General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Reach Pharmacy, 179-181 Main Road, Elderslie, JOHNSTONE, Renfrewshire, PA5 9ES

Pharmacy reference: 1126527

Type of pharmacy: Community

Date of inspection: 29/11/2024

Pharmacy context

This is a community pharmacy in Elderslie. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy dispenses private prescriptions and pharmacy team members advise on minor ailments and medicines use. They provide over-the-counter medicines and prescription-only medicines via patient group directions (PGDs).

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not train all team members within the necessary timescales to ensure they have the right qualifications and skills for their roles and the services they provide.
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

Overall, the pharmacy adequately identifies and manages risks with its activities and services. It keeps accurate records as required by law. And it keeps people's confidential information safe and secure. Team members understand their roles in protecting vulnerable people and how to respond to people's feedback about services. However it doesn't always review and fully implement all its written procedures and team members do not always work in accordance them. And it does not fully consider the risks of not keeping records for some higher-risk medicines. So the team may not always work in the most consistent and safest way.

Inspector's evidence

The pharmacy defined its working practices in a range of standard operating procedures (SOPs) which were accessible to team members. Some of the SOPs had not been reviewed since August 2020 and they had not been read and signed by all the team members that worked there. The SOP that defined the final accuracy check had not been reviewed since August 2020. And it had not been signed by the accuracy checking dispenser (ACD) to show they followed it. Team members were seen to be following safe working practices at the time of the inspection. And the ACD knew only to check prescriptions that had been annotated by a pharmacist.

The SOP for recording dispensing mistakes that were identified in the pharmacy, known as near miss errors, had been reviewed but had not been implemented. And team members had not kept records of near miss errors since August 2023. Team members did not record their signatures on all medicine labels to show who was responsible for dispensing prescriptions. This meant the pharmacist and the ACD could not always help team members learn from their dispensing mistakes. Team members provided a few examples of improvement actions that had helped them to manage dispensing risks. This included separating look alike, sound alike (LASA) medications, such as ropinirole and risperidone and quinine sulphate and quinine bisulphate.

Team members knew to escalate dispensing errors, which were mistakes that were identified after a person had received their medicine. The pharmacist discussed the incidents with team members, so they learned about dispensing risks and any new control measures that had been introduced to keep dispensing services safe. The pharmacist completed an incident report which they shared with the superintendent pharmacist (SI) and the regional manager. This meant they could intervene and introduce extra improvements if necessary. The regional manager visited the pharmacy on a regular basis to ensure it was running safely and effectively. The pharmacy defined its complaints procedure in a documented SOP and team members knew to handle concerns that people raised in a calm and sensitive manner. This included speaking to people in the consultation room if they needed to.

Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed an RP notice which was visible from the waiting area and the RP record was up to date. The pharmacy maintained CD registers and team members checked the balance recorded in the register matched the physical stock, once a week. Team members filed prescriptions so they could easily retrieve them if needed. And they kept records of supplies of unlicensed medicines and private prescriptions which were accurate and correct. The pharmacy trained its team members to safeguard sensitive information. This included managing the

safe and secure disposal of confidential waste. The pharmacy defined its safeguarding procedure in a documented SOP and team members knew to escalate any safeguarding concerns and discuss them with the pharmacist to help vulnerable people. For example, when some people failed to collect their medication on time so that alternative arrangements could be arranged if necessary.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy reviews its staffing levels to ensure it has the right number of pharmacy team members working when it needs them. But it does not ensure that all team members receive appropriate qualification training within the necessary timescales to ensure they have the right skills for their roles and the services they provide. Team members provide feedback and suggest improvements to improve working practices.

Inspector's evidence

The pharmacy's dispensing workload had remained stable over the past year. The pharmacist had worked at the pharmacy for around 20 years and a regular locum pharmacist was providing cover at the time of the inspection. Most of the team were long-serving and experienced in their roles and the following team members were in post; one pharmacist, one full-time ACD, one full-time dispenser, one part-time dispenser, three part-time medicines counter assistants (MCAs) and three part-time delivery drivers. One of the MCAs had worked at the pharmacy every Saturday for approximately one year. But the pharmacy had not enrolled them onto the relevant qualification training. The pharmacy had minimum staffing levels in place with only one team member permitted to take leave at the one-time. And the other pharmacies owned by the same company shared team members to provide cover when necessary.

The pharmacist supported team members to keep up to date and develop in their roles. For example, they discussed the NHS pharmacy first formulary when it was updated. And they had also discussed a new treatment that was being supplied via a patient group direction (PGD) for weight management. This meant that team members knew to advise people on how to complete a pre-screening questionnaire and to provide an information leaflet prior to their consultation with the pharmacist in the pharmacy. Most team members had undergone training to deliver an ear wax removal service and they knew to refer to the pharmacist if they had concerns.

The pharmacist empowered team members to suggest improvements. And they had discussed the drawbacks of relying on the pharmacy's automated re-ordering system and stock shortages. Team members had suggested trialling a manual re-ordering system which was agreed and subsequently introduced which had improved the pharmacy's stock control arrangements. The pharmacist encouraged team members to raise whistleblowing concerns to help to keep pharmacy services safe and effective.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean, and hygienic. The pharmacy has facilities for people to have private conversations with pharmacy team members.

