General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Burnside Pharmacy, 272 Stonelaw Road, Rutherglen, Glasgow, South Lanarkshire, G73 3SB

Pharmacy reference: 9011251

Type of pharmacy: Community

Date of inspection: 26/10/2023

Pharmacy context

This is a busy community pharmacy in Burnside in the town of Rutherglen. Its main activity is dispensing NHS prescriptions. It provides a range of services including the NHS Pharmacy First Plus service and administration of travel vaccinations. It provides some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. And it provides a medicines delivery service for some people in their homes. The pharmacy uses automation as part of its dispensing process.

Overall inspection outcome

✔ **Standards 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 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 has written procedures which help guide team members to work safely and effectively. It mostly keeps the records required by law. Team members keep people's private information secure. And they know how to act in response to a concern about vulnerable people. They record errors they make but may miss some opportunities to fully learn from them.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which helped guide team members to deliver the services safely and effectively. These included controlled drug management (CD), and responsible pharmacist (RP) SOPs. The SOPs had been introduced in 2019 and the superintendent pharmacist (SI) had begun the process of updating the SOPs. Team members had read and signed previous copies of the SOPS to confirm their understanding and compliance with them. For the NHS travel vaccination services, the pharmacists used patient group directions (PGD) and a risk assessment consultation form provided by the NHS. And for the private services, the independent prescribing pharmacists (IPs) used a SOP provided by an external provider which assessed the risks of administering vaccinations, alongside a recognised information website which guided their clinical decision making.

The pharmacy recorded errors identified during the dispensing process known as near misses. The team member who made the error was responsible for recording the details when identified by the pharmacist. The SI reported that the number of near misses involving the incorrect selection of medicines had reduced significantly due to the use of automation in the dispensing process. Records of errors detailed what the error was and how it had been rectified, but generally didn't identify the potential cause of the error, so some opportunities to learn from the errors may be missed. The SI reviewed the data produced once a month and had informal discussions with team members to highlight any trends in near misses. Errors identified after a person had received their medication known as dispensing incidents were recorded electronically and a thorough root cause analysis was completed. And team members had discussions regarding the incidents at the time.

The pharmacy had a roles and responsibilities matrix as part of the SOPs, but this had not been updated in some time. The SI was updating this along with the SOPs. Team members explained they knew which tasks they were responsible for by using a rota produced by one of the regular pharmacists. The RP notice was prominently displayed in the retail area. The pharmacy had a complaints policy which was detailed in its pharmacy leaflet. The SI explained complaints were usually resolved at a local level either by the RP or himself. The team acted on feedback received and had amended their procedure for managing prescriptions people were waiting for. This involved using a red coloured basket so that team members knew the prescription was to be prioritised. There was current indemnity insurance which included the travel vaccinations and prescribing services.

The pharmacy had controlled drug registers but not all entries were completed accurately. A sample of records of received CDs checked contained the information required by law. And CDs returned by people who no longer needed them were recorded on receipt. The pharmacy's private prescription register was recorded on paper and was in order. And associated prescriptions were kept. The pharmacy had accurate records of its RP and unlicensed medicines known as "specials". The records of unlicensed medicines included details of the person who received the medicines so any queries could

be resolved.

Team members were aware of the need to keep people's private information secure. They had received information governance (IG) training when they commenced employment. Team members had reviewed their procedure for attaching people's prescriptions to the bag containing their medicines within the storage area. They ensured these were attached facing away from view so they could not be seen by unauthorised people. Confidential information was kept separately for shredding by a third-party company. Pharmacists had completed safeguarding training. And there was a detailed SOP on a notice board for team members to follow in the event of safeguarding concerns which had up-to-date contact details of the relevant authorities to contact. Delivery drivers also knew to report back any concerns they had for people they were delivering to. The SI gave details of a recent example where team members responded to concerns for a person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to help deliver its services safely and effectively. And it supports team members to improve their knowledge and skills. Team members ask appropriate questions when selling medicines so people receive the care they need.

Inspector's evidence

The pharmacy team at the time of the inspection included the SI, who was the RP, a second pharmacist, a trainee pharmacist, two dispensers, one of whom was a trainee, and a medicines counter assistant (MCA). A third pharmacist arrived in the afternoon and there was a pharmacy student who was completing training as part of their university course. The team further comprised of another full-time pharmacist, two part-time pharmacists, two trained and one trainee dispenser and two delivery drivers. And there were five students who covered Saturdays, two of whom were pharmacy students and two of whom were trainee dispensers. One of the pharmacists had responsibility for staff rotas to help ensure there were sufficient levels of team members working. Team members were seen working well together to manage the workload. Part-time team members could increase their hours so there was contingency for absences. And team members working at another pharmacy within the company worked in the pharmacy when needed. Trainee team members were effectively supervised by the pharmacists.

Pharmacists were given opportunities to develop their knowledge and skills. For example, one pharmacist was currently undertaking an IP qualification and there were three qualified IPs. The SI and another pharmacist had attended a course to develop their knowledge and skills for ear conditions. One of the pharmacists explained that she regularly reflected on her practice as an IP and sought shadowing opportunities and feedback from the more experienced IP to improve her competency and development. Team members were encouraged to develop their knowledge and skills, either through formal qualifications or by regular coaching from the pharmacists. They felt comfortable to raise any concerns and make suggestions for improvement. Team members had not received an annual appraisal in the past year. They asked appropriate questions when selling medicines over the counter and knew to be vigilant to repeated requests for medicines liable to misuse. A dispenser confirmed she would refer such requests to the pharmacist. The pharmacy did not set targets for its team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy. It provides a suitable space for the services it delivers. It has soundproofed rooms where people access services and have private conversations with team members.

