General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Stepps Pharmacy, 183 Cumbernauld Road, Stepps, Glasgow, G33 6EZ

Pharmacy reference: 9011360

Type of pharmacy: Community

Date of inspection: 15/09/2021

Pharmacy context

This is a community pharmacy in Stepps. 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. This 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

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 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 pharmacy had introduced 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 and informed people that social distancing measures were in place. A notice stated a maximum of three people could wait inside the pharmacy at the one time. People were seen to be following the guidelines without any instruction. Team members were wearing face masks throughout the inspection. And they used hand sanitizer that was available throughout the dispensary. Hand sanitizer was also available at the medicines counter for people visiting the pharmacy to use. A screen at the medicine counter acted as a barrier between team members and members of the public. The pharmacy had relocated in June 2020 and the new owner had defined the pharmacy's working instructions in a range of documented procedures. The procedures covered most of the pharmacy's activities and included operating instructions for the dispensing robot and the collection point robot. The procedures were kept electronically and were valid until June 2022. The pharmacy could not provide records to show that team members had read and signed the procedures that were relevant to their roles and responsibilities.

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. An 'accuracy checker' had completed training and was accredited to carry out the final accuracy check. A procedure defined the checking process and the accuracy checker knew only to check prescriptions that had been authorised and annotated by the responsible pharmacist. The pharmacist and the accuracy checker 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. A dispensing robot was used to dispense most of the prescription items. Sampling of the near-miss error records showed 'labelling errors' to be the cause of most of their near-misses. This was due to the reliability and accuracy of the dispensing robot. Team members did not include all the relevant information to help them carry out meaningful near-miss reviews. This prevented them from introducing extra control measures to manage risks. The pharmacy used an incident reporting template for dispensing incidents. A sample report did not include information about the root cause analysis or any improvements to prevent the same incident happening again in the future. The pharmacist trained team members to handle complaints, and a policy was available for team members to refer to. The pharmacy did not display a notice in the waiting area or provide people with information about how to submit a complaint. 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 but it was not visible from the waiting area. The responsible pharmacist record was kept mostly up to date, but some gaps were seen. The times recorded did not always reflect when the responsible pharmacist was on duty. Valid public liability and professional indemnity insurance were in place until March 2022. The pharmacy maintained its electronic controlled drug registers and team members kept them up to date. They checked and verified most of the controlled drug stock once a month. Methadone balances were not always checked regularly, and team members allowed overages in stock to accumulate. Team members segregated controlled drugs that had expired whilst they awaited destruction by the accountable officer. Controlled drugs that people had returned for destruction were also segregated in the cabinet. A destructions register was up to date, but the signatures showing who had witnessed the destructions did not reflect the actual team member. The pharmacist confirmed they witnessed the destruction but had not updated the register. The pharmacy provided a prescription delivery service. This helped vulnerable people and those that were shielding to stay at home. The pharmacy used an electronic system to record the deliveries 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. A policy was available 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, the delivery driver telephoned the pharmacist when he was concerned about an elderly person. The pharmacist contacted the GP to discuss their concerns and added a note to the person's medication record with the outcome following the discussion. The pharmacist was registered with the protecting vulnerable groups (PVG) scheme. They had started working at the pharmacy in April 2021, but they had not updated their PVG registration to show the workplace changes.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. The pharmacist supports team members to develop in their roles. Team members 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

The pharmacy's dispensing workload had increased significantly since its relocation in June 2020. Team members believed this to be partly due to the installation of a collection point robot. The dispensary provided ample space for team members to safely manage the workload and separate workstations allowed team members to maintain a two-metre distance from each other for most of the day. A well-established, experienced team worked at the pharmacy and qualifications and certificates were retained in the pharmacy to provide evidence of accreditation. Two part-time and one full-time dispensers worked at the pharmacy. And a full-time accuracy checker and a part-time pharmacy technician were in post. A new full-time trainee dispenser had been recruited to help manage the increased workload and was about to take up post. A delivery driver had taken up post in June 2021 and had completed the necessary accredited training. The regular pharmacist was supported by the superintendent who provided cover and worked extra when it was busy. They did not rely on locum pharmacists to provide cover. Two pharmacy students worked at the pharmacy every Saturday and worked extra during the summer months when they had a break from university.

