General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gordons Chemists, 19 Mitchell Way, Alexandria, West Dunbartonshire, G83 0LW

Pharmacy reference: 9011444

Type of pharmacy: Community

Date of inspection: 22/10/2021

Pharmacy context

This is a community pharmacy in Alexandria. 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. 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. The inspection was undertaken 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

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 safe working practices. They discuss dispensing mistakes and make some improvements to manage risks and 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 relocated to a new, larger premises in October 2020. The company had implemented 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 to remain outside when the waiting area reached its capacity. Only eight people were allowed inside so they could keep a safe distance from each other. The people in the waiting area were following the guidelines without any instruction. And they used hand sanitizer from a freestanding station at the entrance to the pharmacy. Team members were wearing face masks throughout the inspection, and they were using hand sanitizer which was available throughout the dispensary. They used lateral flow tests twice a week to provide assurance that they were free from the coronavirus infection. Plastic screens were in use at the medicines counter and acted as a barrier between team members and members of the public.

The company had defined the pharmacy's working instructions in a range of documented procedures. The responsible pharmacist had reviewed the procedures in October 2021 and had signed and dated them to confirm they were relevant in managing the risks at the pharmacy. Team members were well-established in their roles and were in the process of re-reading them. They knew to sign and date them to evidence their understanding and compliance.

The pharmacy had procedures to identify and manage dispensing risks. Team members signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. And the pharmacist carried out final checks. They discussed any near-miss errors to help team members improve their accuracy in dispensing. This helped them to avoid the same mistakes happening again in the future. Team members reflected on their errors to understand what might have been the cause. And they were responsible for documenting their errors on the company's near-miss record form. But they had stopped keeping records due to the coronavirus pandemic and time constraints. This meant they were unable to carry out near miss reviews to identify risks and to introduce extra control measures.

Team members explained they had relocated from a smaller premises and the extra shelving helped them to separate items which reduced the risk of selection errors. There was some evidence of rearranging items, for example, team members had moved FlexPens and PenFills and were keeping them in separate fridges. This also minimised the risk selection errors. The pharmacist completed and submitted incident reports when dispensing errors happened. And they shared the learnings and information about any extra control measures they had introduced. For example, they had separated bisoprolol and bendroflumethiazide following a recent incident. The pharmacy did not display information about its complaints process. And it did not invite people to provide feedback to help it

improve its services. The company trained team members to handle complaints, and a policy was available for them to refer to. The surgeries had been sending prescription forms for the same people on consecutive days. And people were not always supplied all their medication at the one time when they arrived to collect them. Team members had agreed to band prescription bags together for the same person, so none were missed.

The pharmacy maintained the records it needed to by law. And valid public liability and professional indemnity insurance were in place until September 2022. 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.

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. Expired stock awaiting destruction was separated and quarantined. Controlled drugs that people returned for destruction were also kept separate. But team members did not always document the returns in the controlled drug destructions register to show what was being kept in the cabinet.

The company provided training so that team members understood how to protect people's privacy and a policy was available for them to refer to. They knew how to securely dispose of confidential waste and a shredder was available and used. The pharmacy did not display information about the pharmacy's data protection arrangements, and it did not inform people about the systems it used to keep their personal information safe. The pharmacist was registered with the protecting vulnerable groups (PVG) scheme. This helped to protect children and vulnerable adults. The company provided training so that team members understood how to safeguard vulnerable people. But it did not have a policy or procedure for the pharmacy team to refer to. Team members knew their vulnerable patient groups, and they knew to seek advice from the pharmacist on the best way to manage concerns. For example, when people did not collect their multi-compartment compliance packs on time. Team members liaised with the prescribing support pharmacists at the local surgeries. This helped them to identify people whose caring arrangements had changed. For example, when people were admitted to hospital.

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 the services they provide.

Inspector's evidence

A well-established, experienced team worked at the pharmacy and team members displayed their qualifications on the dispensary wall. The dispensary was large, and workstations were arranged to allow team members to maintain a two-metre distance from each other for most of the day.

The pharmacy's dispensing workload had fluctuated over the course of the pandemic, but it had stabilized over the past few months. The medicines counter was busier with people seeking advice from the pharmacy team. Two new part-time medicine counter assistants had been recently recruited to help manage the increased workload. The regular responsible pharmacist had been in post for over two years. And a full-time second pharmacist supported them in their role. The responsible pharmacist worked at the medicines counter checking walk-in prescriptions and providing advice to people. This helped them to build relationships with the people that used the pharmacy. They managed the queue and called for support when the waiting area reached its capacity. The second pharmacist worked in the dispensary and checked repeat prescriptions that arrived from the surgeries.

