

Registered pharmacy inspection report

Pharmacy Name: Mackie Pharmacy, 1845 Paisley Road West,
Glasgow, Lanarkshire, G52 3SX

Pharmacy reference: 9011176

Type of pharmacy: Community

Date of inspection: 30/12/2019

Pharmacy context

This is a community pharmacy located on a parade of shops. It provides access to services over extended opening hours. And it dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It also offers a smoking cessation service.

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	Good practice	2.1	Good practice	The pharmacy continuously reviews the number of team members it has in place to safely provide the services it offers. And it has effective arrangements in place to provide its services when team members take planned or unplanned leave.
		2.2	Good practice	The pharmacy team members complete regular training relevant to their roles. And the pharmacy provides time during the working day to support them to do so.
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 team members work to professional standards. They understand their role in protecting vulnerable people. And they complete regular training to ensure they are up-to-date with safeguarding requirements. People using the pharmacy can raise concerns. And team members know to follow the company's complaints handling procedure. This means they listen to people and put things right when they can. Pharmacy team members record and discuss mistakes that happen whilst dispensing. And they use this information to learn and reduce the risk of further errors. They do not always collect detailed information about the causes of mistakes to help inform the changes they make. The pharmacy keeps most of the records it needs to by law. And it provides training for the team on how to keep confidential information. But it does not always have the controls in place to keep people's private information secure.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. The team members had signed to confirm they followed the procedures. And to show they understood their roles and responsibilities. The pharmacy employed two accuracy checking technicians (ACTs). And they knew only to check prescriptions that had been approved and annotated by the pharmacists. The pharmacy had re-located in July 2019. And it had introduced a new dispensing robot at the same time. The pharmacy team had been trained before and after the robot had been introduced. And the pharmacist manager was satisfied that the dispensing processes continued to be safe. The pharmacy dispensed multi-compartment compliance packs for five branches. And it had defined the working practices to ensure that team members provided a safe and effective service. The superintendent pharmacist had arranged to review the existing policies and procedures in January 2020. And to introduce new procedures for the dispensing robot.

The pharmacy team members signed dispensing labels to show they had completed a dispensing task. And the pharmacist and the accuracy checking technicians (ACTs) checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The pharmacy team members had discussed the near-miss process in October 2019 due to the low level of recording. And they had agreed that the levels did not reflect the actual number of errors. The team members had agreed to record all their errors. And to provide information about how the error could have happened. The pharmacy provided individual forms to record near misses. And this provided the opportunity for team members to identify patterns and trends. The pharmacists reviewed the near misses. And they had identified that the number of selection errors had reduced due to the new dispensing robot. The pharmacists had identified that the labelling process accounted for most of the errors. And the team members dispensing medicines into the wrong compartment of compliance packs. The pharmacy team members had discussed the risks. And they had agreed to minimise distractions and to concentrate more on the task at hand.

The pharmacist managed the incident reporting process. And the pharmacy team members knew when incidents happened and what the cause had been. For example, they knew about two recent errors involving dispensing into multi-compartment compliance packs. The pharmacists had reviewed the dispensing process. And had decided to separate the dispensing and the checking function with the pharmacist and the ACT moving to an office to carry out the final accuracy checks. The pharmacy used a

complaints policy to ensure that staff handled complaints in a consistent manner. But it did not display information about its process so that people knew how to complain if they needed to. The pharmacy encouraged people to provide feedback about its services. And the team members had been more engaged with people due to the premises relocation and changes at the pharmacy.

The pharmacy maintained the records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity insurance in place. And it was valid until 31 August 2020. The pharmacy team kept the electronic controlled drug registers up to date. And one of the dispensers had been nominated to carry out balance checks once a month. The pharmacist had recently reviewed this arrangement. And they had planned to train more team members to carry out the activity to share the work-load. The pharmacy team had been using paper records to record controlled drugs that people returned for destruction. But the pharmacist had recently found that the records had been misplaced when the pharmacy had relocated. The pharmacy was using an electronic register to record returns for destruction. And this was up to date with the pharmacist's signature to show who had witnessed the destruction. The pharmacist was in the process of completing an incident report form to be shared with the Controlled Drug Accountable Officer. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. But a sample showed that the trimethoprim PGD had gone past its review date of November 2018. The pharmacist did not use the documents. And accessed the documents from the Community Pharmacy Scotland web-site when needed.

