General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 1157-1159 Shettleston Road, Glasgow, G32 7NB

Pharmacy reference: 9011426

Type of pharmacy: Community

Date of inspection: 31/03/2022

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). The inspection was completed during the COVID-19 pandemic.

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

Pharmacy team members follow good working practices. And they show that they are managing dispensing risks to keep services safe. The pharmacy documents its mistakes and team members learn from them to improve the safety of services. The pharmacy keeps the records it needs to by law, and it suitably protects people's private information.

Inspector's evidence

The pharmacy had introduced new processes to manage the risks and help prevent the spread of coronavirus. Team members monitored the waiting area for congestion. And they asked people to wait outside until it became less busy. The pharmacy provided hand sanitizer for people to use. And pharmacy team members had access to supplies throughout the dispensary. Most of the team members wore face masks throughout the day. And a plastic screen at the medicines counter acted as a protective barrier between team members and members of the public. The pharmacist was not wearing a mask at the start of the inspection but agreed to do so at the request of the inspector. The company used documented working instructions to define the pharmacy's processes and procedures. It kept its procedures online and team members annotated their personal training record when they had read and understood them. The system was password protected, and a new team member who had worked at the pharmacy for six weeks showed they were able to log-on to the system. The team member was also able to evidence that they had read the procedures that were relevant to their role. Sampling showed the company kept the procedures up to date. This included the ‘assembly and dispensing’ procedure which had been reviewed in May 2021.

The new pharmacist manager had been in post for around three months. And they had been carrying out risk assessments to identify areas for improvement. Team members signed medicine labels to show who had ‘dispensed’ and who had ‘checked’ prescriptions. This meant the pharmacist was able to identify dispensers to help them learn from their dispensing mistakes. The pharmacy had been running on locum pharmacists for a few months, and team members had not been recording near miss errors prior to the new manager starting. Sampling showed recent improvement and they had recorded 23 errors in February 2022. The pharmacist was also encouraging them to record information about the root cause to help with the end of month review. The pharmacist produced the near-miss review for February 2022. This included information about patterns and trends such as, quantity errors. During the briefing, team members agreed that re-organising the shelves would reduce the number of near miss errors. They were able to demonstrate they had started the process.

A superintendent’s message from March 2022 communicated information about a recent dispensing incident. The pharmacist discussed the message to ensure team members implemented the learnings. This included separating furosemide tablets and fluoxetine capsules and taking extra care when selecting them. They also knew to review multi-compartment compliance pack dispensing processes to ensure they complied with company procedures. The pharmacist recorded dispensing incidents on an electronic template. The template included information about the root cause and the mitigations to improve patient safety. Sampling showed information about a ‘hand-out’ error. Team members had discussed the error and had agreed to re-read the procedure and to make sure people stated their address and postcode before they issued medication. They also knew to ask people to confirm their

date of birth if they didn’t know their post code. The pharmacy trained its team members to handle complaints. It had defined the complaints process in a procedure for team members to refer to. The procedure had been last reviewed in June 2021. The pharmacy displayed a notice and provided information about its complaints process.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurances in place which were valid until 30/6/2022. The pharmacist displayed a responsible pharmacist notice, but it was not visible from the waiting area. The RP record was up to date, but it did not always show the time the pharmacist ceased to be on duty. Team members maintained the electronic controlled drug registers and kept them up to date. They carried out a balance check every two to three weeks. The register for methadone showed an overage had been recorded on 23 March 2022. The pharmacy used an automated dispensing system for methadone dispensing. And the pharmacist carried out end of day checks to ensure the relevant controlled drug registers reflected the supplies that day. They ticked the relevant box on the system to evidence they had completed the checks. People returned controlled drugs they no longer needed for safe disposal. A destructions register showed the pharmacist had signed the records to confirm that destructions had taken place. Team members filed prescriptions so they could be easily retrieved if needed. They kept records of supplies against private prescriptions and supplies of 'specials’ and they were up to date.

The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. Every three months it prompted people to change their password to safeguard security arrangements. It displayed a notice to inform people about how it used and processed their information. Team members used a designated container to dispose of confidential waste. And an approved provider collected the waste for off-site destruction. The pharmacy trained its team members to manage safeguarding concerns. And it had introduced a policy for them to refer to. It kept contact details for key agencies which included social services. A chaperone notice advised people they could request to be accompanied whilst in the consultation room. Team members knew to speak to the pharmacist whenever they had cause for concern. This included concerns about failed deliveries or collections of multi-compartment compliance packs. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. This helped to protect children and vulnerable adults. The pharmacist recently completed a ‘safeguarding form’ following a concern from the delivery driver. They sent the form to social services for them to act. And they annotated the PMR and sent the form to the superintendent pharmacist’s office for information.