The company used a bank of regular locums and the pharmacy had not experienced any difficulties arranging cover. The area manager was a pharmacist and provided practical support when needed. Four full-time dispensers worked at the pharmacy. One of the dispensers was being supported to enrol on the NVQ pharmacy services level 3 course so that she was eligible to register as a pharmacy technician. Two full-time and two new part-time medicines counter assistants were in post. The pharmacist was about to enrol the two new team members onto the necessary training courses. The pharmacy could call on a 'casual sales assistant' when extra cover was needed. The company had not enrolled the assistant onto the necessary training but had planned to do so. A delivery driver had worked at the pharmacy for several years. The company had trained them in the safe handling of medicines, data protection and safeguarding procedures. 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, how to carry out lateral flow tests and how to provide the new NHS pharmacy first service.

The company encouraged team members to suggest areas for improvement to keep the pharmacy systems safe and effective. And they had contributed to the plan for the relocation to the new premises. A new dispenser had been using their experience of working in another pharmacy. And had been making suggestions about how to manage 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 modern and professional in appearance. It is secure and hygienic and well maintained. Two separate sound-proofed rooms provide an environment where people can have private conversations with the pharmacy's team members.

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 could maintain a safe two metre distance from each other. This helped to reduce the risk of infections. A separate area was used to assemble the large number of multi-compartment compliance packs. And individual storage boxes on a series of shelves kept people's packs separated and safe. The pharmacist had good visibility of the medicines counter from the checking bench. This meant they could intervene and provide advice when necessary. Two sound-proofed consultation rooms were in use and provided a confidential environment for private conversations. One of the rooms was mostly used for supervised consumptions. The other room was fitted with a sink with running water. A private hatch well-away from the main medicines counter was also available. The pharmacy was clean and well maintained. 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 in the waiting area provided information about the pharmacy's services. More people had been consulting the pharmacist for unscheduled care. This included treatments for UTIs and for urgent medication supplies when they had run out. The pharmacy distributed free sanitary products, and the medicine counter assistants knew to offer the free products when people were trying to buy other products. The responsible pharmacist attended a quarterly locality meeting alongside other community pharmacists and GPs. This helped to improve communication and their ways of working. Dispensing benches were organised, and clutter-free and team members 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. Red baskets highlighted prescriptions that people wanted to wait on. This ensured they were dispensed as soon as possible, and people didn't have to needlessly wait. Team members kept the pharmacy shelves neat and tidy and used four large, controlled drug cabinets to keep stock organised and to manage the risk of selection errors. Controlled drugs were added to multi-compartment compliance packs at the time of dispensing and kept in a separate cabinet until they issued them. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members carried out regular 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. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Two medical fridges were used to keep stock at the manufacturer's recommended temperature. They were kept neat and tidy to manage the risk of selection errors. The pharmacist was awaiting delivery of a third fridge to better manage stock. Team members monitored and recorded the fridge temperatures once a day. Records showed that temperatures had remained stable between two and eight degrees Celsius.

The pharmacy dispensed a significant number of CMS serial prescriptions. Team members used the PMR to help them manage dispensing. They referred to the system at the start of each week and dispensed the prescriptions that were due. Team members liaised with the prescribing support pharmacists at the four local surgeries to help them manage concerns such as people who were not collecting their medication on time. The pharmacy provided a prescription delivery service. This helped vulnerable people to stay at home. The delivery driver kept a record of the deliveries they made in the event of queries. 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. And team members knew to always supply

the patient card and patient information leaflet. Team members liaised with the prescribing support pharmacists at the surgeries to ensure that people were suitable for multi-compartment compliance packs. The company had not defined the assembly and dispensing process, and there was no documented procedure for team members to refer to. Two dispensers managed the process and they followed safe working practices and used trackers to manage dispensing. They annotated descriptions of medicines on the packs and supplied patient information leaflets. Drug alerts were processed straight away, and team members checked for affected stock and placed it in quarantine so it could not be used. Sampling showed levothyroxine had been recalled in October 2021 and team members had recorded that they had found zero stock at the time of checking.

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.

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. Team members stored prescriptions for collection out of view of the waiting area. And 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.