General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pollokshields Pharmacy, 275 Maxwell Road, Glasgow, G41 1TE

Pharmacy reference: 9011379

Type of pharmacy: Community

Date of inspection: 27/03/2024

Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via patient group directions (PGDs).

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 team members work to professional standards to keep services safe and effective. They discuss mistakes that happen when dispensing. And they keep records to identify patterns in the mistakes and reduce the risk of errors. 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 superintendent pharmacist (SI) worked on-site at the pharmacy. They defined the pharmacy's working practices in a range of relevant standard operating procedures (SOPs). And electronic versions were readily available for team members to read when they needed to. The SOPs showed they were due to be reviewed in June 2024, but some procedures had not been reviewed since 2018 and others in 2021. The SI monitored compliance with SOPs and team members signed and retained paper-based records to confirm they had read and understood them. The pharmacy employed an accuracy checking pharmacy technician (ACPT) and an accuracy checking dispenser (ACD). The SI had introduced a SOP for conducting final accuracy checks and they knew only to check prescriptions that had been clinically checked and annotated by a pharmacist. A signature audit trail on medicine labels showed who was responsible for dispensing each prescription. This meant the pharmacist, the ACPT and the ACD were able to identify and help team members learn from their dispensing mistakes. This included recording and monitoring errors identified before they reach people, known as near miss errors. They discussed these errors with the pharmacy team to identify any patterns and trends and agree actions to manage dispensing risks. This included applying shelf-edge caution labels to highlight medicines which may be selected in error, such as the different strengths of amitriptyline tablets. Team members knew how to manage complaints and discussed them in private at a separate booth or in the consultation room when necessary. They also knew to escalate dispensing mistakes that people reported after they left the pharmacy. The SI conducted an investigation and completed an incident report if necessary and included information about the root cause and any improvements they had made. They shared incidents with team members, so they learned about dispensing risks and how to manage them to keep services safe.

Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed a responsible pharmacist (RP) notice which was visible from the waiting area and the RP record was mostly up to date. Team members maintained controlled drug (CD) registers and they checked and verified the balances monthly. The pharmacy had recorded CDs that people returned for disposal in the past. Team members filed prescriptions so they could easily retrieve them if needed and they kept records of supplies of unlicensed medicines and private prescriptions that were up to date. They knew to protect people's privacy and they used an on-site shredder to dispose of confidential waste. And they discussed safeguarding concerns with the pharmacist to protect vulnerable people. For example, when people did not collect their medication on time. And when people made excessive requests for codeine-containing medicines.

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

A regular locum pharmacist was covering for the SI who was on leave. They were supported by a part-time manager who was an accuracy checking pharmacy technician (ACPT) and the rest of the pharmacy team. The following team members were in post; a full-time pharmacist, one part-time ACPT, one full-time ACD, one full-time dispenser, two full-time trainee dispensers, one part-time trainee dispenser, one part-time delivery driver and two part-time pharmacy students. The pharmacy had minimum staffing levels in place and the pharmacy students provided cover as required. This helped with the pharmacy's service continuity arrangements. The SI reviewed staffing levels whenever there were changes.

The pharmacy had undergone a change with long-serving staff leaving and new staff being appointed to replace them. Experienced team members provided induction support to new team members. They helped them with the reading and signing of SOPs so they understood them. The SI provided protected learning time to support new team members undergo necessary qualification training. They met with the trainees once a week and supervised them whilst in training.

The SI had qualified as an independent prescriber (PIP) and they encouraged team members to enrol on training courses. This ensured there was succession planning for the future workforce to ensure service continuity. They discussed new initiatives with team members such as the introduction of a new Application to help people order their medicines. They had introduced the system as a trial and the ACPT and the ACD had provided feedback on its use before it was fully implemented. The SI had also discussed valproate containing medication and the team knew about the pregnancy protection programme (PPP).