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 pharmacy proactively supports team members in-training to obtain the skills they need. Other team members identify their learning gaps and complete relevant training as and when required to learn new skills. And they learn from the pharmacist to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's workload had remained at the same level over the course of the coronavirus pandemic. And the number of team members had also remained constant. Locum pharmacists had been providing cover up until a new pharmacist manager had taken up post at the start of 2022. A long-serving full-time dispenser was helping to support two new team members who had been in post for around six weeks. They were also supporting another trainee dispenser who had worked at the pharmacy for around a year and a half. The pharmacy employed a full-time driver to provide a prescription delivery service to vulnerable individuals in their homes. And an area manager visited the pharmacy around every two weeks to provide the newly appointed pharmacist with extra support. They had conducted an external audit to identify areas for improvement. And the pharmacist was in the process of completing an action plan. This included prioritising the training and development of the two new team members to optimise the capacity and capability of the pharmacy team. Induction documentation showed what the company expected new team members to achieve each week. For example, by the end of week one they were expected to have read standard operating procedures for 'prescription receipt' and the 'transfer of prescriptions to the patient'. And on week 13, which was the final week, they enrolled on the dispenser's training course. The company excluded new team members from carrying out high risk tasks during the induction process. For example, it did not authorise them to label or assemble multi-compartment compliance packs until they had enrolled on the dispenser's course. The pharmacist had completed a 'skills-matrix' assessment for the long-serving dispenser so they could identify learning gaps. They had identified that the dispenser had not acquired the necessary skills to manage and process excess stock. And they had arranged training so the dispenser could develop the necessary competencies. The pharmacist supported team members to learn. The long-serving dispenser was developing the necessary knowledge and skills to manage the end of month processes which they had not completed before. This included submitting prescription information for reimbursement and checking the clinical mailbox for the pharmacist. A regular monthly meeting kept team members up to date with service changes. It also kept them up to date with safety improvements following a regular near miss review. This included information about new services such as a new travel vaccination service and a mole screening initiative.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises extensively support the safe delivery of its services. And it manages the space for the storage of its medicines well. The pharmacy has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was in large modern purpose-built premises. Team members had arranged the benches in the dispensary for different tasks. This included a rear bench for multi-compartment compliance pack dispensing. They kept the benches tidy and free from clutter. And separate workstations meant that team members kept their distance from each other whenever they could. The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary. Two sound-proofed consultation rooms were available for use. And they provided a confidential environment for private consultations. The pharmacist used one of the rooms to provide supervised consumptions. And they used the other room for all other consultations. Team members cleaned the surfaces on a regular basis. A sink in the dispensary was available for hand washing and the preparation of medicines. And team members cleaned and sanitised the pharmacy on a regular basis to reduce the risk of spreading infection. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services. Only one team member at a time used a dedicated area for comfort breaks. This allowed them to remove their face masks without being at risk of spreading infection.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy gets its medicines from reputable sources and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are not fit for purpose. The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care.

Inspector's evidence

The pharmacy had a step-free entrance and a pressure activated pad to provide unrestricted access for people with mobility difficulties. The pad worked from the inside of the premises but it did not work from the outside. The pharmacy advertised its services and opening hours in the window. But it did not provide public health information to help keep people safe from coronavirus. The pharmacist provided access to ‘prescription only medicines’ via ‘patient group directions’ (PGDs). And they had contacted the health board to request ‘hard copies’ so they could sign and return them to evidence accreditation to provide the relevant treatments. Team members kept stock neat and tidy on a series of shelves. The pharmacy used controlled drug cabinets. They had adequate space to safely segregate stock items. The pharmacy purchased medicines and medical devices from recognised suppliers. Once a month the company issued a list of products for team members to date-check. They monitored compliance and followed up if the pharmacy did not show they had completed the task. Sampling showed items were within their expiry date.

The pharmacy supplied medicines in multi-compartment compliance packs to people that needed extra support with their medicines. The level of dispensing had remained stable over the course of the pandemic. The pharmacy had defined the assembly and dispensing process in a documented procedure for team members to refer to. The procedure was up to date and had last been reviewed in September 2021. The company had introduced extra measures following a dispensing incident. This included obtaining a check before de-blistering items into the packs. The pharmacist had authorised the experienced team members to assemble packs. Team members used a module on the 'patient medication record' (PMR) to manage the dispensing process. And they referred to supplementary records which contained a list of the person's current medication and dose times which they kept up to date. Team members checked prescriptions against the master records for accuracy before they started dispensing packs. They discussed queries with the relevant prescriber and only made changes to packs on receipt of a new prescription unless it was an emergency. Shelving to store the packs was neat and tidy and team members had highlighted and separated two people with the same name to manage the risk of hand-out errors. The driver delivered around 50% of the packs. And people or their representatives collected the remaining 50%. They kept a supply of face masks, gloves, and hand sanitizer in the delivery vehicle, and they used them during deliveries. They knew to keep a safe distance from people to manage the risk of infection. A handheld device recorded the deliveries and provided an audit trail in the event of queries.

Team members used an automated dispensing system for instalments of some medicines. The pharmacist carried out a clinical check before new prescriptions were entered onto the system. They also carried out accuracy checks before they authorised team members to provide supplies. The

pharmacy sent around half of the prescriptions it received to an off-site dispensing hub. Team members annotated the PMR to show which prescriptions had been approved. And the pharmacist carried out a clinical check before they released them to the hub for dispensing. Once dispensed, the hub placed the dispensed prescriptions in a yellow tote so that team members prioritised them on arrival at the pharmacy. The pharmacist randomly selected a prescription from the tote and carried out a final accuracy check as part of the company's quality assurance procedures. They recorded the check on the relevant form to evidence the checking process.

The pharmacy had two fridges. Team members used one of the fridges for stock items. And they used a second fridge for dispensed items awaiting collection or delivery. Both fridges were well-organised, and team members monitored and documented the temperatures. This meant they were able to evidence that both fridges were operating within the accepted range of 2 and 8 degrees Celsius. The pharmacist had discussed the company's 'high risk medicines' procedure. And team members knew about valproate medication and the Pregnancy Prevention Programme. The pharmacist knew to speak to people in the at-risk group about the associated risks. And team members knew to supply patient information leaflets and to provide warning information cards with every supply. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy prioritised drug alerts and team members knew to check for affected stock so that it could be removed and quarantined straight away. Sampling showed a team member had checked an alert for Similac Alimentum on 31 March 2022. They had annotated the hard copy of the alert to show that stock was not affected.

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 methadone. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy used an automated dispensing system to dispense methadone doses. The pharmacist calibrated the pump once a day to ensure accuracy of doses. 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 carry out conversations in private if needed. 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.