General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Capsule Pharmacy, St Andrews Industrial Estate, Unit 1 Devon Place, Glasgow, G41 1RD

Pharmacy reference: 9011378

Type of pharmacy: Dispensing hub

Date of inspection: 25/07/2024

Pharmacy context

This pharmacy is located on an industrial estate in Glasgow and it is closed to the public. It acts as a hub pharmacy and dispenses medicines in compliance pouches against NHS prescriptions on behalf of the company's community pharmacy. The compliance pouches help people take their medicines properly.

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 team members work to professional standards to keep services safe and effective. They discuss mistakes that happen when dispensing. And they keep some records of the mistakes. But the records are not detailed and do not provide sufficient information to identify patterns and trends. The pharmacy keeps the records it needs to by law, and it protects confidential information to keep it safe and secure. Team members understand their roles in protecting vulnerable people.

Inspector's evidence

The pharmacy defined its working practices in a range of relevant standard operating procedures (SOPs) and they were available for team members to read whenever they needed to. The superintendent pharmacist (SI) had developed and implemented the SOPs when they took over the ownership of the pharmacy in April 2024. The SOPs included procedures for the operation and management of an automated dispensing machine. This was used by team members to assemble and label compliance pouches for a community pharmacy owned by the same company that was located nearby. Team members were in the process of reading and signing the SOPs to confirm their understanding and ongoing compliance. The SI had instructed them to prioritise the SOPs for the automated dispensing machine to ensure they had the necessary knowledge and skills to safely operate it. The regular responsible pharmacist (RP) and an operations manager monitored ongoing compliance with the SOPs and provided extra support when improvement was needed.

The RP at the community pharmacy conducted clinical checks before transmitting prescription details to the pharmacy for dispensing. The pharmacy used bar-code technology to carry out accuracy checks for most of the items it dispensed. The technology recorded a photograph of each individual dose and highlighted any anomalies. These were checked by the accuracy checking dispenser (ACD) and included damaged items or those that were not visible to the technology. Team members dispensed some items that were not suitable for the automated dispensing machine and a signature audit trail showed who was responsible for dispensing each prescription. This helped the pharmacist and the ACD to identify and help team members learn from their dispensing mistakes. Team members knew to report errors identified before they reached people, known as near miss errors. The ACD had recorded a few near miss errors at the time of dispensing. But the records did not provide sufficient information to identify patterns and trends and to introduce sufficient safety improvements if needed.

The pharmacy had introduced a template report to record dispensing mistakes that people reported after they received their items. This included a section to record information about the root cause and any necessary mitigations to improve safety arrangements. An authorised dispenser was responsible for liaising with team members at the community pharmacy. This helped to ensure they supplied medication at the time it was needed. They were also responsible for processing complaints and dispensing mistakes, but none had been communicated since the new owners had taken over. The operations manager was developing a checklist to help team members monitor compliance with the pharmacy's governance arrangements.

Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed a RP notice and the RP record was up to date. Team members maintained controlled drug (CD) registers and they checked and verified the

balances every two weeks. Team members filed prescriptions so they could easily retrieve them if needed and they kept records of supplies of unlicensed medicines that were up to date. The pharmacy trained its team members to safeguard sensitive information. This included using a shredder to dispose of confidential waste safely and securely. The pharmacy trained its team members to identify vulnerable adults and children. They knew to escalate safeguarding concerns and to discuss them with the pharmacist to protect people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy reviews its staffing levels to ensure it has the right number of suitably skilled pharmacy team members working when it needs them. Team members have the right qualifications and skills for their roles and the services they provide. And the pharmacy supports team members to learn and develop.

Inspector's evidence

The new pharmacy owner had conducted a staffing review to identify any shortfalls in the existing pharmacy team. And they had appointed two new full-time dispensers to improve the pharmacy's contingency arrangements and backfill when team members were on leave. The pharmacy had minimum staffing levels in place with only one team member permitted to take leave at a time unless there were exceptional circumstances. The SI mostly provided cover for the regular RP and regular locum pharmacists also provided some cover when necessary. The locum pharmacists had received training about the pharmacy's service model before they took on the role of RP.

The pharmacy had appointed dispensers to the roles of regional manager and operations manager to help the SI develop and monitor the safety and effectiveness of the pharmacy. The following team members were in post; a full-time pharmacist, one full-time ACD, four full-time dispensers, one part-time trainee dispenser, one full-time trainee delivery driver and one part-time technology officer. The pharmacy had informal induction arrangements in place for new team members. They read and signed the pharmacy's SOPs to confirm they understood and would adhere to them. They also shadowed the other team members before the pharmacist deemed them competent to carry out tasks on their own. The pharmacist and an experienced lead dispenser had oversight of the automated dispensing machine operations. They had been training the other team members to operate the machine and to carry out the associated tasks so there was adequate cover when needed. The pharmacy enrolled new team members onto qualification training within the necessary timescales and they provided protected learning time in the workplace. This ensured they were supported in their studies and made satisfactory progress. Team members recorded their learning activities on individual training records and the operations manager reviewed the records to ensure they were developing their knowledge and skills as necessary.

