General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: RX Pharmacy, 600 Broomfield Road, Glasgow, G21 3HN

Pharmacy reference: 9011334

Type of pharmacy: Community

Date of inspection: 09/09/2021

Pharmacy context

This is a community pharmacy in Springburn. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it offers a medicines' delivery service to vulnerable people. The pharmacy provides substance misuse services and dispenses private prescriptions. The pharmacy team members advise on minor ailments and medicines' use. And they supply a range of over-the-counter medicines and prescription only medicines via PGDs.

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	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 acts to keep members of the public and team members safe during the Covid-19 pandemic. It has policies and procedures in place and team members show they mostly follow them. Team members discuss dispensing mistakes and make some improvements to avoid the same errors happening again. The pharmacy keeps the records it needs to by law, and it keeps confidential information safe. Team members securely dispose of personal information when it is no longer required.

Inspector's evidence

The superintendent pharmacist had introduced a policy which described the extra control measures to manage the risks and help prevent the spread of coronavirus. Notices at the entrance reminded people visiting the pharmacy to wear a face covering. Another notice instructed people to remain outside if the waiting area was busy so they could keep a safe distance from each other.

People were seen to be following the guidelines without any instruction from pharmacy team members. A few of the team members were not wearing a face mask at the start of the inspection and donned one at the request of the inspector. Hand sanitizer at the medicines counter was available for people visiting the pharmacy. It was also available in the dispensary and used by team members. A screen was in use at the medicines counter and acted as a barrier between team members and members of the public.

The superintendent had defined the pharmacy's working instructions in a range of documented procedures. They had recently reviewed and updated them in July 2021 to confirm they reflected changes at the pharmacy and continued to manage risks. The pharmacy team was well-established and team members had recorded their signatures to show they understood and followed the procedures. A new dispenser had taken up post the previous week and was in the process of reading them.

The pharmacy had systems and procedures in place to identify and manage dispensing risks. Team members signed medicine labels to show who had 'dispensed' and who had 'checked' each prescription. The pharmacist carried out the final accuracy check and discussed near-miss errors with individuals to help them improve. This also helped them to avoid the same mistakes happening again in the future. Team members reflected on their errors and what might have been the cause. They were responsible for documenting their own errors on an electronic near-miss record form. Sampling showed several records had been made since the beginning of 2021. The records provided some information to identify patterns and trends, but they did not include the name of the medicine involved in the error. There was some evidence of remedial action such as discussing the various inhaler formulations and the similarities in packaging for the different strengths of medication such as ramipril and bisoprolol. Team members had not made any physical changes such as separating medicines or adding shelf-edge caution labels.

The pharmacy did not use an incident reporting template for dispensing incidents. And no incidents had been reported in the past year. The pharmacist trained team members to handle complaints, and a policy was available for team members to refer to. A notice in the waiting area provided people with

information about how to submit a complaint. The pharmacy had been responding to increased requests for healthcare advice. Feedback about the level of service provided throughout the pandemic had been mostly positive.

The pharmacy maintained the records it needed to by law. The pharmacist in charge displayed a responsible pharmacist notice and kept the responsible pharmacist record up to date. Private prescription forms were filed in date order and records were kept up to date. Valid public liability and professional indemnity insurance were in place until 28 February 2022. The pharmacy maintained its controlled drug registers and team members kept them up to date. They checked and verified controlled drug stock once a month. Team members had identified expired stock awaiting destruction. But they had not adequately segregated it from other stock. Controlled drugs that people had returned for destruction were also kept loose in the cabinet. Team members documented the destructions on loose sheets at the front of the controlled drug register folder.

The pharmacy provided a prescription delivery service. This helped vulnerable people and those that were shielding to stay at home. Drivers had been authorised to go into people's home when they were unable to answer the door themselves but only when wearing a face mask and after sanitising their hands. They recorded the deliveries they made in the event of queries. The pharmacist provided training so that team members understood how to protect people's privacy. The pharmacy did not display a notice in the waiting area to inform people about the pharmacy's data protection arrangements and how it safely processed personal information. Team members used a shredder to dispose of confidential waste.

The pharmacist provided training so that team members understood how to safeguard vulnerable people. They had not introduced a policy or procedure for team members to refer to. Team members knew their vulnerable patient groups and knew to refer to the pharmacist for advice on the best way to manage concerns. For example, once a week, they placed multi-compartment compliance packs for collection on a separate shelf. They contacted people or their representatives when packs had not been collected to confirm when they would collect them. This helped them identify people that needed extra support or when people's caring arrangements had changed such as being admitted to hospital. The pharmacist was registered with the protecting vulnerable groups (PVG) scheme. This also helped to protect children and vulnerable adults.

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. Pharmacy team members speak-up and make suggestions to help improve pharmacy services.

Inspector's evidence

A well-established, experienced team worked at the pharmacy and their qualifications were displayed on a notice board in the dispensary. A very large dispensary with ample workstations allowed team members to maintain a two-metre distance from each other for most of the day. The pharmacy's dispensing workload had significantly increased over the course of the pandemic and a new part-time dispenser had been recruited to help manage the increased workload. Two part-time dispensers and one part-time trainee dispenser worked at the pharmacy. One of the dispensers regularly increased their hours to cover planned and unplanned leave. They also increased their hours at busy times to manage the workload. A third-year pharmacy student had been working at the pharmacy over the summer period, this had supported the pharmacy team due to another dispenser being on extended leave.