Inspector's evidence

The pharmacy was clean and tidy and portrayed a professional appearance. There was a retail area to the front of the pharmacy and a dispensary to the rear. There was a good dispensing workflow with various workstations and benches within the dispensary where different team members completed different tasks. There was a side room where multi-compartment compliance packs were dispensed. And there was an automated dispensing robot within the main dispensary. Medicines that were not stored within the automated system were kept neatly on shelves.

There were two soundproofed consultation rooms, and each room was arranged so services could be delivered safely. Both rooms had sinks with hot and cold water. The larger of the two rooms was primarily used for the provision of travel vaccinations. There was a separate sink in the dispensary which was used for the preparation of medicines. The toilet facilities were clean with hot and cold water for hand washing. The medicines counter acted as barrier to restrict unauthorised public access to the dispensary. And the pharmacist’s checking bench was situated so that they could intervene in conversations at the medicines counter if necessary. The temperature was comfortable throughout and the lighting was bright.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And it appropriately manages the delivery of its services so people receive their medicines when they need them. Team members provide relevant information to help people take their medicines safely. And they carry out checks to make sure medicines are in good condition and safe to supply.

Inspector's evidence

The pharmacy had a step-free entrance from the street and there was an automatic door which provided ease of access for people, including those in wheelchairs and with prams. It advertised its opening hours and the services it delivered on the outside of the pharmacy.

The pharmacy provided a delivery service, taking medicines to people in their homes. The deliveries were organised so that they were ready ahead of the driver collecting them. The drivers used sheets with people's names and address on them and these were annotated with stickers that highlighted whether a CD or fridge line was to be included with the delivery. Fridge items that required cold storage were kept in a cool bag and prioritised on the delivery route, so they were out of the fridge for as little time as possible. People were asked to sign to confirm receipt of their deliveries. The drivers had a process to ensure that when people signed for their deliveries other people's confidential information was not shared. The driver left a note if a person was not in, informing them of the failed delivery, and the medicine was returned to the pharmacy. The pharmacy had a process to post medicines through a person's letterbox in exceptional circumstances. And the SI had completed a risk assessment and confirmed this wasn't a matter of routine.

The pharmacy used baskets to keep people's prescriptions and their medicines together to reduce the risk of errors occurring. Team members used different coloured baskets to help manage workload. For example, red baskets were used when people were waiting in the pharmacy, and blue baskets were for prescriptions received from the surgery. Team members used stickers as part of the dispensing process to highlight if a fridge line or controlled drug or intervention by the pharmacist was required. And team members signed dispensing labels to indicate who had dispensed a medication and who had checked it, so team members involved in each stage could be identified. The pharmacy dispensed and supervised the administration of medicine for some people. Team members prepared doses in advance once a week to help manage the workload. The pharmacists were aware of their additional responsibilities when clinically checking higher-risk medicines including valproate and knew the additional counselling required for these people. The pharmacist confirmed counselling had been provided for a person taking valproate who was in the at-risk group. Pharmacists accessed the most up-to-date versions of PGDs for services online. Prescribing pharmacists delivering the NHS pharmacy first plus service communicated any medicines prescribed to the person's GP.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. Team members ordered prescriptions in advance of packs being dispensed so any queries could be resolved before people needed their medicines. They received communications about changes to people's current medication from the doctor's surgery. Each person had a record which contained details of the medicines they took and when. The pharmacy had considered the risks of putting medicines with limited stability into multi-compartment compliance

packs. These were dispensed once a week on the day before they were due. Descriptions of what the medicines looked like were annotated on the packs, so people could identify their medicines in the pack. And team members supplied people with patient information leaflets (PILS) so they had information to help them take their medicines effectively.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only medicines were stored behind the medicines counter which helped ensure sales of these medicines were supervised by the pharmacist. The pharmacy produced a report of medicines that were stored within the automated machine and were going out of date in the next month. And team members checked the expiry dates of these medicines. They returned medicines that were not expiring to the machine and recorded the expiry date onto the system manually. The pharmacy highlighted medicines stored out with the automated machine that were going out of date within three months for use first. And liquid medicines with a shortened expiry date on opening were marked with the date of opening. Team members were unable to produce records confirming date checking had been completed but a random sample of medicines checked found no medicines past their expiry dates. Team members recorded the fridge temperatures daily and these were within range. They received information regarding drug alerts and recalls, printed the alert off and signed to say it had been actioned. And they were stored in a folder for reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses the equipment and facilities in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to both electronic and paper copies of resources including the British National Formulary (BNF) and British National Formulary for children (BNFc). The prescribing pharmacists accessed up-to-date guidelines to inform their prescribing decisions. The pharmacy had crown marked measuring cylinders that were labelled for measuring water and liquid medicines. And there were triangles for counting tablets.

The pharmacy kept equipment used in the delivery of its services in the consultation rooms. There were otoscopes, blood pressure monitors, pulse oximeters and blood pressure monitors used for the pharmacy first plus service. The equipment was in working order. For the travel clinics, there were in-date adrenaline kits, sharps bins and a medical grade fridge for the storage of vaccines. Within the dispensary there were an additional two fridges. The blood pressure monitor and the fridges were calibrated every two years by an external company. The pharmacy had an emergency response kit within the dispensary which contained naloxone and adrenaline and there was an automated external defibrillator (AED) on the outside wall of the pharmacy.

Access to the computer system was password protected and screens were positioned within the dispensary, so they were not visible to the public. Team members used a cordless telephone so that phone calls were kept private. Prescriptions and medicines awaiting collection were stored within the dispensary so that people's private information was secured.

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.