A regular weekly team meeting provided team members with the opportunity to discuss service changes and learnings from incidents. This had included recent legislative changes and team members knew only to dispense full packs of valproate-containing medication unless in exceptional circumstances. The pharmacy encouraged team members to provide feedback to keep services safe and effective. And they provided examples of recent changes that had been implemented. This included the introduction of colour-coding to help manage stock levels and team members knew to place orders according to the minimum re-order levels that were printed on the storage containers. The pharmacy trained team members so they understood their obligations to raise whistleblowing concerns and a documented procedure helped ensure they knew when to refer concerns to the pharmacist or another team member.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. They are clean, hygienic, and secure.

Inspector's evidence

The pharmacy was in large, modern purpose-built premises which provided ample space for its services. The dispensary was located at the rear of the premises. It was well-organised and provided a series of shelves and bench space for dispensing. The ACD carried out final accuracy checks at a designated workstation and one of the dispensers worked in an area that was used to de-blister medicines for use in the automated dispensing machine. Team members kept the areas neat and tidy and free from congestion.

All areas were organised and free from slips, trips and falls hazards. The pharmacy had safeguards in place to restrict access to the pharmacy, and people, including delivery drivers pressed an access control button to alert team members. A reception area and well-equipped offices were available. And these provided suitable areas for activities that required extra safeguards to manage confidentiality. Team members used the dispensary sink for hand washing. And they cleaned and sanitised the pharmacy on a regular basis. Hand washing arrangements were also available in the toilet. 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 provides its services safely. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team conducts checks to make sure medicines are in good condition and suitable to supply. And they identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy operated five days per week from Monday to Friday. People didn't contact the pharmacy directly about prescriptions and they spoke to team members at the community pharmacy. Team members at the community pharmacy had good access to a named dispenser at the pharmacy and they contacted them to provide updates and information about prescription changes. The dispenser worked in an office which was quiet and free from distractions. The pharmacy purchased medicines and medical devices from recognised suppliers and team members conducted monitoring activities to confirm that medicines were fit for purpose. These included regular checks of expiry dates which they documented on a date-checking matrix to show when checks were next due. The pharmacy used two fridges to keep medicines at the manufacturers' recommended temperature. And team members read and recorded the temperatures every day to show that fridges remained within the accepted range of between two and eight degrees Celsius. The fridges were organised with items safely segregated which helped team members manage the risk of selection errors.

Team members used two secure cabinets for some of its items and medicines were organised with segregated items awaiting destruction. The pharmacy received drug alerts and recall notifications. Team members checked the notifications and acted on them when necessary. They kept audit trails to confirm they had conducted the necessary checks which included removing affected items and isolating it from stock. The pharmacy had medical waste bins and denaturing kits available to support the team in managing pharmaceutical waste. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about recent legislative changes which required supplies to be made in the original manufacturer's pack unless in exceptional circumstances.

The pharmacy used an automated dispensing machine to dispense medicines into compliance pouches which helped people take their medicines. Each individual pouch contained all the person's medicines to be taken at a particular time. Team members used supplementary records to carry out checks which helped confirm people’s prescription requirements and identify any changes which they then queried with the team members at the community pharmacy. Team members printed weekly schedules which they followed to make sure they completed all the dispensing tasks within the necessary timescales so that people received their medications on time. Team members transferred medicines from original manufacturer's packaging into containers. They labelled the containers with details that included the manufacturer, the batch number, the expiry date, and the bar code of the medicines. And they transferred the stock in the containers to the canisters in the automated dispensing machine when they were depleted. They used bar-code scanning technology to scan the unique bar-code on the canisters and the labels on the containers. This ensured the canisters were refilled with the correct medication. The base of the canister was a unique shape, and this meant it could only be placed in the machine in one location.

The automated dispensing system manufacturer provided information about medicines that had been removed from the manufacturer's original packaging. And this helped the team identify medicines that were not suitable to be dispensed in this way. Access to the system was restricted to authorised and trained team members using unique passwords and fingerprint scanning. This helped to keep an audit trail of who had accessed the system and who had filled each individual canister. Not all medicines were dispensed from the canisters. Pharmacy team members manually added some higher risk medicines to the system's removable tray to be dispensed into pouches from there. A pharmacist carried out an accuracy check of each medicine after a dispenser added them to the tray. After the medicines were dispensed into pouches, the pharmacy used photographic identification technology to scan the medicines in each pouch. The ACD completed a visual check of pouches that the system highlighted as having a potential inaccuracy or anomaly. Once completed, team members transferred a person's pouches into a box and attached dispensing labels so people had written instructions of how to take their medicines. They included descriptions of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month. Each pouch also displayed printed information about its contents, including the name and quantity of each medicine, the day, date, and time the medicines should be taken and the person's details. Team members responded to prescription changes. They followed a documented procedure which involved removing and adding pouches as required. And updating people's supplementary records to reflect the changes.

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 which included the electronic BNF. The pharmacy had password-protected computers. And team members used separate office areas to hold confidential discussions. A weekly cleaning schedule was displayed next to the automated dispensing machine and team members carried out various cleaning tasks accordingly. This helped to maintain the machine in good working order. A technology officer was responsible for overseeing the ongoing maintenance of the machine and they were able to resolve some operating issues when they arose. The pharmacy had a service contract and team members could call on a service engineer if they needed to. The pharmacy used discreet packaging for deliveries to people in their homes. This meant that people were unable to identity the medicines that were contained within. Team members kept prescriptions out of view of the reception area and it positioned the dispensary computers in a way to prevent disclosure of confidential information.

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.