General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: LG Pharmacy Ltd, 476 St. Vincent Street, GLASGOW, Lanarkshire, G3 8XU

Pharmacy reference: 1094801

Type of pharmacy: Community

Date of inspection: 17/06/2021

Pharmacy context

This is a community pharmacy in a residential area of Glasgow city centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it offers a medicines' delivery service to vulnerable people. The pharmacy provides substance misuse services and dispenses private prescriptions. The pharmacy team members advise on minor ailments and medicines' use. And they supply a range of over-the-counter medicines.

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 doesn't adequately identify and manage all the risks associated with the services it provides. It does not carry out a formal risk assessment before introducing new systems of work. And it does not review and update SOPs to provide assurance they are up-to-date and relevant for the services it provides.
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 not all met**

Summary findings

The pharmacy doesn't adequately identify and manage all the risks when it introduces new systems. It has policies and procedures for some of its services. But they are out of date and team members don't always follow them. The pharmacy keeps records to help ensure the safety of its processes. And it makes some improvements when mistakes happen. The pharmacy has arrangements in place help keep members of the public and team members safe during the Covid-19 pandemic. It keeps the records it needs to by law, and it keeps confidential information safe. Team members securely dispose of personal information when it is no longer required.

Inspector's evidence

The pharmacy had introduced new arrangements to manage the risks and help prevent the spread of coronavirus. A poster on the entrance door reminded people visiting the pharmacy to wear a face covering as required by law. Another notice informed them the waiting area could only accommodate a maximum of two people to allow them to maintain a safe two-metre distance from each other. People were seen to be following the guidelines without any instruction from the pharmacy team members. Hand sanitizer was available in the waiting area and throughout the dispensary. A Perspex screen was in place at the medicines counter. This acted as a protective barrier between team members and members of the public. Pharmacy team members were wearing face masks throughout the inspection. They used a separate downstairs area as a rest room and organised themselves so only one person used it at a time so they could remove their face mask. The pharmacy used working instructions for most of its processes and procedures. But sampling showed the superintendent pharmacist was not keeping them up to date and relevant for the practices at the pharmacy. For example, a SOP for controlled drug dispensing had been last reviewed in November 2015. The pharmacists were not annotating prescriptions to authorise the accuracy checking dispenser to carry out the final accuracy check. This contravened the final accuracy checking SOP and created the risk of some prescriptions being supplied without the necessary safety checks. The superintendent pharmacist was in the process of developing SOPs to operate a dispensing robot they had introduced in November 2020. The manufacturer of the robot had provided SOP templates to support the pharmacy. But completion had been delayed due to prescription workload increases and a refit to increase the pharmacy's capacity. The superintendent had not completed a formal risk assessment before introducing the robot. They had discussed the safety features of two different robots. And they had arranged a site visit to two different pharmacies to observe the different systems in operation. The superintendent had discussed the potential risks associated with each of the robots and how the safety features mitigated the risks. A locum pharmacist was providing cover for the superintendent pharmacist who was on leave. They had last worked at the pharmacy around November 2020. They were carrying out final accuracy checks and were content to check the packs that had been dispensed by the robot.

Team members recorded their signatures to show they followed the procedures. The dates against their signatures showed they had not read the SOPs since they were last updated. The pharmacy had procedures in place to help it learn from its mistakes. Team members signed medicine labels to show who had 'dispensed' and who had 'checked' each prescription. This helped them to learn about their near-miss errors through feedback, and to avoid the same mistakes in the future. Team members recorded their near misses, and the superintendent pharmacist and the accuracy checking dispenser

reviewed the entries at the end of the month. They identified patterns and trends, for example, when dispenser's error rates increased so they were more aware. Team members were able to provide some examples of changes they had made to prevent recurring errors. This included moving amitriptyline to a separate section well-away from atenolol, and separating ropinirole and risperidone. The dispenser knew about near-misses associated with the dispensing robot. On investigation they found the errors were due to 'jumping tablets' which were occurring at the time of sealing the packs. This was discussed and team members new to take greater care when handling packs. The pharmacy kept records of dispensing incidents. And could provide evidence of learnings and improvements to manage the risk of a recurrence. For example, following a labelling error attached to the correct medication, team members knew to slow down to give themselves time to check their dispensing for accuracy. Team members completed training so they followed the complaints procedure and they were effective at handling complaints. The pharmacy did not display a complaints notice with contact details. A suggestions box was located at the medicines counter. The pharmacy had received mostly positive feedback about the level of service it had provided throughout the pandemic. Team members were unable to provide examples of improvements due to feedback received.

