

Registered pharmacy inspection report

Pharmacy Name: Westray Pharmacy, 9-11 Westray Circus, Glasgow, Lanarkshire, G22 7BE

Pharmacy reference: 9010762

Type of pharmacy: Community

Date of inspection: 22/02/2022

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 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 limited the number of people in the waiting area to three at a time. This helped people keep a safe distance from each other. Sometimes people queued outside and followed the guidelines. This was without any instruction from the pharmacy team members. Hand sanitizer was available in the waiting area and throughout the dispensary. Pharmacy team members were wearing face masks throughout the inspection. And a plastic screen was in place at the medicines counter. This acted as a protective barrier between team members and members of the public. 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 some of the procedures had been recently updated. This included the 'assembly and labelling' and 'accuracy checking' procedures which were valid until September 2022. Some procedures had not been updated since October 2019. This included 'dispensing supervised methadone' and 'dispensing controlled drugs'. The responsible pharmacist was satisfied they still reflected the pharmacy's safe working practices. The pharmacy employed an 'accuracy checking technician' (ACT). The ACT followed the pharmacy's accuracy checking procedure. This included only checking prescriptions that had been annotated by a pharmacist. The ACT checked a significant number of 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 March 2021. This included checking prescriptions against supplementary records and helped to reduce the risk of dispensing errors.

Pharmacy team members mostly signed medicine labels to show who had 'dispensed' and who had 'checked' each prescription. However, gaps were seen on multi-compartment compliance pack medicine labels. This meant that the pharmacist and the ACT could not always identify dispensers to help them learn from their dispensing mistakes. Team members were consistent in recording near miss errors. This helped them to identify patterns and trends which they acted on. This included separating tramadol/trazodone and Losec MUPS/Omeprazole capsules. The pharmacist had taken up their post in October 2021. They had not received any reports or complaints about dispensing incidents since they started. They knew where to find the company's incident report template in the event they needed to use it. The template included a section for outcomes from 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 reviewed in October 2019. The pharmacy displayed a notice in the waiting area which provided information about how to complain. And it invited people to provide feedback about the service they used. It also provided feedback forms which were kept at the medicines counter. People had provided some feedback which had mostly been positive with no indication of the need for improvements.

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. Team members maintained the electronic controlled drug registers and kept them up to date. They checked and verified the balances on a regular basis. People returned controlled drugs they no longer needed for safe disposal. Team members kept records of the destructions of these and the responsible pharmacist 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'. They kept the records up-to-date. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. Team members used a shredder to dispose of confidential waste. The pharmacy displayed a notice to inform people about how it used and processed their information. This was in relation to the NHS Pharmacy First service. The pharmacy trained its team members to manage safeguarding concerns. It had not introduced a policy for them to refer to but kept an up-to-date list of contact details for key agencies. 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. Team members retrieved packs that were due for collection. They put them at the medicines counter until people or their carers collected them. They checked the shelf at the end of the week, and this helped them identify potential concerns which they followed up. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. This helped to protect children and vulnerable adults. A chaperone notice on the main consultation room door advised people they could be accompanied if they wished.

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 company had maintained the number of team members it employed. And it authorised over-time to provide extra cover when necessary. The pharmacist arranged for relief pharmacists or locum pharmacists to provide cover when they planned annual leave. The pharmacy team was supported by an area manager. They carried out on-site visits once a week and provided support whenever it was needed. The superintendent pharmacist arranged quarterly meetings for all pharmacist managers to attend. They had been running the meetings via Zoom during the pandemic. The last meeting in November 2021 had included a discussion about a new National Patient Group Direction (PGD) for the supply of desogestrel, a progestogen-only pill for bridging contraception.

Most team members were long-serving and experienced in their roles and responsibilities. A new team member had been in post for one month. The pharmacist had enrolled them on the necessary dispenser's course. And they had read the procedures that were relevant to their role. This was evidenced on the sign-off sheets that were attached to each procedure. The pharmacy team included one full-time pharmacist, one full-time accuracy checking technician (ACT), one full-time dispenser, one full-time trainee dispenser, two part-time trainee dispensers, one part-time medicines counter assistant and one student pharmacist who worked on a Saturday. The pharmacy employed a full-time delivery driver. The driver was undergoing an accredited course. This helped them to be effective in their role. It also provided the necessary assurances that the delivery service was safe and effective. The ACT kept up-to-date with new medicines protocols. This helped them to support the pharmacist to identify prescribing errors. For example, they had recently learned that the dose of simvastatin had been reduced from 40mg to 20mg for people taking amlodipine.

