

# Registered pharmacy inspection report

**Pharmacy Name:** Reach Pharmacy, 2 Old Gartloch Road, Gartcosh,  
GLASGOW, Lanarkshire, G69 8EU

**Pharmacy reference:** 1093332

**Type of pharmacy:** Community

**Date of inspection:** 06/03/2020

## Pharmacy context

This is a community pharmacy on a parade of shops in the village of Gartcosh. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It offers a repeat prescription collection service and a medicines' delivery service. And 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. The pharmacy offers a travel health clinic. And it provides vaccinations for travel and flu immunisation.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The team members follow the pharmacy's working instructions. And they record mistakes that happen whilst dispensing. The team members use this information to learn and to reduce the risk of further errors. But they don't always keep records about the changes they make. And they can't always show they have eliminated the risks in the pharmacy. The team members understand their role in protecting vulnerable people. And people using the pharmacy can raise concerns. The pharmacy uses a complaint handling procedure. And this ensures that the team members handle complaints in a consistent manner. The pharmacy keeps the records it needs to by law. And it provides training for the team on how to keep confidential information. It has controls in place to keep people's private information secure

### Inspector's evidence

The pharmacy used working instructions to define the pharmacy's processes and procedures. The team members had signed to confirm they followed the procedures. And to show they understood their roles and responsibilities. The pharmacist displayed the responsible pharmacist notice. And people could identify the pharmacist in charge. The pharmacy team members signed dispensing labels to show they had completed a dispensing task. And the pharmacist gave feedback to dispensers who failed to identify their own errors. The pharmacist had recently introduced a quadrant stamp. And they stamped and annotated prescriptions to show they could be checked by the trainee accuracy checker under the supervision of the pharmacist. The pharmacist and the team members documents near-misses on an electronic record. And this helped them to identify patterns and trends and to make changes to manage the risks in the pharmacy. For example, they had attached a shelf-edge caution label to highlight the selection risks with vitamin D preparations and trazodone/tramadol. The pharmacist did not document the actions they agreed upon following the near-miss review. And they were unable to confirm whether or not the actions had been effective. The pharmacist managed the incident reporting process. And they updated the pharmacy team members about incidents and what the cause had been. The pharmacist had access to an incident report template. But they had not received any reports of dispensing errors and they had not recorded any incidents.

The pharmacy provided a complaints policy to help the team members handle complaints in a consistent manner. And it displayed a notice to inform people about its complaints handling process. The pharmacy encouraged people to give feedback about the services they received. And the pharmacist had advised people to contact the pharmacy to order their repeat prescriptions. This was due to prescriptions being taken to the wrong pharmacy for dispensing.

The pharmacy maintained the records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity insurance in place. And it was valid until 10 September 2020. The pharmacy team members kept the electronic controlled drug registers up to date. And they carried out balance checks every two weeks, with methadone checked more frequently due to the manufacturer's overage in each bottle. The pharmacy team 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 pharmacists used patient group directions (PGDs) to improve access to medicines and advice. And they knew to access the NHS Lanarkshire website to obtain the current version of the pharmacy first PGDs.

The pharmacy displayed a notice to inform people about its data protection arrangements. And to provide assurance that it kept personal information safe. The company trained the team members during their induction period to comply with data protection arrangements. And they knew how to safely process and protect personal information. The team members disposed of confidential waste in designated containers. And the company arranged for the containers to be collected for off-site shredding.

The pharmacy used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The pharmacy did not provide formal safeguarding training. But the team members knew to refer concerns to the pharmacist. For example, one of the dispensers had informed the pharmacist about some-one who told them they had taken two days' worth of their medication all at once. The pharmacist had contacted the GP to arrange extra support. And the person's family now collected their multi-compartment compliance packs instead of the pharmacy delivering them to the person at home.

