General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Pulse Pharmacy Ltd, 10 Newdyke Road, Kirkintilloch, GLASGOW, Lanarkshire, G66 2PX

**Pharmacy reference:** 1091848

**Type of pharmacy:** Community

**Date of inspection:** 25/02/2022

## Pharmacy context

This is a community pharmacy in Kirkintilloch. 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 one at a time. This was due to the size of the area which did not allow people to maintain a two metre distance from each other. The pharmacy did not provide hand sanitizer in the waiting area and it was only available on request. Team members kept sanitizer on each of the dispensary benches and used it regularly to sanitise their hands. They were wearing face masks throughout the inspection. And a plastic screen at the medicines counter acted as a protective barrier between them and members of the public. The pharmacy used documented working instructions to define the pharmacy's processes and procedures. Team members had recorded their signatures to show they had read and understood them. And sampling showed the procedures were up-to-date. This included the ‘dispensing’ and ‘accuracy checking’ procedures which were valid until November 2022. The pharmacy employed an ‘accuracy checking technician’ (ACT). The ACT followed the pharmacy’s accuracy checking procedure. This included only checking prescriptions that had been annotated by a pharmacist. The ACT checked a significant number of multi-compartment compliance packs. They had had not been authorised to check prescriptions for insulin or controlled drugs. Dispensing of the packs was carried out by experienced dispensers. They followed the pharmacy’s procedure for the assembly of packs which had been reviewed in December 2021. This included checking prescriptions against supplementary records which helped to reduce the risk of dispensing errors.

Pharmacy team members signed medicine labels to show who had ‘dispensed’ and who had ‘checked’ each prescription. The pharmacist and the ACT were able to identify dispensers to help them learn from their dispensing mistakes. The trainee pharmacist had been supporting the team members to record their near miss errors. They had also been promoting the pharmacy’s no blame culture. The near-miss errors records showed the team members had been consistently recording their mistakes. This helped them to identify patterns and trends which they acted on. This included separating doxycycline 50mg/100mg and amoxicillin packs sizes of 15/21. The ACT had identified near miss errors involving multi-compartment compliance packs. This was in connection with doses ‘jumping’ into the wrong compartments when they were moved. They had reminded team members to take more care. One of the team members had completed an incident report template following a dispensing incident. The template included a section to record the outcome from the root cause analysis, and any mitigations to improve patient safety. The form showed that the wrong medications had been supplied to the wrong person. The team member had not followed the pharmacy’s standard operating procedure. And the pharmacist had reminded everyone to always ask people to provide their address so it could be checked against the prescription. This helped to mitigate against people with similar names. The pharmacy trained its team members to handle complaints. It had defined the complaints process in a procedure for team members to refer to. The procedure was valid until November 2022. The pharmacy

