

Registered pharmacy inspection report

Pharmacy Name: Scots Pharmacy, 665 Clarkston Road, GLASGOW,
Lanarkshire, G44 3SE

Pharmacy reference: 1099285

Type of pharmacy: Community

Date of inspection: 07/10/2024

Pharmacy context

This is a community pharmacy on the main street in Netherlee, East Renfrewshire. Its main services are dispensing NHS prescriptions, including serial prescriptions. And it provides medicines in multi-compartment compliance packs for people who need help to take their medicines at the right times. It provides a medicines delivery service, and it supplies palliative care medicines under the Community Palliative Care Network.

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

The pharmacy adequately identifies and manages the risks with the services it provides. And team members discuss ways to reduce dispensing mistakes and mitigate risk. The pharmacy keeps most of the records as required by law. And it adequately protects people's confidential information. Team members understand their role in helping to protect vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) available to its team members designed to help them work safely and effectively. SOPs were paper-based and stored in a folder. Some SOPs were overdue their review date. This included SOPs about delivering medicines safely with a review date of February 2024 and an SOP about the date checking of medicines with a review date in August 2024. Team members had read the SOPs and completed a signature sheet to show they had understood them. The superintendent pharmacist (SI) explained SOPs were in the process of being reviewed, following a change of ownership in October of 2023 and a change in ways of working. At the time of inspection, the SI was working alone until the afternoon due to annual leave of team members. They described the roles and responsibilities of their team members and the tasks they undertook within the pharmacy, and they confirmed team members were aware of the responsible pharmacist (RP) regulations and what activities they could or couldn't undertake in the absence of the RP. The SI described a recent instance where the RP didn't make it to the pharmacy for opening time. A dispenser prepared the shop for opening and participated in tasks relating to the front shop only such as cleaning and preparing the healthcare counter. There was an emergency protocol in place to address any disruption to services.

Team members signed medicines labels to show who had dispensed and checked each medicine. This allowed the RP to help team members learn from dispensing mistakes identified within the pharmacy known as near misses. Team members maintained a paper-based near miss log. This included details such as the date and time the near miss happened and the type of error, for example, the wrong quantity or strength of a medicine. Team members weren't consistent with the recording of near misses and the SI acknowledged this. From the sample seen the last near miss recorded was in January 2024. The lack of regular monitoring of near misses meant team members may miss opportunities to share learning and reduce the risk of dispensing errors happening again. Mistakes identified after a person received their prescription, known as dispensing incidents, were recorded on an incident report form then reviewed by the SI. Although team members did not have recent documented records of dispensing incidents, The SI explained team members have an informal safety care meeting once a week. And they described discussions team members had and steps they had taken to mitigate the risk of mistakes occurring, by implementing shelf dividers to separate the strengths of certain medicines or similar packaging to avoid selection errors. The SI carried out audits on processes within the pharmacy. For example, they regularly reviewed prescriptions stored in the retrieval area awaiting collection, particularly serial prescriptions. This helped him identify any issues with people not taking their medicines as they should and enabled him to alter the point in the cycle in which the prescriptions were assembled in future. The pharmacy had a complaints procedure and welcomed feedback. Team members were trained to resolve complaints and aimed to do so informally. If they could not resolve the complaint, they would refer to the SI who would initiate the formal complaints procedure.

The pharmacy had current professional liability insurance. It displayed an RP notice that was visible from the retail area and reflected the correct details of the pharmacist on duty. The RP log held electronically was mostly up to date with minor omissions of when the RP ceased duties at the end of the day. Team members maintained complete paper-based controlled drug (CD) registers. A random balance check on the physical quantity of two CDs matched the balances recorded in the register. The SI aimed to complete CD balance checks regularly however the last documented balance check was in March 2024. The pharmacy had records of CDs that people had returned for safe disposal. And CDs awaiting destruction were stored appropriately, segregated from other stock. Records relating to private prescriptions were accurate but not wholly up to date. There was a sample of seven prescriptions from August 2024 that had not been entered into the register. This was highlighted during the inspection, and the SI confirmed a member of the team working that afternoon would ensure the entries were up to date. The pharmacy had records relating to unlicensed medicines. And details of supply were mostly included to provide an audit trail.

There was a General Data Protection Regulation (GDPR) policy in place. And team members understood the importance of protecting people's confidentiality. The SI destroyed confidential waste off-site, the risks of which were discussed during the inspection. Following the inspection, the SI confirmed going forward they would arrange a third party contractor to collect confidential waste to destroy securely offsite. The pharmacy had a safeguarding policy. The SI provided examples of signs that would raise concerns and of interventions they had made to protect vulnerable people. And the pharmacy had details of local safeguarding agencies.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members have the appropriate qualification training for their roles and the services they provide. They are empowered to raise concerns and suggest improvements to provide a more effective service.