Inspector's evidence

The pharmacy was in a purpose built premises that presented a professional appearance to the people that used it. The dispensary was organised with separate dedicated areas for the dispensing and checking of prescription items. And the pharmacist was able to intervene at the medicines counter when needed. Team members used dispensing baskets to help organise the workspace on the dispensing benches. And they organised the shelves and kept them tidy to manage the risk of medicines becoming mixed up. A separate rear area was used for multi-compartment compliance pack dispensing. This ensured sufficient space for the prescriptions and the relevant documentation to carry out the necessary checks and keep dispensing safe.

The pharmacy had a consultation room with hot and cold running water. It also had a separate booth where people could speak to the pharmacist and team members in private. A clean sink in the dispensary was used for medicines preparation and team members cleaned all areas of the pharmacy daily. This ensured the pharmacy remained hygienic for its services. Lighting provided good visibility throughout. And the ambient temperature provided a suitable environment to store medicines and to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it provides its services safely. The pharmacy gets its medicines from reputable sources, and it mostly stores them appropriately. The pharmacy team check medicines are in good condition and suitable to supply. And they identify and remove medicines from use that are no longer fit for purpose.

Inspector's evidence

The pharmacy was on a main road, and it provided its services six days a week from Monday to Saturday. The premises had a step-free entrance and an automatic door and people with mobility issues were able to gain access without restrictions. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members conducted monitoring activities to confirm that medicines were fit for purpose. They checked medicine expiry dates around every three months, but they did not keep records, so they knew when checks were next due. A random check of dispensary stock found no out-of-date medicines. The pharmacy used a large fridge to keep medicines at the manufacturers' recommended temperature. And team members monitored and recorded the temperature every day to show that the fridge remained within the accepted range of between two and eight degrees Celsius. The fridge was organised with items segregated which helped team members manage the risk of selection errors. But team members also used the fridge for personal foodstuffs. And following the inspection, the inspector advised the regular pharmacist to remove the items to manage the risk of cross-contamination.

The pharmacy used secure cabinets for some of its medicines and they were kept well-organised. The pharmacy received drug safety alerts and medicine recall notifications. Team members checked the notifications and maintained an audit trail to show they had conducted the necessary checks. The pharmacy had medical waste bins and denaturing kits available to support the team in managing pharmaceutical waste. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so people were able to read the relevant safety information. They also knew about recent legislative changes which required them to provide supplies in the original manufacturer's pack unless in exceptional circumstances. Following the inspection, the inspector spoke to the regular pharmacist who confirmed they had completed nine risk assessments to confirm the appropriateness of supplies in split packs. The pharmacy used containers to keep individual prescriptions and medicines together during the dispensing process. This helped team members manage the risk of items becoming mixed-up. It also helped them prioritise prescriptions, for example, when people wished to wait on their medication.

The pharmacy supplied medicines in multi-compartment compliance packs to a considerable number of people. An experienced dispenser and the ACD managed dispensing, and they provided cover for each other when they were on leave. They kept a notice board up-to-date so that the rest of the pharmacy team could respond to queries. Supplementary pharmacy records helped them to manage dispensing. And the pharmacy kept records of the person's current medicines and administration times which allowed team members to carry out checks and identify any changes that they queried with the GP surgery. They kept an audit trail of prescription changes in a record book to refer to. The pharmacist annotated the prescriptions to show they had completed a clinical check and team members entered

the prescription information onto the pharmacy's patient medication record (PMR) which was transmitted to a dispensing hub pharmacy in another branch. They did not send prescriptions that were subject to frequent changes or prescriptions that contained CDs and they dispensed them in the pharmacy instead. The hub pharmacy delivered the multi-compartment compliance packs to the pharmacy and team members matched the items with the prescriptions. They kept the packs in a separate area until they were needed. Team members supplied patient information leaflets (PILs), and they provided descriptions on the packs of to help people identify their medicines. Team members attached a label to packs that had been quarantined to show they were not to be supplied. For example, when people had been admitted to hospital.

The pharmacist supported people with weight loss following a consultation in the pharmacy. They supplied treatments when it was safe and appropriate to do so according to a PGD that was valid until 30 June 2026. All consultations were documented including those when the decision was not to prescribe as not suitable. The pharmacist notified the person's GP surgery of prescribed treatments, and this was documented to show they had done so.

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 access to the digital version of the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for substance misuse medicines. The pharmacy used a machine to facilitate the removal of ear wax. Team members cleaned the transparent tubing that was attached to the machine in between treatments.

The pharmacy had installed a prescription collection machine. And people could collect their medicines out of hours when it was safe for them to do so. The pharmacist had arranged training before team members were expected to use the machine. And they knew who to contact if they experienced problems. The machine had been out of order for one day and team members had contacted the engineer who was due to attend the pharmacy in the next few days to carry out repairs. Team members had considered some of the risks of continuing to place prescriptions into the machine. But they had not contacted people whose prescriptions were already in the machine to let them know. And there was a risk that they would visit the pharmacy after the pharmacy closed and be unable to retrieve their medication.

The pharmacy stored prescriptions for collection out of view of the public waiting area and it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could conduct conversations in private if needed, using portable telephone handsets.

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.