General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Reach Pharmacy, 1094 Argyle Street, GLASGOW, Lanarkshire, G3 8LY

Pharmacy reference: 1092708

Type of pharmacy: Community

Date of inspection: 18/03/2022

Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy also 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). A travel vaccination and sexual health clinic operates from the pharmacy. The inspection was completed during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards 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 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 not all 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. They keep the records they need to by law. And they mostly protect people's private information to keep it safe. The pharmacy can show how it adequately manages its dispensing risks. But it cannot evidence it documents mistakes to help learn from them and reduce the risk of making similar mistakes.

Inspector's evidence

The pharmacy had introduced new processes to manage the risks and help prevent the spread of coronavirus. A plastic screen was in place at the medicines counter. And this acted as a protective barrier between team members and members of the public. The medicines counter assistant monitored the number of people in the waiting area for congestion. And people were seen to be standing outside until the waiting area was less busy. This ensured people kept a safe distance from each other. The pharmacy displayed some service information in the main window. But it did not provide information about preventing the spread of the coronavirus. And it did not provide hand sanitizer for people to use on arrival at the pharmacy. Team members had access to sanitizer. They applied it to their hands throughout the day and they wore face masks throughout the inspection. This ensured they minimised the risk of transmitting any infections.

The pharmacy used documented working instructions to define the pharmacy's processes and procedures. Sampling showed the pharmacist had reviewed them in August 2018 and they were past their review date of August 2020. This included the ‘assembly and labelling’ procedure. Most team members had last recorded their signatures in 2019 to evidence they had read and understood the procedures. But the ‘foundation year trainee pharmacist’ (FYTP) who had been in post since 2021 had not signed them. Pharmacy team members signed medicine labels to show who had ‘dispensed’ and who had ‘checked’ each prescription. This meant that the pharmacist could identify dispensers to help them learn from their dispensing mistakes. The pharmacy had defined the 'near miss record keeping' process in a documented procedure. But team members were unable to produce records at the time of the inspection. This meant they were less likely to identify patterns and trends in dispensing errors. Team members had taken some action to manage the risk of some errors recurring. This included placing Sandoz K in between the different strengths of sertraline to manage the risk of selection errors. Team members knew where to find the company’s incident report template to support locum pharmacists. The template included a section for the outcome of the root cause analysis, and any mitigations to improve patient safety. There was evidence to show that team members were recording dispensing incidents.

The pharmacist used a notice board to remind team members about recent changes to improve practices. A monthly meeting was used to discuss the changes in detail to make sure that everyone understood. For example, the previous month the pharmacist had instructed team members to annotate ‘NC’ on methadone prescriptions when people did not collect their doses. And, to complete the ‘purple instalment forms’ to show that doses had been supplied. This helped to identify when people were not taking their medication correctly and to provide extra support when required. 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 pharmacy did not display a notice in the waiting area

or provide information about how to complain. People had verbally expressed satisfaction with the services they received with no areas highlighted for improvement.

The pharmacists used ‘patient group directions’ (PGDs) to provide treatments for medical conditions. The locum pharmacist who was providing cover at the time of the inspection accessed the appropriate PGDs from the health board’s website. This ensured they only used the most up-to-date versions of the documents. A nurse provided travel vaccinations and a sexual health service from one of the consultation rooms. Sampling showed they provided vaccinations using PGDs. This included yellow fever and chicken pox vaccinations, both of which were valid until January 2023. The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurances in place which were valid until October 2022. The superintendent pharmacist had contacted the insurance provider to include the travel vaccination and sexual health service. The nurse had insurance cover with the ‘Royal College of Nursing’ (RCN). The pharmacy displayed a responsible pharmacist notice. It was visible from the waiting area and named the pharmacist on duty at the time. The responsible pharmacist kept the RP record up to date. This showed who had been on duty when the pharmacy was operational.

