General Pharmaceutical Council

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: 10/08/2020

Pharmacy context

During the Covid-19 pandemic the pharmacy is mainly dispensing NHS prescriptions and delivering medicines to people at home. It supplies some medicines in multi-compartment compliance packs. It provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use and supplies a range of over-the-counter medicines.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 up-to-date working instructions to help manage the risks to its services. The pharmacy keeps some records about dispensing mistakes that happen. But the low level of recording during the pandemic reduces the opportunity for team members to learn and make improvements. The pharmacy mostly keeps the records it needs to by law, and the pharmacy team keeps them up to date. Members of the team protect people's personal information. And they prevent people from seeing sensitive information they are not authorised to see. They know the importance of their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had carried out risk assessments throughout the Covid-19 pandemic to manage the risk of virus transmission. A Perspex screen created a barrier between the team members and people that visited the pharmacy. And the number of people in the waiting room at the one time was restricted to one. Notices in the window provided public health information about the transmission of the virus and how to protect themselves from it. This included social distancing and the wearing of masks. The pharmacy had hand sanitiser available in the dispensary, and it was used on a regular basis by the team members. The pharmacy team members were wearing appropriate face masks as personal protective equipment (PPE). They observed social distancing as far as possible while working in the dispensary.

The pharmacy displayed the responsible pharmacist notice, and it showed the name and registration number of the pharmacist in charge. The pharmacy had been inspected in October 2019, and an action plan had been issued to make improvements. The pharmacy had made some progress against the action plan, but actions were still outstanding at the time of the follow-up inspection. These were immediately resolved by the Superintendent. The team members could not find the pharmacy's working instructions, and they had not been able to access them since the last inspection. The superintendent emailed the inspector the documents, and they had been updated in December 2019. They also emailed them to the team members and instructed them to read and sign them as a priority.

The team members signed dispensing labels to show they had completed a dispensing task. This allowed the pharmacist to support individual team members to learn and improve their accuracy in dispensing. This also provided an audit trail of those involved in the dispensing. The team members had been keeping near miss errors but they had been unable to sustain this during the Covid-19 pandemic due to the extra workload and workplace pressure this created. They had started recording a few errors at the start of May 2020, when the workload had fallen. This helped to improve their awareness of risks. The low level of recording had been sufficient to inform them about the need for improvements.

The company used an on-line form to report dispensing incidents. The last report had been submitted to the Superintendent at the end of 2019 due to a mix-up with atenolol and amitriptyline. The report highlighted the risks associated with self-checking and to obtain a second check unless there are exceptional circumstances. The pharmacy displayed a complaint notice, and the team members knew to handle complaints in a sensitive manner. They also knew to refer dispensing incidents to the pharmacist.

The pharmacy mostly maintained the records it needed to by law. But the pharmacist in charge had not been updating the responsible pharmacist record to show when they had finished for the day. This meant they couldn't show when they stopped being in charge of the pharmacy. The pharmacy supplied aesthetic products against private prescriptions written by nurse prescribers. The pharmacist had face-to-face contact with the nurse prescribers when they collected the products on behalf of the people they wrote prescriptions for. This provided the opportunity to discuss any concerns that they had. The team members knew they could contact the superintendent pharmacist if they had concerns or needed extra support. The private prescription register was up to date, and it met legal requirements. Specials records were kept up to date with details of each person who had received a supply. The pharmacy had public liability and professional indemnity insurances in place, and they were valid until February 2021.

The pharmacy team members kept people's names and addresses well away from the waiting area, and they used a shredder to dispose of sensitive data. The pharmacy did not display information about its data protection arrangements. And it did not tell people that it kept their information safe. The locum pharmacist produced certificates to show they had registered with the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The company did not formally train its team members to identify vulnerable adults and children. But they knew to refer concerns to the pharmacist so they could take the necessary actions to protect people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members are qualified for their roles and the services they provide. The pharmacy supports trainees to develop their skills. And it provides protected learning time in the workplace for them to complete training courses. The pharmacy updates the team members about changes to pharmacy services when they arise. But it doesn't provide ongoing training so that team members continue to develop in their roles. The team members support each other in their day-to-day work. They are enthusiastic and knowledgeable in their roles, and they suggest improvements to make services more effective.

Inspector's evidence

The pharmacy's workload had increased over the past six months due to the Covid-19 pandemic. And one of the team members had left her position. This had led to a staffing review, and the company had appointed a new trainee dispenser and was in the process of recruiting another dispenser. The part-time medicines counter assistant who normally worked on a Saturday had increased their hours at the start of the pandemic. And this had provided extra support to cope with the increased workload demands. A new pharmacist manager had been appointed in February 2020, and a new locum pharmacist was providing cover at the time of the inspection. The rest of the team was well-established, and the team members were experienced in their roles and responsibilities.

The pharmacy kept copies of qualifications and training certificates on the wall to show the team members were qualified for their roles. The following team members were in post; one full-time pharmacist, three part-time dispensers, one full-time trainee dispenser, one part-time medicines counter assistant (MCA) and two part-time delivery drivers. The team members submitted holiday requests in advance with only one person permitted leave at the one time. This ensured that minimum levels were maintained. The dispensers worked part-time, and they worked extra to cover annual leave and unplanned periods of leave.