## 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 discuss their learning needs at regular review meetings. And they are encouraged and supported to enrol onto pharmacy courses. The pharmacist supports the pharmacy team members to learn. And this ensures they keep up-to-date and current in their roles. The pharmacy team members support each other in their day-to-day work. They can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

### Inspector's evidence

The pharmacy workload had been gradually increasing over the ten years since it first opened. And the pharmacy had gradually appointed extra team members, so it maintained the capacity and capability to provide the services it offered. The pharmacy team members were well-established. And they were experienced and knowledgeable in their roles and responsibilities. The pharmacy kept training qualifications on-site. And the following team members were in post; one full-time pharmacist, one full-time dispenser, two part-time dispensers and one delivery driver. The pharmacy managed annual leave requests. And it maintained minimum levels by authorising only one team member to be off at the same time. The team members covered for each other. And the pharmacy employed pharmacy students in the summer months to provide extra cover.

The pharmacy did not provide structured training. And the pharmacist briefed the team members to ensure they kept up-to-date and current in their roles. For example, they knew about the valproate pregnancy protection programme, the falsified medicines directive (FMD) and data protection procedures. The pharmacy had registered the team members with an e-learning provider. And one of the dispensers had completed a few modules, such as hay-fever training. The pharmacist had enrolled one of the dispensers on an accuracy checking course. And this would enable them to carry out final accuracy checks on prescriptions that had been authorised by a pharmacist. The pharmacist had also planned to enrol one of the other dispensers onto the course. And this would provide the pharmacist with extra support and more flexibility within the pharmacy team.

The pharmacist provided flu vaccinations. And they had completed training, so they were accredited to administer vaccinations against a private 'patient group directive' (PGD). The pharmacy was about to introduce 'Medicspot'. And this provided on-line access to a GP and a range of diagnostic technology that could be used during the consultation. The pharmacist had arranged for on-site training. And this would cover aspects such as how to operate the system and the necessary infection control arrangements.

The company did not use performance targets to grow the services it provided. The team members were focussed on speaking to people about its services when appropriate. And they did not feel undue pressure when carrying out tasks. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had re-organised the shelves they used to keep the multi-compartment compliance packs. And they had separated the packs for delivery and the packs for collection for ease of access. They had also introduced a list to show the people they delivered to at home. And this ensured that the pharmacy team and locums were kept up to date.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The premises are clean and hygienic. It has a consultation room that is professional in appearance. And it provides an appropriate space for people to sit down and have a private conversation with pharmacy team members.

### Inspector's evidence

A well-kept waiting area presented a professional image to the public. And it provided seating and some patient information leaflets for self-selection. The dispensary was organised. And the team members used a section of bench at the rear of the pharmacy to dispense multi-compartment compliance packs. The pharmacist used a separate front bench. And they could supervise the medicines counter and make interventions when they needed to. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy had a consultation room and a separate booth. And the team members used the booth for supervised services. And they used the consultation room for health checks and to administer vaccinations.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know what services are available to them. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information.

### Inspector's evidence

The pharmacy had step-free access. And the team members had good visibility of the entrance so they could provide assistance if necessary. The pharmacy kept a few leaflets in the waiting area. But it did not display its opening hours in the window. The pharmacy displayed the NHS recommended public information about COVID-19 at the entrance to the pharmacy. And the pharmacist kept themselves up-to-date with the government's information about the spread of the virus. The pharmacist spoke to people about their medicines. For example, when people asked to collect their medication earlier or later than they expected them to. And this ensured they identified compliance issues and provided them with extra support when necessary.

The pharmacist provided travel vaccinations in partnership with CityDoc travel health clinic. And the pharmacist had been accredited to provide vaccinations through attendance at CityDoc's off-site five-day training course. The pharmacist ensured they kept up-to-date and competent in their role. And they completed CityDoc refresher training at least once a year. The pharmacist had attended separate training that had been provided by 'health protection Scotland' (HPS). And they were accredited and authorised to provide yellow fever vaccinations. The pharmacist administered vaccinations using a range of CityDoc PGDs. And the doctors issued 'patient specific directions' (PSDs) when appropriate, when individuals did not meet the PGD criteria.