The pharmacy displayed a notice which informed people about its data protection arrangements. But this was not visible from the waiting area. The pharmacy provided a policy to keep the team members informed about its data protection requirements. But it did not always provide the necessary controls to keep confidential information safe. The pharmacy kept confidential information in an unlocked cupboard in the consultation room which was in regular use. And the team members could not provide assurance that this had not been accessed by people who had been in the room. The team members used a shredder to dispose of confidential waste. And they archived spent records for the standard retention period. The pharmacy used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. And it had registered the pharmacists with the scheme. The pharmacy had trained the team members to identify vulnerable people. And the team members knew to refer concerns to the pharmacists.

Principle 2 - Staffing ✓ Good practice

Summary findings

The pharmacy monitors its staffing levels. And it ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And they identify and discuss their learning needs at regular review meetings to keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. It provides access to ongoing training and protected learning time in the work-place. The pharmacy team members support each other in their day-to-day work. And they can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

Inspector's evidence

The pharmacy had experienced a significant growth over the past six months. And it was dispensing more NHS prescriptions since it had relocated. The pharmacist was carrying out regular reviews to ensure that the pharmacy team continued to have the capacity and capability to provide its services. And they had been authorised to increase the number of team members to meet the extra demand. The pharmacy had appointed an extra medicines counter assistant and a dispenser. And this was due to an increase in the number of people asking to wait on their prescriptions. The pharmacy had also appointed an extra two dispensers. And this was due to the pharmacy dispensing multi-compartment compliance packs for five branches.

The pharmacy team members formed two distinct teams. And each team was managed by a pharmacist who organised rotas and authorised annual leave. The pharmacy used minimum levels to ensure it maintained services. And it also used locums and pharmacy students at busy periods, such as during the relocation and at Christmas and holiday time. The pharmacy team members were well-established. And they were experienced and knowledgeable in their roles. The pharmacy kept some of the team's qualifications on-site. And the following team members were in post; two full-time pharmacists, two full-time accuracy checking technicians (ACTs), one trainee ACT, one full-time pharmacy technician, one full-time trainee pharmacy technician, two full-time dispensers, four part-time dispensers, two full-time trainee dispensers, one Saturday trainee dispenser, one part-time locum dispenser, one full-time trainee medicines counter assistant (MCA), two part-time MCAs, one Saturday MCA and one delivery driver.

A new pharmacist manager had been in post for two months. And they had previously managed the multi-compartment compliance packs dispensing service. The company used an annual performance review to develop the team members. And the new pharmacist was about to issue the forms that the company used to identify performance gaps and development needs. The company supported the team members to develop in their roles. For example, it had agreed to support dispensers to train and arrange pharmacy technician registration if they wished to. A team member had asked to undergo training so that she could provide the smoking cessation service, and this had been agreed. The pharmacy provided each team member with an hour of protected learning time each week. And it provided more time for those on formal courses if needed. The superintendent recognised when people needed to carry out training in their own time. And this was rewarded.

The company provided training, such as access to monthly on-line learning. And the team members had been instructed to complete 'safeguarding vulnerable children and adult training' in the last six months.

The team members had been mostly focussed on learning about the new dispensing processes and how to operate the dispensing robot. And the manufacturer had provided on-site training on two separate occasions. The pharmacy team had achieved 'super-user' status. And this meant they could resolve operating problems and carry out minor repairs and maintenance. The company was supporting the pharmacist to undergo independent prescribing training. And the pharmacist had been authorised to arrange locum pharmacist cover when necessary.

The company did not use numerical performance targets to grow its services. And the pharmacy team knew to focus on how well they were providing the current services. The team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had asked for a partition between the front dispensary and the rear area that they used to dispense the multi-compartment compliance packs. And this had been agreed and a sliding door had been installed.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises is clean and hygienic. It has a consultation room that is professional in appearance. And it is an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

The pharmacy had relocated in July 2019. And it offered modern facilities from which to provide its services. The pharmacy had a well-kept waiting area. And it provided seating for people whilst they waited to be attended to. The pharmacy provided a consultation room which included an integrated hatch. And people could talk in private with the pharmacy team about their health concerns. The pharmacy had a front dispensary and separate medicines counter. And the pharmacy team provided advice on minor ailments and medicines' use and supplied a range of over-the-counter medicines. The pharmacy used a dispensary at the rear of the pharmacy to dispense, check and store multi-compartment compliance packs. And it provided adequate benches and shelves to be used as workstations and to store medicines and devices. The ACTs and the pharmacists each had their own workstations. And the pharmacist supervised the medicines counter from the checking bench. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides good access to medicines and advice. But it does not display information about its extended opening times. The pharmacy has working instructions in place for its services. And the instructions support the pharmacy team to work in a safe and effective way. The pharmacy sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team's knowledge up-to-date about high-risk medicines. This means that team members know how to support people taking these medicines and when to provide them with extra information.