The pharmacist provided the trainee dispenser with protected learning time. This ensured they made satisfactory progress with their training course. The pharmacy did not use formal performance reviews to develop the team members. And it did not provide ongoing training so that the other team members continued to develop in their roles. The pharmacist updated the team members whenever there were changes or new initiatives. This ensured the pharmacy team members stayed up-to-date in their roles. For example, they had learned about the new 'NHS Pharmacy First' service that launched at the end of July 2020. The company did not use numerical targets to grow the services it provided. The team members promoted the services that would benefit people. For example, the prescription delivery service and the new 'NHS Pharmacy First' service. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and hygienic and has infection control arrangements in place. It has consultation facilities to meet the needs of the services it provides, and people can speak in private.

Inspector's evidence

The pharmacy had created a new reception area at the entrance. And the team members spoke to people at a desk which had the added protection of a Perspex screen. They permitted only one person to enter the pharmacy at the one time. This kept people as far apart as possible from the team members on duty. The consultation room was not being used at the time of the inspection. The pharmacy had placed a notice in the window with the pharmacist's contact details. It advised people to telephone them for advice instead of going to the pharmacy in person. This ensured that consultations were confidential and people's privacy was protected.

The pharmacy had allocated areas and benches for the different dispensing tasks. The team members used separate benches for dispensing and checking prescriptions. For example, they used a rear bench for multi-compartment compliance packs. This managed the risk of benches becoming congested. The pharmacist supervised the new reception area from the checking bench. This meant they could make interventions when necessary. The pharmacy was well-lit, and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays information in the window to keep people up to date about the services it provides. It provides public health information and safety information to protect people from Covid-19. The pharmacy mostly stores and manages its medicines appropriately. And the team members act on safety notices and remove faulty medicines from use. They know the importance of making additional checks with people about their high-risk medicines. And when to speak with people about their medicines to help keep them safe. The pharmacy has working instructions for the team members to follow to support them to deliver services in a safe and effective way.

Inspector's evidence

The pharmacy had stepped access, and the team members kept a portable ramp at the entrance to the pharmacy. This was used to improve access for people with mobility difficulties. The pharmacy displayed information about the services it provided. But it didn't inform people about its opening hours. This meant that some people were not informed about the pharmacy's lunch-time closure. The pharmacy displayed public health safety notices to protect people from the coronavirus. It provided a delivery service to vulnerable people at home and those shielding from the virus. The driver knew to place items on the doorstep and to keep a safe two metre distance away until the person took receipt of them.

A locum pharmacist was providing cover at the time of the inspection, and they kept copies of the relevant up-to-date patient group directions (PGDs) on their android phone. The PGDs were in date, and the pharmacist had completed the necessary training and was accredited for and authorised to operate within the scope of the PGDs. The pharmacy team members knew about 'high-risk' medicines. They knew to look for information stickers on prescriptions bags and to act accordingly. For example, a 'pharmacist' sticker meant calling on the pharmacist to provide extra advice, such as for new medicines. A 'fridge' sticker meant they had to retrieve extra items from the fridge.

The team members used dispensing baskets, and they kept prescriptions and medicines contained throughout the dispensing process. The pharmacy provided multi-compartment compliance packs to around 180 people. And it had capped the service in-line with the available resources and to keep the service safe. The team members did not always provide descriptions of medicines on the labels. This could make it harder for the person or their carer to identify the medicines inside. They did not always supply patient information with the packs. This could mean that people don't have all the information they need to take their medicines safely. The team members used a separate bench to assemble and check the packs. And they used a separate rear room to store the packs until they were supplied. The pharmacy used various trackers to help them manage dispensing. This helped the team members order prescriptions from the surgeries in advance of them being needed. It also helped them identify when medication was due to be delivered to people at home.

The pharmacy purchased medicines and medical devices from recognised suppliers. The team members carried out regular stock management activities; they highlighted short-dated stock and split packs during regular checks. This helped them to supply medication that was within its expiry date, and to manage the risk of quantity errors. The pharmacy used a fridge for general stock. It also used a second

fridge to store aesthetic products but also personal foodstuffs that belonged to the team members. The team members used a fridge thermometer to monitor the temperature of one of the fridges. But they did not use a thermometer to monitor the general stock. The inspector found the boxes in the fridge to be cold, but the pharmacy could not verify that the temperature had remained in the range of 2 and 8 degrees Celsius. The inspector contacted the superintendent who arranged to have the affected stock immediately placed in quarantine. They also arranged for a two-week temperature audit of the fridge before deciding whether the stock had been kept between 2 and 8 degrees Celsius and was fit for purpose.

The team members knew about the valproate pregnancy protection programme. They knew to issue information leaflets and cards to keep people safe. The team members knew about the Falsified Medicines Directive (FMD). But the company had not provided the necessary resources to implement the system. The team members acted on drug alerts and recalls. They recorded the date they checked for affected stock and what the outcome had been. For example, they had checked for digoxin tablets in August 2020 with no affected stock found.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. 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). It used crown-stamped measuring equipment, and the measure for methadone was highlighted. This meant it was used exclusively for this purpose.

The pharmacy kept cleaning materials for hard surface and equipment cleaning. Members of the team kept the pharmacy sink clean and suitable for dispensing purposes. They kept computer screens out of sight of people in the waiting area, and used a portable phone to keep personal conversations private. The team members wore face masks throughout the day, and they washed and sanitised their hands on a regular basis.

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.