Team members kept the electronic controlled drug registers up to date. And the trainee pharmacist checked and verified the controlled drug balances, including the methadone balance once a week. This ensured discrepancies were identified, investigated, and resolved in a timely manner. People returned controlled drugs they no longer needed for safe disposal. This had happened infrequently over the course of the coronavirus pandemic. Team members produced records to show the last destruction had taken place in October 2020. The pharmacy kept prescription forms in good order. They kept records of supplies against private prescriptions and supplies of 'specials’ and kept them up to date. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. A nurse provided travel vaccinations and a sexual health service from one of the consultation rooms. The room was not in use at the time of the inspection. And team members had not locked it to keep people's personal information secure. This increased the risk of unauthorised access and access to confidential information. The risks were discussed. Team members used a separate container to dispose of confidential waste. This was collected by an approved provider that securely destroyed the waste at an off-site facility. The pharmacy did not display a notice to inform people about how it used and processed their information to provide them with assurance their information was managed appropriately.

The pharmacy trained its team members to manage safeguarding concerns. But it had not introduced a policy for them to refer to. 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 monitored packs that were due for collection. This helped them identify potential concerns which they followed up on. The dispenser on duty provided a few examples of when she had contacted family members and/or the GP practice. The pharmacy displayed a chaperone notice. It advised people they could be accompanied by another adult whilst in the consultation room. 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 last inspection. And the company had increased the number of regular team members it employed. Two full-time dispensers had worked at the pharmacy for more than a year. And they followed a staff rota and a 'model-day' that listed the necessary tasks that had to be completed over the working week. The pharmacy had two distinct areas where team members carried out different tasks. This included a rear area of the dispensary and another area that looked out onto the medicines counter at the front of the pharmacy. The dispensers rotated between the areas and this ensured they maintained their competence in all the tasks they were required to carry out. One of the dispensers was on leave at the time of the inspection. And the pharmacy team had made sure they were ahead with tasks to minimise the impact. The pharmacy student that normally worked Saturdays had increased their hours and was providing extra cover to support the dispenser. A locum pharmacist who had recently completed their pre-registration training at the pharmacy was providing cover for the regular pharmacist. Team members were experienced in their roles and responsibilities. The pharmacy team included one full-time pharmacist, two full-time dispensers, one part-time medicines counter assistant, one full-time 'foundation year trainee pharmacist' (FYTP), one pharmacy student and one full-time delivery driver.

The pharmacy provided a nurse-led travel vaccination and sexual health clinic. The superintendent pharmacist checked the nurse's registration status and training qualifications to ensure they were valid and up to date. They had provided evidence of accreditation to provide yellow fever vaccinations which expired on 23 March 2023. The nurse had experience of providing travel vaccinations for around five years. They kept up to date with travel vaccination requirements and PGDs which they obtained from Pharmadoctor and Citydoc. A team member worked alongside the nurse, and the superintendent pharmacist had enrolled them on the dispenser's training course and a phlebotomy course. The nurse had provided the team members with relevant training. This included the skills and knowledge to carry out PCR and Lateral Flow Tests.

The pharmacist kept the pharmacy team up to date with service developments. Recent topics had included a new 'Hospital at Home Service'. Team members knew they would sometimes have to contact the Hospital at Home Team instead of the GP practice to arrange new prescriptions for multi-compartmental compliance packs. One of the dispensers provided an example of a recent change to a health board initiative. And they knew that vitamin D had replaced free supplies of vitamin A, C and D for mothers and children. The company was in the process of introducing a dispensing robot in one of its other branches. It had arranged for one of the dispensers to attend the branch for off-site training, so they were familiar with the new system. This would help when the pharmacy sent prescriptions to the hub branch for dispensing multi-compartment compliance packs. The trainee pharmacist met with the pharmacist on a regular basis to discuss progress against the required training outcomes. They were proactive at identifying learning opportunities. This included taking the lead for conducting

consultations under the supervisions of the pharmacist, such as recommending treatments using ‘patient group directions’ (PGDs). They also had responsibility for carrying out regular tasks such as checking and verifying controlled drug balances. But their training had not included reading the pharmacy SOPs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises adequately support the safe delivery of services. And pharmacy team members effectively manage 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 well-segregated areas for the different dispensing activities. Team members had organised the dispensing benches which they kept clutter free. The workstations were at least two metres away. This meant team members kept a safe distance from each other throughout 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. And team members kept the storage shelves for the packs well-organised.