The pharmacy maintained the records it needed to by law, and the pharmacist in charge kept the responsible pharmacist record up to date. But they had not displayed a responsible pharmacist notice to show people who was in charge. The pharmacy had public liability and professional indemnity insurance in place, and they were valid until 21 October 2021. The pharmacy kept its controlled drug registers up to date, and team members regularly checked the balance of controlled drugs at least once a month. They checked and verified the methadone balance on a weekly basis. Expired stock awaiting destruction was kept well away from other stock. A controlled drug register was used to record controlled drugs that people had returned for destruction. Records showed the superintendent pharmacist had witnessed destructions carried out by dispensers. The pharmacy provided a prescription delivery service. This helped vulnerable people and those that were shielding to stay at home. Due to the pandemic team members didn't ask people to sign for receipt of their medication. They kept a record of the deliveries in the event of queries. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. It did not display a notice to inform people about how it used or processed their information. Team members used a shredder to safely dispose of confidential waste and spent records. The pharmacy provided training so that team members knew to follow safeguarding procedures. They were aware of the signs of abuse and neglect, and the pharmacist was registered with the protecting vulnerable group (PVG) scheme. This helped to protect children and vulnerable adults. Team members knew to speak to the pharmacist whenever they had cause for concern. For example, they liaised with the community addictions team (CAT).

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. Pharmacy team members are empowered to help improve pharmacy services.

Inspector's evidence

The pharmacy's prescription workload had increased significantly over the past year due to coronavirus. The superintendent pharmacist had purchased a dispensing robot in November 2020 to increase capacity and for the extra safety measures it provided. A trainer from the company had been on-site at the pharmacy for two weeks. And they had trained and supported three team members to operate the new system. A dispenser demonstrated the system at the time of the inspection. They evidenced the knowledge and skills needed to operate the system. The dispenser explained the trainer could be easily contacted for ongoing support when needed. The pharmacy team was well-established and included; one full-time pharmacist (superintendent), one full-time accuracy checking dispenser, two full-time dispensers, three full-time trainee dispensers and one full-time medicines counter assistant. One of the trainee dispensers had been moved from the upstairs dispensary and had been trained to operate the dispensing robot. Another two trainee dispensers had been trained to operate the robot. Only one dispenser at a time was permitted to take leave. The pharmacy was about to recruit a new team member to work in the upstairs dispensary. This was also due to an increase in deliveries which were provided by the trainee dispensers.

Team members had kept well throughout the pandemic and no-one had needed to self-isolate. An accuracy checking dispenser carried out final accuracy checks, but they were not authorised to check multi-compartment compliance packs. They were due to contact the training provider by August 2021 to provide the necessary evidence for re-accreditation to continue in their checking role. They had not been following the requirements of the final accuracy checking SOP, and they confirmed they would review their current practice alongside the superintendent pharmacist. The pharmacy provided training on an ad-hoc basis to ensure team members were up to date and improving in their roles. Team members had kept up to date with the relevant coronavirus guidance. This included how to keep themselves and other people safe. In August 2020, three team members had enrolled on dispensers training. They had completed a few modules but had put the training on hold during the installation of the robot and whilst a refit was taking place. The superintendent pharmacist had contacted the training provider to check progress and was planning on restarting the training in the next few months. One of the team members had attended off-site training and had been trained to administer naloxone in emergency situations. She had recently applied the knowledge and skills when someone had collapsed. She remained at the person's side until the ambulance arrived. 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 is clean, tidy, secure and is well maintained. It has two sound-proofed rooms where people can have private conversations with the pharmacy team members. It has made suitable changes to its premises to help reduce the risk of spreading coronavirus.

