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: 16/03/2022

Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy 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

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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

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 permitted a maximum of two people to enter the pharmacy at the one time. And floor markings helped people to keep a safe two metre distance from each other. The pharmacy provided hand sanitizer in the waiting area for people to use. And pharmacy team members had access to supplies throughout the dispensary. A plastic screen at the medicines counter and in the consultation room acted as a protective barrier between team members and members of the public. The pharmacy team wore face masks throughout the day. This helped to protect colleagues from infections.

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. Sampling showed the pharmacist had last reviewed the procedures in July 2021. This included the ‘assembly and dispensing’ and ‘accuracy checking’ procedures which were valid until June 2022. The pharmacy employed an ‘accuracy checking dispenser’ (ACD) who knew only to check those prescriptions that had been annotated by a pharmacist. The pharmacist had not authorised the ACD to check multi-compartment compliance packs which were processed by a dispensing robot. The pharmacy had introduced the robot to dispense the packs in November 2020. The superintendent pharmacist who worked at the pharmacy had introduced and approved working instructions to safely operate the robot for team members to refer to. Following a risk assessment they decided to train and authorise only two dispensers to operate the robot. This ensured that only competent team members operated the system and understood the risks associated with it.

Pharmacy team members signed medicine labels to show who had ‘dispensed’ and who had ‘checked’ prescriptions. This meant that the pharmacist and the ACD were able to identify dispensers to help them learn from their dispensing mistakes. Individuals recorded their own errors to help them reflect and to identify the root cause which they also recorded. This helped further to avoid making the same mistakes in the future. The ACD carried out a documented near-miss review at the end of the month to identify patterns and trends and to make improvements. This had included providing extra feedback when the incidence of near-miss errors was higher than usual. Team members had separated stock to manage the risk of selection errors. For example, prednisolone/propranolol, ropinirole/risperidone, and atenolol/amitriptyline. A root-cause analysis of the near-miss errors associated with the dispensing robot showed them to be dispenser mistakes and not technological errors. For example, when the dispenser had removed the wrong tablets in response to error information provided by the robot. And when packs were not handled with care causing tablets to ‘jump’ from one slot to another. The dispenser knew to take greater care in the future.

Team members knew where to find the company's incident report template in the event locum pharmacists needed to produce a report. The template included a section for the outcome of the root cause analysis, and any mitigations to improve patient safety. 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 had been last reviewed in June 2021. The pharmacy did not display a notice or provide information about its complaints process.

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 pharmacist displayed a responsible pharmacist notice, but it was not visible from the waiting area. The RP record was up to date and showed which pharmacist had been on duty when the pharmacy was operating.

Team members maintained the controlled drug registers and kept them up to date. The pharmacist had authorised one of the dispensers to carry out and evidence a monthly stock check. And another team member checked and verified the methadone balance once a week on a Monday after dispensing the required doses. People returned controlled drugs they no longer needed for safe disposal. A destructions register showed the pharmacist had signed 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 records were up-to-date. 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 and processed their information. Team members used a shredder to dispose of confidential waste. And the general waste bins did not contain any confidential waste. The pharmacy trained its team members to manage safeguarding concerns. And it had introduced a policy for them to refer to. It kept contact details for 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. 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. The superintendent pharmacist worked at the pharmacy, and a regular locum pharmacist had been covering two days a week for the past ten years. Another regular locum pharmacist provided cover when the superintendent was on annual leave. The pharmacy team was well-established and included one full-time pharmacist (superintendent), one full-time accuracy checking dispenser (ACD), three full-time dispensers, one full-time trainee dispenser, one full-time medicines counter assistant, one full-time delivery driver and one part-time pharmacy student. The pharmacy had succession planning arrangements in place. For example, the pharmacist was about to enrol one of the medicine counter assistants onto the dispensers training course. This would allow them to undergo training to develop the knowledge and skills needed to carry out the tasks associated with the dispensing robot. The pharmacy had purchased the robot in November 2020 and the pharmacist had only authorised two dispensers to operate the system until it was fully embedded. They had recently recruited a new team member to work on the medicines counter and to provide backfill for the trainee dispenser who was being moved.

The pharmacist delegated responsibility to competent team members. One of the dispensers managed the dispensing of methadone doses, the 'medicines care and review' (MCR) dispensing and weekly instalment dispensing. Another dispenser was responsible for sharing updates from the Health board regarding the NHS Pharmacy First service. This included printing and cascading the medicines formulary following changes. The pharmacist provided training support in the workplace. This ensured that trainees made good progress with their courses. Regular weekly and monthly meetings kept team members up to date with changes. This included recent information about a new hospital discharge procedure and the receipt of prescriptions sent by the hospital to the pharmacy's clinical inbox. The 'accuracy checking dispenser' (ACD) was responsible for checking the pharmacy's clinical inbox for hospital prescriptions. These were assembled by dispensers and checked by the pharmacist who informed the person's GP via an SBAR communication to update their medical records. Team members had recently learned about a new National Patient Group Direction (PGD) for the supply of desogestrel, a progestogen-only pill for bridging contraception. The pharmacist had delivered training so that team members could competently gather people's information before the consultation. This included directing eligible people to a Q code that was displayed on the consultation room door. People scanned the Q code using their phone, and this provided information about the progesterone-only-pill. Team members had asked the pharmacist for an aide memoire to remind them of the questions and the pharmacist had produced a laminated guide for them to use. The pharmacy had introduced a whistleblowing policy, and team members 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

Team members had arranged the benches in the main dispensary for different tasks. Most of the workstations were at least two metres apart and team members tried to keep their distance from each other throughout the day. Team members had organised the dispensing benches which were mostly clutter free. The pharmacy had renovated a downstairs room for the installation of a dispensing robot. The robot dispensed medicines into multi-compartment compliance packs. And the new dispensary had been purpose built to accommodate the new working arrangements. Team members used a series of storage shelves for the packs which they kept well-organised.