Inspector's evidence

The pharmacy owner and SI worked full-time as the RP, at the time of inspection they were working alone with a secondary school pupil, who was on a work placement in the pharmacy for one week. They explained this was their first day and they had been undertaking observation activities of the SI completing everyday tasks within the pharmacy. They were observed accompanying the pharmacy delivery driver as he delivered prescriptions to the local care home. The pharmacy employed two part-time dispensers, one part-time trainee dispenser and a delivery driver who worked every day. The pharmacy had recently appointed an accuracy checking pharmacy technician (ACPT) who was scheduled to commence employment imminently and there was a current vacancy for another ACPT. The SI managed annual leave requests to ensure staffing levels remained sufficient to manage the workload safely. They explained that staffing was a problem at the time of inspection due to a member of the team leaving recently, and contingency cover wasn't always available. They didn't foresee this being a long-term problem when the ACPT commenced employment. The SI they was observed to be managing the workload safely and in a calm manner. They regularly reviewed ways of working and capacity of team members. For example, certain services weren't actively being promoted during times of staffing pressures, such as a blood pressure measuring service. However, at the time of inspection a person enquired about the service and the SI arranged a time that was appropriate to accommodate a blood pressure consultation.

Team members undertaking accredited qualification training received protected learning time. They received appraisals annually to review progress and identify any individual learning needs. Team members were supported to learn and develop further, the SI explained they encouraged team members to hold responsibility for specific tasks within the pharmacy under their supervision. For example, specific record keeping and date checking of retail and dispensary stock. The trainee dispenser was in the process of developing a protocol to manage the date checking of stock within the pharmacy. Team members received specialist training for specific services the pharmacy offered, for example to be able to provide medicines under the Community Palliative Care Network. Following the change of ownership in October 2023 ways of working were changed within the pharmacy. And team members were encouraged to share feedback and provide suggestions to improve the efficiency in the way the pharmacy operated. This included informal meetings once a week to prioritise workload and raise any concerns. Examples of ways of working that had been changed following team discussions were the way in which multi-compartment compliance packs were processed and assembled. Team members recorded details of certain tasks on a white board within the dispensary as a method of non-verbal communication. This included when a prescription should be ordered from the GP practice and when it should be labelled and dispensed. This meant continuity of work as part-time members of the team could easily see which stage of the cycle needed to be actioned that week.

The SI asked appropriate questions when selling over-the-counter medicines. And team members discussed any concerns relating to the sale of medicines liable to misuse, such as codeine-containing

medicines with the RP. The SI encouraged a supportive and open culture within the pharmacy team this was to provide a comfortable environment, should team members feel they need to raise professional concerns.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are clean, secure and provide a professional environment for the services delivered. And people can access a private consultation room to have confidential conversations with a team member.

Inspector's evidence

The pharmacy premises were clean, modern, and provided a professional appearance. There was a well-presented retail area with chairs for people waiting that led to a healthcare counter and dispensary. The healthcare counter acted as a barrier to prevent unauthorised access. The dispensary was positioned in a way that allowed the pharmacist to supervise team members undertaking activities in the retail area. And they could easily intervene in a sale if necessary. The dispensary was well-organised with plenty of workbench space. Medicines were stored neatly on shelves throughout the dispensary and in drawers. The dispensary had a sink with access to hot and cold water for professional use and handwashing. There was no area for team members to have rest breaks, the SI explained there was a plan to develop a staff area in the future. However currently team members used a small area of the dispensary for rest breaks. The area was segregated from medicinal stock and kept clean and tidy. Bathroom facilities were clean and hygienic with access to hot and cold water. There was a separate area for stock holding at the rear of the dispensary.

The consultation room was well-advertised, of good size and fit for use. Lighting and temperature were kept to an appropriate level throughout the premises.

Principle 4 - Services ✓ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy services safely and effectively. The pharmacy sources medicines and medical devices from reputable suppliers. It generally stores them appropriately and team members carry out the appropriate checks to ensure they are fit for supply.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance from the main street and an automatic door that was opened by using a push pad. It advertised some of the services it offered in the main window alongside its opening hours. The pharmacy had a sample of healthcare leaflets available for people to read or takeaway, including information about support available to people suffering from lymphoma. And for services available in the local community such as healthcare at home. Pharmacy team members provided large print medicines labels to help people with visual impairments take their medicines safely. And they had access to an interpreter service to communicate with people who did not use English as their first language. The pharmacy provided a delivery service to people who had difficulty collecting their prescription. The delivery driver used a paper sheet to record the delivery of each prescription. And the pharmacy kept records of this for a specific time frame before destroying them safely.