Inspector's evidence

Team members had arranged the benches in the main dispensary for different tasks. Workstations were at least two metres apart and team members tried to keep their distance from each other for most of the day. A dispensing robot was used to assemble multi-compartment compliance packs. It was housed in a downstairs dispensary that had been re-designed to accommodate the new working processes. The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary. Two sound-proofed consultation rooms were available. But only one was being used at the time of the inspection. A protective Perspex screen was in place, and team members cleaned the surfaces in between use. The room was well-equipped with running water. And it provided a confidential environment to have private consultations. A sink in the dispensary was available for hand washing and the preparation of medicines. The pharmacy was clean and well maintained. Team members cleaned and sanitised the pharmacy throughout the day to reduce the risk of spreading infection. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is unable to provide assurance that new services are safely provided. It provides services which are easily accessible. And it generally manages its services to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them safely and securely. Team members carry out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy advertised its services and opening hours in the windows at the front of the pharmacy. It displayed leaflets behind a protective Perspex screen at the medicines counter for people to request them. A level entrance provided access for people with mobility problems. This included the significant number of wheelchair users that visited the pharmacy. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members kept the pharmacy shelves neat and tidy, and organised three controlled drug cabinets to manage the risk of errors. They used one of the cabinets for multi-compartment compliance packs. Team members carried out an annual expiry date check and used a highlighter pen on packs of short-dated medicines. Sampling of around 30 medicine packs showed they were all well within their expiry date. A large medical fridge was in use and team members monitored and recorded the fridge temperatures on a daily basis. The records showed temperatures had remained between the accepted range of two and eight degrees Celsius. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to contact prescribers if they received new prescriptions for people in the at-risk group, and always made sure they supplied the warning cards that came with the original packs. Drug alerts were prioritised, and team members knew to check for affected stock so that it could be removed and quarantined. One of the dispensers produced a drug alert they had received the day before for co-codamol tablets. They had signed the form to show they had checked for affected stock and that none had been found. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Team members accepted unwanted medicines from people for disposal. They put on disposable protective gloves before handling the packages and before processing the waste for destruction. Team members dispensed methadone doses a few days before they were due. They secured them in the controlled drug cabinet for safe keeping. The pharmacist carried out an accuracy check at the time of dispensing and again at the time of supply.

The pharmacy used dispensing baskets in the main dispensary to manage the risk of items being mixed-up. Dispensing benches were organised and clutter-free. The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people and a dispensing robot had been installed in the downstairs dispensary. The robot took up most of the space and the surrounding benches were organised and clutter free. The pharmacy's PMR system was integrated with the robots operating system. Prescriptions were clinically checked by the pharmacist, processed via the PMR and sent to the robot for dispensing. The robot was capable of processing up to 200 lines of medications. And team members filled the individual cartridges with mostly fast-moving stock. They retained pack information which included the bar-code, batch number and expiry date. And they scanned the bar codes and scanned the cartridges (which had already been calibrated) when they replenished medications. The robot used the bar-code information to identify the correct medication at

the time of dispensing. The robot had the capacity to dispense up to 15 items into each pack. Some medicines were excluded entirely such as controlled drugs. A monitor on the robot provided information about the packs once they had been filled. And the screen showed the completed packs with any errors highlighted in amber. This meant an additional manual check was carried out by the dispenser and the pharmacist. The errors mostly arose as result of the robot not being able to see all of the tablet due to being hidden behind another tablet. For those medicines that were not in the robot, team members manually dispensed the doses into trays for the robot to add into the packs. The manufacturer had advised the team members to 'trust' the robot. But the superintendent had decided to continue to carry out final accuracy checks. The robot printed a consolidated label onto each pack. It included patient information, dosage instructions and a photograph of each medication. The dispenser signed the pack to show they had carried out the necessary checks. And the pharmacist signed the pack to show they carried out the final accuracy check. The robot had helped to manage the increased workload, and the pharmacy was able to dispense two weeks in advance of packs being needed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and well-maintained. It takes precautions so that people can safely use its facilities when accessing its services during a pandemic.

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. Separate measures were used for methadone and a methadone pump was in use. Team members calibrated the pump every week before it was used to provide assurance it was measuring accurately. A service agreement was in place for the dispensing robot. Engineers carried out checks every six months to maintain the dispensing robot and to manage the risk of system failures. They could connect to the robot from an off-site location to carry out checks if team members were experiencing problems. Team members cleaned the robot daily to remove the build-up of dust from tablets. 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 members. The pharmacy had a cordless phone, so that team members could have conversations with people in private. 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.