. One of the dispensers had handled a dispensing incident after the regular pharmacist had left. But, she had not informed the superintendent pharmacist about the error or the locum pharmacist who was responsible for it. A copy of the prescription had been kept. And an entry had been made on the near-miss record form. The pharmacy used a complaints SOP to ensure that staff handled complaints in a consistent manner. And it used a notice to inform people how they could complain or provide feedback. The pharmacy received mostly positive feedback with no suggestions for improvement received.

The pharmacy maintained the pharmacy records it needed to by law. But, the pharmacists did not always enter the time when their responsible pharmacist duties ended. Public liability and professional indemnity insurance were in place and valid until February 2020. The pharmacy team kept the controlled drug registers up to date. But, they did not carry out regular balance checks on all controlled drug stock. And only checked controlled drugs at the time they were dispensed. The team members recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The locum pharmacist had been accredited to provide access to medicines and advice via patient group directions (PGDs). But, the PGDs at the pharmacy were out-of-date.

The pharmacist trained new team members about data protection processes and procedures. And they knew how to safeguard confidential information. The pharmacy did not display a data processing

notice. And it did not inform people how it managed their confidential information. The team members shredded confidential information. And they stored prescriptions for collection out of view of the waiting area. The team members kept computer screens facing away from the waiting area. And they used a password to restrict access to patient medication records.

The locum pharmacist had registered with the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. But, the company had not trained its team members to recognise the signs and symptoms of neglect or abuse in vulnerable groups. The pharmacy team knew to discuss concerns with the pharmacist so that extra support was provided if needed. For example, they contacted the community addictions team (CAT) after three days if people did not arrive for medication that needed close supervision. And they put measures into place if people did not present as well as they were expected to.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy monitors its staffing levels. And it ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members support each other in their day-to-day work. And they suggest service changes to make sure they have effective working practices. The team members have limited access to training. And they are not encouraged to develop in their roles.

Inspector's evidence

The pharmacy had not experienced any work-load increases over the past year. And the number of NHS prescription items had remained mostly the same. The regular pharmacist had left the previous month. And the superintendent pharmacist had been carrying out interviews to appoint a replacement. A locum pharmacist was providing cover at the time of the inspection. And she worked at the pharmacy on a regular basis. The company did not use performance targets. And the pharmacy team did not feel undue pressure to increase services.

The team members had worked at the pharmacy for a significant length of time. And they knew the people that used the pharmacy. The pharmacy kept training qualifications on-site. And the following team members were in post; one full-time pharmacist, four part-time dispensers, one part-time medicines counter assistant (MCA) and two part-time delivery drivers. The pharmacy team members submitted holiday requests in advance with only one person permitted leave at the one time. And this ensured that minimum levels were maintained. The dispensers worked part-time. And they worked extra to cover annual leave and unplanned absences.

The pharmacy did not use performance reviews to develop the pharmacy team. And the pharmacist updated team members whenever there were changes or new initiatives. This ensured the pharmacy team members were up-to-date and competent in their roles. For example, they had been informed that pregabalin and gabapentin had been reclassified as a schedule three controlled drug.

The superintendent pharmacist provided guidance for locum pharmacists. But, the document had passed its review date of 1 February 2017. And it did not reflect the current arrangements. The pharmacy team members raised concerns and provided suggestions for improvement. For example, they had changed the way they managed multi-compartmental compliance pack dispensing. And this was due to increases in the number of people registered with the service.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are clean. And it provides a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

A well-kept waiting area presented a professional image to the public. The pharmacy provided seating and provided a few patient information leaflets for self-selection. The pharmacists supervised the medicines counter from the checking bench. And this allowed them to make interventions when needed. The pharmacy team had allocated benches for the different dispensing tasks. And they used a separate bench to dispense multi-compartmental compliance packs to manage the risk of dispensing errors. The pharmacy provided a consultation room which was professional in appearance.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy sources and generally manages its medicines appropriately. But it does not always store some high-risk medicines safely and effectively. And this could increase the risk of dispensing errors. The pharmacy has working instructions in place for its services. But, the pharmacy does not routinely review them to ensure that processes are as safe and effective as they need to be. The pharmacy dispenses multi-compartment compliance packs to people. And it provides them with extra information to help them to take their medicines. The pharmacist identifies people taking high-risk medicines. But, they do not always keep records when appropriate to do so. This means that team members may not know when to provide extra information and advice. The pharmacy does not display its opening times and lunch-time closing. And it only provides a few healthcare leaflets for self-selection. This means that people using the pharmacy may not be as up-to-date about services that they need to be.