The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary. Two sound-proofed consultation rooms were available. Only one of the rooms was being used at the time of the inspection. A protective Perspex screen was in place in the consultation room and team members cleaned the surfaces in between consultations. The room was well-equipped and included a sink and running water. It also provided a confidential environment for 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 twice a day to reduce the risk of spreading infection. An alarm sounded to remind them to carry out cleaning tasks. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services. Separate downstairs areas were used for comfort breaks. This allowed team members to remove their face masks without being at 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 manages its services well to help people receive appropriate care.

Inspector's evidence

The pharmacy had a step-free entrance and provided unrestricted access for people with mobility difficulties. It advertised its services and opening hours in the window. And it provided public health information to help keep people safe from coronavirus. This included advising people to wear a mask before entering the pharmacy. The pharmacist provided access to 'prescription only medicines' via 'patient group directions' (PGDs). They kept 'hard copies' of the PGDs in a folder that was easy to access. Sampling showed that the PGDs for trimethoprim, fusidic acid and nitrofurantoin were valid until April 2022. Team members kept stock neat and tidy on a series of shelves and drawers. They also placed stock into 200 individual cartridges in the dispensing robot. The pharmacy had four controlled drug cabinets. The cabinets provided adequate space to safely segregate stock items. Team members arranged stock for ease of access. For example, they used one of the cabinets for multi-compartment compliance packs, and another for methadone. There was space for out-of-date medications. The controlled drug officer from the health board had attended the week before to carry out a witnessed destruction. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members checked expiry dates every six months. And the pharmacist and the 'accuracy checking dispenser' (ACD) checked the expiry date as part of their accuracy checking procedure to mitigate against expired stock. Team members obtained an accuracy check when they de-blistered medicines into large tubs for the dispensing robot. They kept records to show all items they had de-blistered. This included the signature of the person who had de-blistered the medication and the dispenser who had checked for accuracy. The outer pack was also retained alongside the medication for them to refer to. This included the bar-code that they needed to scan for accuracy at the time of replenishing stock in the robot. They kept the batch number and expiry date of each product. This meant they were able to retrieve items in the event of a product recall. The pharmacy had two fridges. Team members used one of the fridges for stock items. And they used a second fridge for dispensed items awaiting collection or delivery. Both fridges were well-organised, but team members only monitored and documented the temperature of one of the fridges. This meant they were unable to evidence that both fridges were 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. A shelf edge caution label instructed team members to provide a patient information leaflet and warning card with every supply. The pharmacist had attached dispensing information to the checking benches. This instructed pharmacists and the 'accuracy checking dispenser' (ACD) to check the dispensing label did not cover warning information on the pack, to check that a warning card was provided with every supply and to ensure people had received the patient guide. The pharmacist added notes to people's PMR, and kept records of interventions.

The pharmacy supplied medicines in multi-compartment compliance packs. This had remained at the same level since the last inspection in June 2021. The pharmacy had introduced a dispensing robot in November 2020 to assemble the packs. And it had defined the dispensing process in a series of documents for team members to follow. The pharmacist carried out clinical checks on receipt of new prescriptions. And the dispensers processed the prescriptions on the pharmacy's PMR system which they then transmitted to the dispensing robot. The robot was housed in a separate purpose-built dispensary. Team members used a separate workstation to carry out accuracy checks. This included referring to dispensing information on the robot's monitor. It also included checking the prescription against each person's medication records. Team members used a diary to record pack changes that the surgery had requested. They only actioned the changes on receipt of a new prescription. The pharmacist then signed the record to show they had actioned the change request. The pharmacy delivered most of the packs. And team members had developed a schedule to show when they were due. The delivery driver kept a supply of face masks, gloves, and hand sanitizer in the delivery vehicle, and they used them during deliveries. They knew to keep at a safe distance from people to manage the risk of infection. The pharmacist had nominated an experienced dispenser to assemble methadone doses once a week. The team member used a separate, well-organised area to carry out dispensing. They also used a methadone pump for measuring doses and had decanted the contents of 10 x 500ml stock bottles of methadone into a 5000ml container. This was necessary so the pump would fit the lid and for methadone doses to be dispensed. The 5000ml container had been labelled and included information about its contents, batch number and expiry date. The team member had completed an 'opioid substitution therapy' (OST) audit at the request of the Health Board. One outcome had been to introduce records of referrals to the 'community addictions team' (CAT). Team members accepted unwanted medicines from people for disposal. And the pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy prioritised drug alerts and the pharmacist had nominated a team member to manage the process. They knew to check for affected stock so that it could be removed and quarantined straight away. The team member annotated and retained the drug alerts in a folder to show 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). Team members used crown-stamped measuring cylinders, and they used separate measures for methadone. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy used a methadone pump to dispense methadone doses. They calibrated the pump once a week and sent it to the manufacturer for servicing once a year. 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. 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.

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.