Inspector's evidence

The pharmacy had step free entrance and an automatic door. And it provided unrestricted access for people with mobility difficulties. The pharmacy displayed leaflets in the waiting area. And the pharmacists spoke to people about their medication. The pharmacists had been registering people with the chronic medication service (CMS). And the team members dispensed serial prescriptions. The pharmacists intervened when they identified people that may be having difficulty with their medicines. For example, the pharmacist had referred someone who had reported using one glyceryl trinitrate spray every three days.

The team members dispensed a significant number of prescriptions for people who wanted to wait on their medicines. And this was due to the pharmacy being located close to a doctor's surgery. The team members promoted a five-minutes waiting time. And they were able to meet this standard due to the number of team members in the dispensary, and having access to two PMRs. The dispensing benches were organised. And the pharmacy team used dispensing baskets to keep prescriptions and medicines contained throughout the dispensing process.

The pharmacy dispensed multi-compartment compliance packs for around 1300 to 1500 people from five of its sister branches. And the level of dispensing had remained mostly stable over the past year. The pharmacy managed the dispensing process with separate team members carrying out separate dispensing activities. The ACT re-ordered prescriptions and ensured that the branches sent new prescriptions in plenty of time. And the pharmacist carried out checks to ensure that prescriptions were clinically appropriate. The pharmacy used supplementary records to help the team members carry out the necessary checks. And the pharmacist annotated prescriptions to show they had carried out clinical checks. The ACT and the pharmacist worked along-side each other in a separate office. And this managed the risk of distractions. Two dispensers processed the prescriptions. And they generated labels and picked stock which they placed in large baskets ready to be assembled. Five dispensers assembled the packs. And they each had enough work-space on a large central desk to do so. The dispensers kept bulk containers of commonly used medicines in the middle of the desk. And they had discussed the risk of forgetting to add medication if the bulk containers were being used to dispense another pack. The team members used a series of shelves to keep the packs until they were supplied. And they isolated packs when they were notified about prescription changes. The team members used a change form. And they kept records of the changes in the patient's notes. The team members periodically supplied patient information leaflets. And they annotated descriptions of medicines for around 75% of the items they dispensed into packs. The pharmacy provided a delivery service. And the delivery driver asked people to sign an electronic device to show they had received their medicines.

The team members used a Methameasure to dispense methadone doses for around 52 people. And they obtained an accuracy check when they added new prescriptions to the system. The team members also obtained a check at the time they made a supply. And this ensured they supplied doses that were in accordance with prescriptions. The team members had added a caution label to the keyboard to highlight two people with the same surname and a similar sounding Christian name.

The pharmacy purchased medicines and medical devices from recognised suppliers. And the team members carried out regular stock management activities, highlighting short dated stock and split-packs during regular checks. The pharmacy kept most of its stock inside the dispensing robot. And the robot recorded the expiry dates at the time the team members added new stock to it. The team members produced reports at the end of the month. And they instructed the robot to remove stock that was close to its expiry date. The team members carried out expiry dates of stock not kept in the robot. And they used a matrix to keep on track. The team members monitored and recorded the fridge temperatures. And they demonstrated that the temperature had remained between two and eight degrees Celsius. The team members kept controlled drugs in four cabinets. And they managed the risk of selection errors, for example, they kept sugar-containing and sugar-free methadone separated.

The pharmacy team members acted on drug alerts and recalls. And they recorded the date they checked for affected stock and the outcome. For example, in December 2019 they had acted on an alert concerning ranitidine with no stock found. The pharmacy team members had been trained about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards and when to issue them. The pharmacist monitored prescriptions for valproate. And they spoke to people that could be affected to confirm they knew about the risks. The company had provided training about the Falsified Medicines Directive (FMD) and what it aimed to achieve. And it had introduced systems to meet the needs of the directive. But it was not scanning packs due to problems with the robot's ability to scan 2-d bar-codes.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

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. And the measures for methadone were highlighted, so they were used exclusively for this purpose. The pharmacy used a dispensing robot. And it included a service level agreement to manage the risk of service disruptions. The pharmacy could request a service engineer to attend within 24 hours. And the company had arranged training for the pharmacy team to resolve minor operating problems. For example, they knew how to access medicines in the event of a breakdown. The pharmacy used a MethaMeasure for dispensing methadone doses. And the team members calibrated the machine every morning to ensure it was measuring accurately. The pharmacy kept cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team. The pharmacy team members used portable phones. And they took calls in private when necessary.

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.