The pharmacy provided 'pharmacy only' (P) and 'general sales list' (GSL) medicines via its internet service. The pharmacist checked the invoices for P medicines. And they carried out identity checks to ensure that supplies were safely provided. The pharmacist had refused to provide supplies when people did not meet the required identify checks. And they kept an audit trail to evidence the decision they had made. The pharmacy used Royal Mail for deliveries. And they obtained a signature to confirm receipt and to provide proof of delivery. This meant that items were taken to the Post Office when no-one was at the address. And a card with details about how to collect the items was left at the address.

The pharmacy had partnered with an online prescriber. And they provided supplies against private prescriptions once or twice a month. The pharmacist carried out the necessary checks. And confirmed the prescriber was registered with the 'general medical council' (GMC).

The pharmacy team members used dispensing baskets. And they kept prescriptions and medicines contained throughout the dispensing process. A team member processed prescriptions. And a different dispenser assembled stock and carried out dispensing. This helped them to identify near-misses and to take corrective action. The pharmacy dispensed multi-compartment compliance packs for around 60

people in their homes. And it dispensed packs for another 90 people in a nursing home. The team members had read and signed the company's working instructions to confirm that dispensing was safe and effective. And they used a rear bench that was sufficient in size and layout to safely assemble and check the packs. The team members kept track of when supplies were due. And this ensured they made supplies on time. The team members used supplementary records to support the dispensing process. And they isolated packs and updated records when people's prescription needs changed. For example, when they went into hospital. The team members kept a signature audit trail to show who had dispensed and who had checked the packs. And this helped them to identify dispensing risks and areas for improvement. The team members supplied patient information leaflets. And they provided descriptions of medicines to support people to take their medicines correctly.

The pharmacy provided a delivery service to housebound and vulnerable people. And the delivery driver obtained signatures to confirm that people had received their medication. The team members dispensed methadone doses once a week for around 3 people. And they obtained accuracy checks before placing them in a controlled drug cabinet for safe keeping until they were needed. The team members retrieved prescriptions when people arrived for their doses. And they obtained a final accuracy check at the time of supply to confirm that doses that were in accordance with the prescriber's instructions.

The pharmacy purchased medicines and medical devices from recognised suppliers. And the team members carried out regular stock management activities to check for short dated stock and split-packs. The team members monitored and recorded the fridge temperatures. And they demonstrated that the temperature had remained between two and eight degrees Celsius. The team members kept controlled drugs in a suitable cabinet. And they managed the risk of selection errors, for example, they kept out-of-date and returned medication separated from routine stock until they were destroyed. The pharmacy was in possession of an MHRA wholesale dealers license. And the MHRA had carried out an inspection in 2019.

The team members acted on drug alerts and recalls. And they recorded the date they checked for affected stock and the outcome. For example, in March 2020 they had acted on an alert concerning Emerade syringes. And on checking the shelves they had no affected stock. The pharmacist had spoken to the team members about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards and when to issue them. The pharmacist monitored prescriptions for valproate. And they spoke to people that could be affected to confirm they knew about the risks. The pharmacist had spoken to the team members about the Falsified Medicines Directive (FMD) and what it aimed to achieve. And they were using the system in their day-to-day processes when they received packs with 2D data barcodes and an anti-tamper device.



## 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). It used crown-stamped measuring equipment. And the measures for methadone were highlighted, so they were used exclusively for this purpose. The pharmacy kept 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 had access to a portable phone. And they were able to take calls in private when necessary.

### What do the summary findings for each principle mean?

Finding	Meaning
<span style="color: green;">✓</span> <b>Excellent practice</b>	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.
<span style="color: green;">✓</span> <b>Good practice</b>	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
<span style="color: green;">✓</span> <b>Standards met</b>	The pharmacy meets all the standards.
<b>Standards not all met</b>	The pharmacy has not met one or more standards.