displayed a notice in the window which provided information about how to complain. And it invited people to provide feedback about the service they used which had been mostly positive.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurances in place which were valid until 31 May 2022. The pharmacist displayed a responsible pharmacist notice and kept the RP record up to date. Team members maintained the electronic controlled drug registers and kept them up to date. They checked and verified the balances on a regular basis. People returned controlled drugs they no longer needed for safe disposal. Team members kept records of the destructions and the pharmacist had authorised the trainee pharmacist to sign the records to confirm that destructions had taken place. Team members kept prescription forms in good order. They kept records of supplies against private prescriptions and supplies of 'specials' and they were up-to-date. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. Team members used designated bags to dispose of confidential waste. The bags were collected by a verified supplier for off-site disposal. The pharmacy displayed a notice to inform people about how it used and processed their information. The pharmacy trained its team members to manage safeguarding concerns. It had not introduced a policy for them to refer to but kept an up-to-date list of contact details for the key agencies which included the community addictions team (CAT). Team members 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. Team members retrieved packs that were due for collection. They put them at the medicines counter until people or their carers collected them. And they checked the shelf for uncollected packs. This helped them identify potential concerns which they followed up. The 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. A new part-time dispenser had been appointed to help manage the extra dispensing workload. The pharmacist had arrangements in place for regular locum pharmacists to provide cover when needed. This had been effective and with cover being provided. Most team members were long-serving and experienced in their roles and responsibilities. The pharmacy team included one full-time pharmacist, one full-time trainee pharmacist, one part-time accuracy checking technician (ACT), three full-time dispensers, one part-time dispenser, three student pharmacists who worked on Saturdays and provided mid-week cover when they were available and one full-time delivery driver. The pharmacist had authorised the trainee pharmacist to support the team members to learn. They had provided them with an update when the pharmacy had introduced a new National Patient Group Direction (PGD) for the supply of desogestrel, a progestogen-only pill for bridging contraception. And they had also refreshed the teams knowledge of the PGD used to provide treatments for urinary tract infections (UTIs). The pharmacist supported the trainee pharmacist to learn. And they met with them every week or every fortnight to discuss progress against training objectives. The trainee pharmacist had been taking the lead and carrying out consultations, in collaboration with the pharmacist. And they sought authorisation from the pharmacist before supplying medicines against Patient Group Directions (PGDs). Team members were proactive at recommending areas for improvement. One of the dispensers had suggested using a red marker to write people's names on prescription bags for improved visibility. This had been implemented and had been effective at managing the risk of hand-out errors. 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 pharmacy had adequate well-segregated areas for the different dispensing activities. A series of dispensing benches were organised and clutter free. Workstations were at least two metres apart and team members kept a safe distance from each other for most of the day. The pharmacist supervised the medicines counter from the checking bench. They were able to intervene and provide advice when necessary. A separate bench was used to assemble and label multi-compartment compliance packs. Team members kept the storage shelves for the packs well-organised. The pharmacy had a sound-proofed consultation room. The room provided a confidential environment for private consultations. It was not being used for consultations at the time of the inspection due to its small size. A sink in the dispensary was available for hand washing and the preparation of medicines. Team members cleaned and sanitised the pharmacy at least once a day to reduce the risk of spreading infection. Lighting provided good visibility throughout. The ambient temperature provided a suitable environment to store medicines and to provide services. A separate area was used for comfort breaks. Only one team member at a time used the area. This allowed them to remove their face mask and manage the risk of infections.

## Principle 4 - Services ✔ Standards met

### Summary findings

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. And it has arrangements to identify and remove medicines that are not fit for purpose. The pharmacy provides services which are easily accessible. And it generally manages its services well to help people receive appropriate care.

### 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 provided access to 'prescription only medicines' via 'patient group directions' (PGDs). This included a new national PGD for supplies of desogestrel, a progestogen-only pill for bridging contraception. They kept it in a dedicated folder alongside the other PGDs for ease of access. Team members did not use the consultation room to carry out private consultations due to its small size and spoke to people at the medicines counter. They were able to safeguard people's privacy as they only allowed one person at a time into the waiting area.

Team members kept stock neat and tidy on a series of shelves. The pharmacy had two large, controlled drug cabinets. The cabinets had adequate space to safely segregate stock items. Items awaiting destruction were separated and kept at the bottom of one of the cabinets. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members used a date-checking matrix to show they checked stock on a regular basis. A large medicines fridge was used to keep stock at the required temperature. The fridge was organised and well-managed. Team members monitored and documented the temperature of the fridge to show it was operating 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 knew to supply patient information leaflets and to provide warning information.

The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people. This had remained at the same level over the course of the pandemic. The pharmacy had defined the assembly and dispensing process in a documented procedure for team members to refer to. The procedure was up-to-date and had last been reviewed in March 2021. A separate bench was used to assemble and label the packs. Team members used trackers to manage the dispensing process. This helped them to order new prescriptions and ensure they had sufficient time to process subsequent supplies. 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. They discussed queries with the relevant prescriber and they only made changes to packs on receipt of a new prescription. The delivery driver kept a supply of face masks, gloves and hand sanitizer in the delivery vehicle and used them during their deliveries. Dispensers annotated prescription bags when they knew that people were self-isolating due to Covid-19 infections. This reminded the driver to keep at a safe distance to manage the risk of infection.

Team members used a methadone pump to measure doses. They used a 5000ml container to securely attach the pump and decanted the contents of stock bottles into the container. Team members had not labelled the container to show the contents, the manufacturer, the batch number, and the expiry date. This did not comply with labelling regulations. 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 annotated and retained the drug alerts in a folder to show what the outcome of the checks had been. For example, fluorouracil injection had been checked on 14/2/2022 with no stock affected.

## 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). Team members used crown-stamped measuring cylinders, and they used a separate measure to dispense methadone doses. They had highlighted the measure, so it was used exclusively for this purpose. They also used a methadone pump which had been recently purchased. 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. |