The pharmacy had two sound-proofed consultation rooms. The rooms provided a confidential environment for private consultations. A nurse provided travel vaccinations and a sexual health service from both rooms. The service operated from the rooms mostly in the mornings. This did not create access problems for other people requiring private consultations for other services such as supervised consumptions. And team members were able to arrange access when required. A sink in the dispensary was available for hand washing and the preparation of medicines. The pharmacy had introduced a new cleaning rota. Team members cleaned and sanitised the pharmacy at least once a day 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. A small area at the rear of the dispensary was used for comfort breaks. This allowed team members to remove their face masks without being at risk of infections.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services to help people receive appropriate care. The pharmacy gets its medicines from reputable sources. But it doesn't record the checks it makes to show it stores medicines appropriately.

Inspector's evidence

The pharmacy advertised its services in the windows at the front of the pharmacy. But it did not provide information about its opening hours or how to avoid spreading coronavirus. A step-free entrance provided unrestricted access for people with mobility difficulties. And the waiting area had seating for people that were waiting to be seen. The pharmacy employed a nurse to provide a travel vaccination and sexual health service. They provided the vaccinations using PGDs. And they collected blood and urine samples which they sent to the Doctors Laboratory (TDL) for testing. The nurse and another team member who was undergoing dispenser's training and phlebotomy training carried out PCR and Lateral Flow Testing for people that needed certification to travel. The samples were collected and sent to an external laboratory for testing.

The pharmacy purchased medicines and medical devices from recognised suppliers. Team members monitored the stock to ensure it was fit for purpose. This included checking expiry dates to make sure items were in date and monitoring fridge temperature to ensure the fridge was operating within the accepted range between 2 and 8 degrees Celsius. Team members were unable to produce records to confirm that date checking was up to date. But sampling showed items were within the manufacturer's expiry date. A record sheet on the vaccines fridge showed it had been operating within the accepted range. But the record sheet for the dispensary fridge was blank and team members had not recorded the temperatures. At the time of the inspection the fridge was operating within the accepted range and the thermometer showed 3.6 degrees Celsius. Team members used dispensing baskets to manage the risk of items becoming mixed-up. They also kept stock neat and tidy on a series of shelves to manage the risk of selection errors. Team members kept CD cabinets well-organised to manage the risk of selection errors. 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 cards with every supply.

The pharmacy supplied medicines in multi-compartment compliance packs to people that needed extra support. The service had increased slightly since the last inspection. The pharmacy had defined the assembly and dispensing process in a documented procedure for team members to refer to. But the procedure had not been reviewed since August 2018. Team members used supplementary records to help them manage dispensing tasks. This included information about when they needed to order new prescriptions, and which team members had dispensed and checked them. This provided an audit trail and helped the pharmacist to support dispensers to learn if errors occurred. Team members checked new prescriptions against individual patient records for accuracy before they started dispensing packs. And they discussed queries with the relevant prescriber. The driver referred to a schedule to help them with their deliveries. They had supplies of face masks, gloves, and hand sanitizer for personal protection and to protect others. 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. It also had arranged for the uplift of clinical waste from the travel vaccination and sexual health service via a specialist provider. Drug alerts were prioritised, and team members checked for affected stock so that it could be removed and quarantined straight away. The pharmacist kept information about the drug alerts in an electronic folder. They were able to show they had acted on alerts and what the outcome of the checks had been.

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. Team members cleaned them after use and kept most of them on a rack above the sink. They kept the measures for methadone separate under the sink. 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. Team members cleaned and sanitised the consultation rooms in between use. 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.