Team members understood their obligations to raise whistleblowing concerns with the pharmacy manager. They also knew when to refer concerns to the pharmacist. The SI encouraged the pharmacy team to suggest improvements to the pharmacy's working arrangements. And team members provided several examples of these. This included changing the layout of items to help new team members during their induction period, such as separating unit dose vials and individual bottles of the same medicines to avoid confusion. And they had created a new stock management system after they had identified the need to better manage the pharmacy's stock. The SI attended prescribing review meetings that were organised by the Health Board. This helped them to develop in their prescribing role. They had discussed their new prescribing role with the nearby GP practices so that they were able to introduce the service gradually. And they had conducted a skill-mix review at the time and had delegated tasks to the ACPT and ACD so they could support them in their new role.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean, and hygienic. The pharmacy has adequate facilities for people to have private conversations with pharmacy team members.

Inspector's evidence

The pharmacy was in a large, modern purpose-built premises. A downstairs dispensary was mostly used to dispense and store multi-compartment compliance packs. This ensured there was sufficient space to layout the required components and safely de-blister medicines before placing them in the packs. It also provided extra storage space and facilities for comfort breaks. The pharmacy team managed the available workspace well to ensure dispensing procedures were conducted safely and effectively. They had designated workstations in the main dispensary depending on the various tasks they conducted. This included separate areas for final accuracy checks.

The pharmacist had good visibility of the medicines counter and could intervene when necessary. The pharmacy had a separate dedicated consultation room that was well-equipped and lockable. It provided an environment for people to speak freely with the pharmacist and other team members during private consultations. There was a clean, well-maintained sink in the dispensary that was used for medicines preparation. And team members cleaned and sanitised all areas of the pharmacy on a regular basis. This ensured the pharmacy remained hygienic for its services. Lighting provided good visibility throughout. And the ambient temperature provided a suitable environment to store medicines and 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 provided access via a ramped entrance which helped people with mobility difficulties. Two large monitors in the waiting area provided people with information. This helped to inform them about health conditions and treatments. Team members were able to communicate with people who do not have English as their first language so they could access the information they needed. The SI provided the NHS Pharmacy First Plus service and provided treatments for acute common clinical conditions. They communicated their prescribing decisions when appropriate with the person's GP. This ensured their medical records were kept up to date. 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 checks of expiry dates which were 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 the SI read and recorded the temperature 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. One of the fridges was used only for items that had been dispensed and awaited collection. Team members used secure cabinets for some of its items. Medicines were well-organised and team members knew to segregate 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 them 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 the warning labels on the valproate packs, and they knew to apply dispensing labels so people were able to read the relevant information. They also knew about recent legislative changes which required them to provide supplies in the original manufacturer's pack unless in exceptional circumstances.

The pharmacy used containers to keep individual prescriptions and medicines together during the dispensing process. This helped team members manage the risk of items becoming mixed-up. Containers were colour coded and this helped to prioritise prescriptions according to when they were needed. The pharmacy supplied some people with multi-compartment compliance packs to help them with their medicines. And the SI had delegated responsibility to the ACD for overseeing dispensing to ensure there was compliance with the pharmacy's operating procedures. New team members in training annotated prescriptions when they selected items for dispensing. And all team members obtained an accuracy check before they de-blistered medicines and placed them in the packs. This helped to identify and correct selection errors and helped trainees to develop their knowledge and skills. They also used large baskets for the assembly and dispensing of the packs due to the size of the

components. Supplementary records helped team members manage dispensing to ensure people received their medication at the right time. They referred to records that provided a list of people's current medication and the time of the day it was due. And they checked new prescriptions for accuracy and kept records up to date. Some people arranged collection of their packs. And team members monitored the collections to confirm they had collected them on time. This helped them to identify when they needed to contact the relevant authorities to raise concerns.

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, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for substance misuse medicines. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy also used a dispensing pump and only senior team members were authorised to calibrate the device before use. This ensured it accurately measured the required doses. Team members used separate triangles that were labelled and used to count medicines when extra care was needed. A blood pressure monitor was available and had been in use for around a year. The SI had considered keeping records to ensure the monitor was calibrated or replaced on a regular basis. But they had not implemented a recording system to show this was being carried out. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could conduct conversations in private if needed, using portable telephone handsets.

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.