General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Maryhill Dispensary Ltd, 51 Gairbraid Avenue, Glasgow, Lanarkshire, G20 8FB

Pharmacy reference: 9010455

Type of pharmacy: Community

Date of inspection: 17/02/2022

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

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

Pharmacy team members follow good working practices. And they show that they are managing dispensing risks to keep services safe. The pharmacy documents some of 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. The waiting area extended into the communal area of the health centre. Team members permitted a maximum of eight people to enter the immediate vicinity of the pharmacy at the one time. They used a series of tensor barriers to help people queue. This allowed them to maintain a two-metre distance from each other. The pharmacy provided hand sanitizer at the medicines counter. And pharmacy team members used the same supply to sanitise their hands. Not all the team members were wearing face masks at the start of the inspection. They donned one at the request of the inspector. A plastic screen in the consultation booth acted as a protective barrier between team members and members of the public. There was no such protective barrier at the medicines counter. And team members had placed chairs in front of the medicines counter to keep people at a safe distance. 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 June 2021. This included the ‘assembly and dispensing’ and ‘accuracy checking’ procedures which were valid until June 2024. The pharmacy employed an ‘accuracy checking technician’ (ACT). The ACT followed the pharmacy’s accuracy checking procedure. This included only checking those prescriptions that had been annotated by a pharmacist. The ACT checked multi-compartment compliance packs. Dispensing of the packs was carried out by experienced dispensers. They followed the pharmacy’s procedure for the assembly of packs which had been reviewed in June 2021. This helped to reduce the risk of dispensing errors. Pharmacy team members signed most of the medicine labels to show who had ‘dispensed’ and who had ‘checked’ each prescription. Sampling showed they did not always sign the labels on multi-compartment compliance packs. The pharmacist and the ACT were able to identify dispensers to help them learn from their dispensing mistakes. Near-miss error records showed that team members had recorded four errors since the start of January 2022. The records showed two errors involving co-codamol tablets. Team members were in the process of re-arranging stock and had already separated co-codamol tablets and co-codamol caplets to manage selection risks. The pharmacy kept tramadol/trazodone and frusemide 20mg/frusemide 40mg tablets separate due to an unacceptable level of dispensing mistakes. The pharmacy had not received any recent complaints or reports involving dispensing incidents. It did not use an incident report template for recording the root cause of dispensing incidents. And it was not recording 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 was valid until June 2024. 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 30 April 2022. The pharmacist displayed a

responsible pharmacist notice and kept the RP record mostly up to date except for a few missing entries. Team members maintained the controlled drug registers and kept them up to date. The registers showed they had carried out and evidenced a full stock check in June, July, and August 2021. Since then, they checked the balance of controlled drugs at the time of dispensing. This meant that slow-moving stock was not checked on a regular basis. The pharmacist checked the methadone balance at the end of the day. And they annotated the register to confirm they had checked the balance. People returned controlled drugs they no longer needed for safe disposal. A completed destructions register showed entries up until 2018. The register showed the pharmacist had signed the records to confirm that destructions had taken place. The pharmacist was unable to locate the current register. Two sealed bags in the controlled drug cabinet contained controlled drugs that had been returned for destruction. They were kept separate from the rest of the stock. Blank controlled drugs destructions registers were available for team members to use. 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 designated bags to dispose of confidential waste. A verified supplier collected the bags for off-site disposal. The pharmacy trained its team members to manage safeguarding concerns. It had not introduced a policy for them to refer to. It kept contact details for key agencies which included the community addictions team (CAT). It also kept contact telephone numbers for vulnerable people and the people that looked after them in the event of concerns. 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

Most of the 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 reduced since the start of the coronavirus pandemic. The pharmacy team had changed significantly over the same period and new team members had been appointed. The pharmacist had previously worked in a nearby sister branch. They had started working in the pharmacy around July 2021 when the previous pharmacist had left their post. A new 'accuracy checking technician' (ACT) had started in October 2021. The pharmacist had yet to enrol a new pharmacy assistant on the necessary dispenser's training course even though they had been in post since February 2021. The pharmacist had arrangements in place for locum pharmacists to provide cover when needed. And a second pharmacist worked alongside the regular pharmacist three days a week. The pharmacy team included one full-time pharmacist, one part-time pharmacist, one full-time accuracy checking technician (ACT), one full-time dispenser, one full-time pharmacy assistant, two student pharmacists who each provided two and a half days cover mid-week and one full-time delivery driver. A trainee pharmacy technician from a nearby sister branch was providing cover at the time of the inspection.