The responsible pharmacist, who had worked at the pharmacy for around six years had been discussing staffing levels with the owners due to ongoing workload increases. They had planned to cap multi-compartment compliance pack dispensing due to the available staffing levels. One part-time delivery driver had worked at the pharmacy for around four years. The pharmacist had trained them in the safe handling of medicines, data protection and safeguarding procedures. The pharmacist had been discussing the new trainee dispenser's coursework with her. Most of the modules had been completed and support was agreed to enable completion as soon as possible. A pre-registration pharmacist had been in post from 2020 to 2021 and had recently passed the registration assessment. A new trainee pharmacist was about to begin their foundation training year alongside the pharmacist who was the designated tutor.

The pharmacy did not provide ongoing structured training over and above what team members needed to achieve the necessary qualifications. But the pharmacist kept team members up to date with practice changes and other requirements. This had included information and procedures to keep people safe during the pandemic. The pharmacist was currently undergoing 'pharmacist independent prescriber' (PIP) training. They completed some learning on-site and called on team members to share relevant information. For example, whilst watching a video about the range of inhaler devices available. The 2020-2021 pre-registration pharmacist had been coaching team members to ask the correct WWHAM questions when people requested to purchase OTC medicines. For example, the pharmacy received a significant number of requests for skin complaints and they provided information about the questions to ask.

The pharmacy student knew about the valproate Pregnancy Protection Programme and knew to provide the correct information to highlight the associated risks. Team members were encouraged to suggest areas for improvement to keep the pharmacy systems safe and effective. Due to the extra

demands on the delivery service, the driver had discussed the current schedule with the pharmacist so that new deliveries were organised for suitable days to avoid extra pressure on the service. This had been agreed and had made a positive impact on the workload. 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 is clean, tidy, secure and professional in appearance. It has two separate sound-proofed rooms where people can have private conversations with the pharmacy's team members. It has made suitable changes to its premises to help reduce the risk of spreading coronavirus.

Inspector's evidence

This was a large, modern, purpose-built pharmacy. The dispensary had ample workstations on a series of benches. The dispensing benches were arranged so that team members did not face each other. This allowed them to maintain a safe two metre distance from each other to reduce the risk of infections. It also reduced the risk of distractions. Team members used two rear benches to assemble and manage the large number of multi-compartment compliance packs it dispensed. And they used a separate storage area with shelving designed to keep packs for each individual self-contained until they were collected or delivered. Another area was allocated for the delivery driver to use. Team members placed deliveries that were due on the shelves and the driver had ample space to organise them. The pharmacist observed and supervised the medicines counter from the checking bench. They could intervene and provide advice when necessary. Two sound-proofed consultation rooms were in use and provided a confidential environment for private consultations. One of the rooms was mostly used for supervised consumptions. The other room was fitted with a sink with running water and was used for all other consultations. The pharmacy was clean and well maintained. One of the dispensers was cleaning and sanitising the pharmacy to reduce the risk of spreading infection. A sink in the dispensary was available for hand washing and the preparation of medicines. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people access appropriate care. The pharmacy gets its medicines from reputable sources and it stores them properly. The team carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy promoted its services and opening hours in the window at the front of the pharmacy. It had a double automatic door and a step-free entrance which provided good access for people with mobility difficulties. Several leaflets at the medicines counter provided information about the pharmacy's services. There had been an increased demand for access to the pharmacist. People had been uncertain about whether they were able to visit their GP practice or hospital for assistance. For example, people had visited the pharmacy for treatments for burns and other injuries. In some instances, the pharmacist had to refer them to Stobhill Hospital because of the severity of the wounds. They provided wound closure strips and dressings in the event they had to wait to be seen. The PGD Flucloxacillin was checked and was seen to be valid until May 2023.

The pharmacy used dispensing baskets to keep items contained throughout the dispensing process. This managed the risk of prescription items becoming mixed-up and the cause of dispensing errors. Dispensing benches were organised and clutter-free. Team members kept the pharmacy shelves neat and tidy and two large controlled drug cabinets were organised to manage the risk of selection errors. Methadone was kept in a separate cabinet. Controlled drugs were added to multi-compartment compliance packs at the time of supply. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members carried out monthly expiry date checks and documented the checks on a date-checking matrix to keep track. A random check of around 12 products showed the stock to be within its expiry date. A highlighter pen had been used to highlight the date on items that were due to expire in 2021. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. A large medical fridge was used to keep stock at the manufacturer's recommended temperature. It was kept neat and tidy to manage the risk of selection errors. Team members monitored and recorded the fridge temperatures once a day. Records showed that the temperature had remained stable between two and eight degrees Celsius.

The pharmacy kept a record of the deliveries it made to people at home. Due to the pandemic, the delivery driver didn't ask people to sign for medicines. Team members were aware of 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 on receipt of new prescriptions for people in the at-risk group. The pharmacy supplied medicines in multi-compartment compliance packs for people in their own homes. The superintendent had defined the assembly and dispensing process in a documented procedure for team members to refer to. The pharmacist processed the prescriptions and produced medicine labels for the team members to dispense. Dispensers checked prescriptions against patient medication record sheets before they started dispensing. The record sheets provided information about requests not to supply 'patient information leaflets' (PILs). Team members sometimes annotated descriptions of medicines on the packs, but not always. Drug alerts were

processed straight away. Team members knew to check for affected stock so that it could be removed and quarantined. A drug alert for Rosuvastatin had arrived on the day of the inspection and was about to be checked. A previous drug alert for metformin had been processed and checked in August 2021.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy’s equipment is clean and well-maintained. It uses equipment appropriately to protect people's confidentiality. It takes precautions so that people can safely use its facilities when accessing its services during a pandemic.

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. Separate measures were used for methadone. A measuring pump was used every day for methadone doses. Team members measured 10ml to calibrate the pump each day to provide assurance it was measuring accurately. The pharmacy stored prescriptions for collection out of view of the waiting area. It arranged computer screens so they could only be seen by pharmacy team members. The pharmacy had a cordless phone, so that team members could have conversations with people in private. 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.