The pharmacist kept the pharmacy team up to date with service developments. Recent topics had included recognising the signs and symptoms of colds and flu. This included discussions about the treatments they could provide via the NHS Pharmacy First service. The pharmacist had introduced a training record template for individual team members. This was blank and had not been updated to reflect recent training. 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 was arranged over two floors. The dispensary had ample well-segregated areas for the different dispensing activities. A series of dispensing benches were organised and clutter free. Workstations were at least two metres apart and team members kept a safe distance from each other for most of the day. A large downstairs area provided extra storage for excess stock and other items. The pharmacist supervised the medicines counter from the checking bench. They were able to intervene and provide advice when necessary. A separate area was used to assemble multi-compartment compliance packs. Team members kept the storage shelves for the packs well-organised. The pharmacy used two sound-proofed consultation rooms. The rooms provided a confidential environment for private consultations. One of the rooms was used solely methadone consumptions. Team members cleaned the rooms after each consultation. The main consultation room was well-equipped with a sink and hot and cold running water. A sink in the dispensary was available for hand washing and the preparation of medicines. Team members cleaned and sanitised the pharmacy on a regular basis to reduce the risk of spreading infection. Lighting provided good visibility throughout. The ambient temperature provided a suitable environment to store medicines and to provide services.

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. But it has expired medicines on its shelves. And its arrangements to identify and remove expired medicines are not always effective. 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 advertised its services and opening hours in the windows at the front of the pharmacy. An automatic door and a step-free entrance provided unrestricted access for people with mobility difficulties. The pharmacist provided access to 'prescription only medicines' via 'patient group directions' (PGDs). This included a new national PGD for supplies of desogestrel, a progestogen-only pill for bridging contraception. The pharmacist had signed the PGD which was valid until November 2023. They kept it in a dedicated folder alongside the other PGDs for ease of access. The pharmacist provided flu vaccinations and kept up to date with service requirements. Team members cleaned and sanitised the consultation room after each consultation.

Team members used dispensing baskets to manage the risk of items becoming mixed-up. They kept stock neat and tidy on a series of shelves. The pharmacy had two large, controlled drug cabinets. The cabinets had adequate space to segregate stock items. Methadone and items awaiting destruction were kept in one cabinet. And assembled multi-compartment compliance packs and the rest of the stock was kept in the other cabinet. 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. External stock takers also date-checked stock once a year. Sampling showed several products had expired in 2021. The products were confined to a small section of shelves for products beginning with the letter C. No expired stock was found in the other sections. As part of their final accuracy checking procedure, the pharmacist checked the product's expiry date to mitigate the risk of expired products being kept in stock. A large medicines fridge with a glass door was used to keep stock at the required temperature. The fridge was organised with general stock at the top, insulin products on the middle shelves and items for delivery at the bottom. 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. They kept records on people's PMR following any discussions about their medication. Team members knew to supply patient information leaflets and to provide warning cards.

The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people. This had increased slightly 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 March 2021. A separate area was used to assemble and store the packs. Team members ordered new prescriptions after they removed the third pack of the four-week cycle for supply. This ensured they had sufficient time to process subsequent

supplies. Supplementary records which contained a list of the person's current medication and dose times were kept up to date. Team members checked prescriptions against the master records for accuracy before they started dispensing packs. Queries were discussed with the relevant prescriber and they recorded changes on people's records. The pharmacy supplied medicines to four care homes. This included a significant number of multi-compartment compliance packs. The pharmacy had defined the dispensing process in two documented procedures for team members to refer to. The procedures had last been reviewed in October 2019. The pharmacy used a planner which was colour-coded to show when new prescriptions were needed and when supplies were due. This helped team members effectively plan and prioritise tasks to safely manage dispensing. The pharmacist had met with staff at one of the care homes. This had resolved misunderstandings and had led to improvements.

Team members used crown-stamped measuring cylinders to dispense methadone doses. These were highlighted so they were used exclusively for this purpose. Separate measures were used for other products, such as for measuring water for antibiotic liquids. Team members had developed a rota for dispensing methadone doses. They kept it above the dispensing bench so they could refer to it. They dispensed doses the day before they were due. The pharmacist checked the doses and the team members placed them in the controlled drug cabinet until they were needed. The pharmacist also checked the doses against the prescription at the time of supply. Team members accepted unwanted medicines from people for disposal. 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 retained the drug alerts in an electronic folder. They were unable to show they had acted on the alert or 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). It used crown-stamped measuring equipment. Team members had placed red elastic bands around the base of some measures. This showed they were only to be used for measuring methadone. 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. The pharmacy used a cordless phone. This meant that 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 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.