The pharmacist provided training support in the workplace, so that trainees made good progress with their courses. The 'accuracy checking technician' (ACT) had worked in a care home dispensary before they took up their post. And the pharmacist had been providing support to help them update and develop the necessary knowledge and skills for their roles and responsibilities. They had recently learned how to operate the Methameasure device. This included calibrating and cleaning the device and communicating the registered methadone balance to the pharmacist at the end of the day. The pharmacist checked the pharmacy's 'clinical mailbox' twice a week and updated team members whenever there were changes. This included information about a new National Patient Group Direction (PGD) for the supply of desogestrel, a progestogen-only pill for bridging contraception. And information about a new dietetics initiative which involved pharmacists and dieticians working together to supply Ensure products. 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 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

The pharmacy had ample well-segregated areas for the different dispensing activities. Team members had organised the dispensing benches which were clutter free. Team members were mostly working at the same dispensing bench even though the other benches were at least two metres away. This meant they did not always take the opportunity to keep a safe distance from each other throughout the day. The pharmacist supervised the medicines counter from the checking bench which was opposite the main dispensing bench. They were able to intervene and provide advice when necessary. A separate bench was used to assemble and label multi-compartment compliance packs. Team members kept the storage shelves for the packs well-organised.

The pharmacy had a sound-proofed consultation room, and team members used a separate, private booth to provide supervised consumption services. The room and the booth provided a confidential environment for private consultations. A sink in the dispensary was available for hand washing and the preparation of medicines. Team members cleaned and sanitised the pharmacy two or three time a day to reduce the risk of spreading infection. A cleaner who was employed by the health centre cleaned the floors in the morning when the pharmacist was present. Lighting provided good visibility throughout. The ambient temperature provided a suitable environment to store medicines and to provide services. A large dedicated room was 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 generally manages its services well to help people receive appropriate care.

Inspector's evidence

The pharmacy was in a health centre and a step-free entrance provided unrestricted access for people with mobility difficulties. It had recently reduced its opening hours and closed at lunchtime for one hour. It continued to provide its services at the same time as the GP practices in the health centre. The pharmacy advertised its services and opening hours in the waiting area. The pharmacist provided access to 'prescription only medicines' via 'patient group directions' (PGDs). They did not keep 'hard copies' of the PGDs and accessed the electronic versions of the documents on the Health Board's web page. This was demonstrated at the time of the inspection. Team members kept stock neat and tidy on a series of shelves and drawers. The pharmacy had two large, controlled drug cabinets. The cabinets had adequate space to safely segregate stock items. Items awaiting destruction were separated and kept at the top of one of the cabinets. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members used a date-checking matrix to show they checked stock on a regular basis. This had been updated at the end of 2021. Sampling showed one product had expired at the end of January 2022. The pharmacist checked the expiry date as part of their accuracy checking product to mitigate against expired stock. A large medicines fridge was used to keep stock at the required temperature. The fridge was organised and well-managed. Team members monitored and documented the temperature of the fridge to show it was 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. The pharmacist knew to contact prescribers if they received new prescriptions for people in the at-risk group. Team members knew to supply patient information leaflets and to provide warning information.

The pharmacy supplied medicines in multi-compartment compliance packs. This had remained at the same level over the course of the pandemic. The pharmacy had defined the assembly and dispensing process in a documented procedure for team members to refer to. The procedure was up-to-date and had last been reviewed in June 2021. The pharmacist managed the dispensing process. They ordered new prescriptions, carried out a clinical check and produced the backing sheets that team members attached to the packs. Team members used a separate bench to assemble and label the packs. And they used dedicated shelves to store the packs. They used individual boxes to store people's packs, and separated packs when people had similar names to manage the risk of hand-out errors. Team members obtained an accuracy check before they de-blistered medicines. And they checked prescriptions against the backing sheets for accuracy before they started dispensing the packs. The 'accuracy checking technician' (ACT) checked most of the packs. They knew to check for the annotation that indicated that the pharmacist had carried out a clinical check. The pharmacy delivered some of the packs. The delivery driver kept a supply of face masks, gloves and hand sanitizer in the delivery vehicle and used them during their deliveries. They knew to keep at a safe distance from people to manage the risk of

infection. Team members used a Methameasure to dispense doses. They obtained a clinical check at the time they entered new prescriptions onto the system. And they obtained an accuracy check from the pharmacist at the time they dispensed a dose. 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. Drug alerts were prioritised, and team members knew to check for affected stock so that it could be removed and quarantined straight away. The pharmacist annotated and retained the drug alerts in a folder to show what the outcome of the checks had been. For example, Naprosyn tablets had been checked on 3/2/2022 with no stock affected.

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 a separate measure to measure methadone. They had highlighted the measure, so it was used exclusively for this purpose. They also used a Methameasure device for methadone doses. 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.