The pharmacy purchased medicines from recognised wholesalers and generally stored them appropriately in the manufacturers original packaging. A team member had responsibility for checking the expiry dates of medicines within the pharmacy. They were in process of developing a date checking matrix where they would record their actions. A sample of 20 medicines showed one had expired, which was highlighted at the time of inspection and segregated from other stock. There were several medicines stored out with the manufacturer's original packaging in medicines bottles on the shelf above the area in which multi-compartment compliance packs were assembled. Hand-written labels attached to the medicine's bottles showed what medicine should be contained inside, but batch numbers and expiry dates were not always recorded on the labels. This was discussed at the time of inspection and the inspector highlighted the importance of this should a medicine be identified in a Medicines Healthcare and Regulatory Agency (MHRA) product recall or patient safety alert. This SI agreed and provided assurances medicines were not supplied without a batch number or expiry date, and the medicines would be destroyed appropriately. The pharmacy used one well-organised fridge to store its medicines and prescriptions awaiting collection that required cold storage. The fridge was operating within the recommended limits of between 2 and 8 degrees Celsius. Team members checked the fridge temperature daily to ensure it continued to operate at the appropriate temperature. However, records could not be seen from the months of February 2024 until the day of inspection. The SI explained they had changed computer software and as a result he did not have records to view between these dates. Paper-based records seen until January of 2024 showed team members were consistent with daily temperature monitoring.

The dispensary had separate areas for the dispensing and checking of prescriptions. And team members used baskets during the dispensing process to separate people's prescriptions and prevent medicines from becoming mixed up. The SI was undertaking both the dispensing and checking of prescriptions. They explained this is a rare occurrence and described a safeguard they used to reduce the chance of a mistake occurring. They dispensed prescriptions and if time allowed, they would place the prescription

on a separate shelf to have a final accuracy check the following day. The SI added a handwritten prompt to the outside of the bags of dispensed medicines to indicate it contained a fridge line, CD or a higher-risk medicine that required further counselling. They were aware of the Pregnancy Prevention Programme and the risks associated with supplying valproate-containing medicines. They supplied valproate out with the manufacturer's original packaging to one person in a multi-compartment compliance pack. They had assessed the risk and found this as being the most appropriate way in which the person should receive this medicine. The pharmacy received Medicines Healthcare and Regulatory Agency (MHRA) product recalls and patient safety alerts via email. At the time of inspection records could not be seen but the SI described the process for managing these and the action taken for the most recent recall received.

Some people received serial prescriptions under the Medicines:Care and Review service. Team members prepared prescriptions in advance of people's expected collection dates. They kept records of expected collection dates. This helped manage workload within the pharmacy. And allowed the pharmacist to identify any issues with people not taking their medicines as they should. The pharmacy provided medicines in multi-compartment compliance packs for people who needed help to take their medicines. Team members managed this workload on a robust four-week cycle, this allowed them time to resolve any queries with people's medication. They kept records of people's current medicines and administration times on a master sheet. This was checked against prescription before dispensing. Team members kept records of any changes to people's medicines for example, if the strength of a medicine was increased or decreased. And they recorded the date the change had been communicated on a communication form that was kept alongside the person's updated master sheet. They attached backing sheets to each pack which included details such as directions for use and a description of what each medicine looked like. Patient information leaflets (PILs) were included monthly so people had up-to-date information relating to their medicines. On the sample of packs seen specific mandatory warning labels and an audit trail of who had dispensed and checked each pack wasn't always included. The SI provided assurances this would be addressed.

The pharmacy provided the NHS Pharmacy First service. Team members were trained to ask appropriate questions within their competence before referring to the pharmacist for treatment. The pharmacist provided treatment for common conditions such as urinary tract infections (UTIs) under a patient group direction (PGD). The pharmacy kept records of treatment provided of referral decisions and communicated these to people's GPs to ensure their medical records were kept up to date. The pharmacy was part of the Community Palliative Care Network. The pharmacist attended specialist in person training. And they worked under a service specification and medicines list to ensure people had access to palliative care medicines. They were supported by local health board colleagues and received up to date information to continue to provide the service safely.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Pharmacy team members have access to the suitable equipment that is fit for purpose and safe to use. And they use the equipment appropriately to protect people's confidential information.

Inspector's evidence

Team members had access to internet services to obtain current information and guidelines to support them in their roles. For example, The British National Formulary (BNF) and Stockley's medicines interaction checker.

The pharmacy had a set of clean CE-stamped measuring cylinders and tablet counters that were fit for use. There was a range of equipment available in the consultation room to support the pharmacist in delivering the NHS Pharmacy First Plus service in the future. This included a blood pressure monitor and in-ear thermometer. Electrical equipment was visibly free from wear and tear.

Prescriptions awaiting collection were stored in a retrieval area behind the healthcare counter that was completely private and not visible to people waiting in the retail area. There was a separate area with a computer used for the checking of prescriptions in front of the dispensary, and in line with the healthcare counter. It was screened to allow privacy and prevent disruptions during the checking process. Computers were positioned in a way that prevented unauthorised view. And cordless telephones were in use to allow private conversations in a quieter area.

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.