Inspector's evidence

The pharmacy had stepped access. But, the team members had access to a portable ramp to provide support for people with mobility difficulties if needed. The pharmacy did not display its opening hours in the pharmacy window. And people were not kept up to date. For example, they were not informed the pharmacy closed for lunch. The pharmacy displayed a few leaflets in the waiting area and in the consultation room. The pharmacy dispensed around 20 private prescriptions per week for aesthetic products. And the prescriptions were mostly written by independent nurse prescribers. The superintendent pharmacist had produced guidance to support locum pharmacists. And this included providing key contact details should extra support be needed. The pharmacist carried out clinical checks to verify that supplies were appropriate. And they recorded supplies in the electronic private prescription register. The locum pharmacist provided advice to people at the medicines counter. For example, when a mother was seeking advice about migraine relief for herself and her 12-year-old son.

The pharmacy team kept the dispensing benches organised. And they used dispensing baskets to keep prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 180 people. And the number of people registered with the service had doubled in the past three years. But, this had recently been capped until a new pharmacist manager was in post. The team members had read and signed the dispensing procedure. And one of the dispensers had been nominated to manage the dispensing activities to ensure the service was safe. All the dispensers had been trained to dispense the packs. And they provided support when needed, for example during annual leave and unplanned absences. The team members used an allocated section of the rear dispensing bench to assemble packs. And used a rear room to store the packs. The team members removed and isolated packs when they were notified about prescription changes. And they updated the patient's medication record at the time the change was notified. The pharmacy supplied patient information leaflets and descriptions of medicines. And this provided extra support to help people take their medicines as prescribed. The pharmacy provided a delivery service. And a delivery driver asked people to sign for their prescriptions to confirm receipt. The pharmacy supplied methadone doses to around 12 people. And one of the dispensers assembled the doses at the start of the week for the rest of the week. The pharmacist checked the doses before they were placed in the controlled drug (CD) cabinet for safe keeping. And the dispensed doses were checked against the prescription at the time they were supplied.

The pharmacy team kept controlled drugs (CDs) in one small cabinet. But, the size of the cabinet was insufficient to safely accommodate the stock levels that were required. The cabinet was congested with stock being kept in a chaotic manner. And the pharmacy was not adequately managing the selection risks associated with controlled drug dispensing.

The team members kept the pharmacy shelves neat and tidy. And purchased medicines and medical devices from recognised suppliers. The pharmacy team carried out regular stock management activities. And highlighted short dated stock using stickers, and part-packs using crosses during regular checks. The team members monitored and recorded the fridge temperatures. And demonstrated that the temperature had remained between two and eight degrees Celsius. The pharmacy accepted returned medicines from the public. And disposed of them in blue containers that the health board collected.

The pharmacy team members checked nhs.net emails. And acted on drug alerts and recalls. For example, they had actioned an alert concerning Emerade products in October 2019. But, the team members did not retain the drug alert documentation. And they did not keep an audit trail to evidence that they were always actioned. The pharmacy team members had learned about the requirements of the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards. The dispensers confirmed that the regular pharmacist had monitored prescriptions for valproate. But, sample PMR records had not been annotated to confirm that safety checks had been carried out. And the team members were not kept up-to-date with the need for safety messages. The pharmacist had not briefed the team members about the Falsified Medicines Directive (FMD). And the pharmacy had not installed the scanners and the software needed to implement the system. The team members did not know when a new system was due to be implemented.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

Inspector's evidence

The pharmacy had access to a range of up to date reference sources, including the British National Formulary (BNF). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. And the team members had a separate measure for methadone. The pharmacist occasionally carried out blood pressure testing. But, did not keep records to show when it had been first used or when it had been last calibrated. The pharmacy provided cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team. The pharmacy team members used a portable phone. And they took calls in private when necessary.

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.