The pharmacist was about to start 'pharmacist independent prescriber' (PIP) training and they supported the other team members to develop in their roles. A team member who had worked as a delivery driver had completed training courses to work on the medicine counter and more recently to work as a dispenser. The pharmacist had contacted the health board after reading about a training initiative for pre-registration pharmacy technicians. Following a discussion, they had agreed to participate in the initiative and created a training post two days per week. The trainee was employed in a primary care role and worked nearby in the local surgeries alongside the practice pharmacists. Team members provided examples of training and a few of the dispensers had planned to compete training to provide professional ear cleaning in the pharmacy. The manufacturers of the dispensing robot and the collection point robot provided on-site training over two days before both systems were introduced. This involved one to one training so that team members could ask relevant questions. The pharmacist had introduced a regular weekly meeting and team members were encouraged to suggest areas for improvement to keep the pharmacy systems safe and effective. One of the dispensers had been trained to use a collection point robot in the last pharmacy she worked at. She had used her experience to contact the system provider to arrange for QR technology to be added to the system. Team members were then able to scan the QR codes and load the collection point more effectively. Another team member had heard about the 'Ask for ANI' scheme and this had led to a discussion about those at risk or suffering from abuse. 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 modern, purpose-built, 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 modern, purpose-built pharmacy that had introduced robotics at the time of its relocation in June 2020. A dispensing robot was at the rear of the dispensary and ample workstations and 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 for most of the day to reduce the risk of infections. A collection point robot was in a separate room which included bench space for team members to safely scan and load prescriptions inside it. A dedicated room was used to assemble and manage the large number of multi-compartment compliance packs the pharmacy dispensed. A dedicated bench was used by the accuracy checker and a series of shelves kept packs compartmentalised until they were collected or delivered. 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. A portable screen was used to act as a barrier between team members and members of the public. 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 other consultations. A separate kitchen area was used for comfort breaks and allowed team members to safely remove their face masks without putting each other at risk of infections. The pharmacy was regularly cleaned 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 uses automation to provide an efficient and safe service. It manages its services well to help people receive 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 an 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. A collection point robot was used for people to collect their prescriptions when the pharmacy was closed. The number of people going inside to use the pharmacy had reduced and the demand for the pharmacy's delivery service had also reduced. Most of the prescriptions the pharmacy dispensed were from the two local surgeries. The surgeries employed practice pharmacists, and there was good communication between the pharmacy and the surgeries. The pharmacist produced and distributed a briefing to keep surgery staff up to date with the pharmacy's services and medicines shortages. The pharmacist had started providing a flu vaccination service. They had contacted local businesses to provide them with information about the service.

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 risk of dispensing errors. Dispensing benches were organised and clutter-free. Team members kept the pharmacy shelves neat and tidy. Multi-compartment compliance packs were kept in one of the cabinets and individual storage containers kept packs separate. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members placed invoices in a basket and the pharmacist checked them to confirm the orders received were as expected. The dispensing robot applied a 12-month expiry date to stock at the time it was loaded. And team members instructed the robot to remove items that were due to expire once a month. A list showed items being kept outside of the robot that were due to expire in the coming months. Team members referred to the list and removed items before they expired. A random check of around 12 products showed stock to be within its expiry date. The pharmacy had medical waste bins and usually kept CD denaturing kits to support the team in managing pharmaceutical waste. A large medical fridge was used to keep stock at the manufacturer's recommended temperature. And a small fridge was used for items that had been dispensed and were due to be collected or delivered. They were kept neat and tidy to manage the risk of selection errors. Team members monitored the fridge temperatures, but they did not always document the checks to provide assurance that the temperature had remained stable between two and eight degrees Celsius. On the day of the inspection the temperature was within the accepted range.

The pharmacy kept electronic records of the deliveries it made to people at home. Due to the pandemic, the delivery driver didn't ask people to sign for medicines. A procedure for dispensing valproate was available for team members to refer to. They 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 contacted prescribers on receipt of new prescriptions for people in the at-risk group. And they always supplied original packs which included warning cards and patient information

leaflets. The pharmacy supplied medicines in multi-compartment compliance packs for people in their own homes. The pharmacy dispensed packs for 120 people. This had increased from around 80 people since the pharmacy's relocation. The pharmacist had carried out a review of the dispensing process when he took up post and had changed the process so that it was more effective. For example, they had introduced trackers and dispensed the packs in advance of them being needed. A form was attached to some packs and updated when a controlled drug was supplied. The assembly and dispensing process was defined in a documented procedure for team members to refer to. A dispenser managed the dispensing process and ordered prescriptions to arrive in time. Dispensers checked prescriptions against patient medication record sheets before they started dispensing. They ensured descriptions of medicines were provided on the packs and supplied patient information leaflets with the first pack of the four-week cycle. A procedure for how to handle drug alerts was available for team members to refer to. Drug alerts were processed straight away, and team members knew to check for affected stock so that it could be removed and quarantined. A drug alert for Ikervis eye drops had arrived on the day of the inspection and was being actioned.

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 used a dispensing robot and a collection point robot. Six-monthly service contracts were in place to mitigate the risk of breakdowns. Team members could access stock in the dispensing robot in the event of a break down. A camera inside the collection point robot allowed the engineer to resolve issues remotely. 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 new blood pressure machine provided a print-out of results. The pharmacist knew they would have to maintain and calibrate the machine on a regular basis to provide assurance it was accurate. 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.