General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Forbes Chemist, 193-197 Kirkintilloch Road, Bishopbriggs, Glasgow, East Dunbartonshire, G64 2LS

Pharmacy reference: 9011475

Type of pharmacy: Community

Date of inspection: 09/12/2021

Pharmacy context

This is a community pharmacy in Bishopbriggs town centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It also offers a medicines' delivery service to vulnerable people and an out-of-hours prescription collection service. 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 '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

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 mostly follow them. The pharmacy team discuss dispensing mistakes and make 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 new processes to manage the risks and help prevent the spread of coronavirus. A notice at the entrance to the pharmacy reminded people visiting the pharmacy to wear a face covering. It also reminded them of the signs and symptoms of the coronavirus and to self-isolate if affected. The waiting area was large and could safely accommodate up to four people at a time at a safe distance to manage the risk of coronavirus transmission. People were seen to be following the guidelines without any instruction from the pharmacy team members. Hand sanitizer was available in the waiting area and throughout the dispensary. A plastic screen was in place along the entire length of the medicines counter. This acted as a protective barrier between team members and members of the public. Pharmacy team members were not wearing face masks at the beginning of the inspection and they donned one at the request of the inspector. The pharmacy used working instructions to define the pharmacy's processes and procedures. The responsible pharmacist had signed and dated the procedures following a review in May 2021. This provided the necessary assurance to show they were up to date and authorised for use. Team members had access to the procedures, and they had recorded their signatures to show they had read and understood them. Pharmacy team members signed medicine labels to show who had ‘dispensed’ and who had ‘checked’ each prescription. The pharmacist spoke to team members to help them learn from their dispensing mistakes. And they recorded near miss errors and carried out documented reviews each month to identify patterns and trends which they acted on. For example, at the end of August 2021 they had identified ‘selection errors’ as the cause of near misses. And they discussed the learnings with the pharmacy team. This included taking care when putting stock away, supporting new team members to recognise selection risks, to be aware of ‘look alike and sound alike’ (LASAs) drugs and to carry out an accuracy check before passing to the pharmacist for a final check. Team members had separated stock to manage selection risks, for example cyanocobalamin and cyclizine tablets. The pharmacist kept electronic reports following dispensing incidents. This included information about the root cause and any improvements they had made to manage the risk of it happening again. The pharmacy trained its team members to handle complaints and had defined the complaints process in a documented procedure for team members to refer to. It provided contact details on a TV advertising monitor in the waiting area so that people knew where to submit complaints should they need to.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurance in place, and they were valid until 30 April 2022. The pharmacist in charge displayed a responsible pharmacist (RP) notice and kept the RP record up to date. Team members maintained the electronic controlled drug registers and kept them up to date. They aimed to check and verify the stock at least once a month. A sample of registers showed the balances had been last

checked in September 2021. Space at the bottom of the controlled drug cabinet was available to quarantine stock. And a red basket contained expired stock awaiting a witnessed destruction. A destructions register was used to record controlled drugs that people returned for destruction. It showed 11 entries, but the items were not seen in the cabinet. The pharmacist confirmed they had witnessed the destruction of the controlled drugs but had failed to sign and date the entries. Team members kept prescription forms in good order. For example, they kept records of the 'specials' supplies that they made. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. The pharmacy displayed a notice to inform people about how it used or processed their information. Baskets were used to collect confidential waste and spent records, and team members used a shredder to dispose of it securely. The pharmacy trained its team members including the delivery driver, to manage safeguarding concerns and a policy was available for them to refer to. They knew to speak to the pharmacist whenever they had cause for concern. The pharmacy provided multi-compartment compliance packs to a significant number of people. Team members used a series of shelves to store them until the driver delivered them to people at home. They used separate shelves for packs that people collected. Sampling showed packs dated Jun 2021, September 2021, and October 2021 still on the shelf. The pharmacist believed that the packs were for people that had been admitted to care homes, but they had failed to remove the packs from the shelves. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. This also helped to protect children and vulnerable adults.

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 pharmacy services.

Inspector's evidence

The pharmacy's workload had increased over the past year following a relocation to a new premises in December 2020. The responsible pharmacist had taken up their position in April 2021 and a few new team members had replaced people who had left. Most of the team members were established and experienced in their roles and responsibilities. The pharmacy team included one full-time pharmacist, one full-time pre-registration pharmacist, two full-time and one part-time dispenser, one part-time trainee dispenser, one full-time delivery driver and two Saturday trainee medicines counter assistants.

The pharmacist supported the trainees with their courses and provided them with some protected learning time, so they made satisfactory progress. A pre-registration pharmacist had completed their training and was being supported to develop whilst they awaited their registration assessment results. This included providing consultations for treatments such as UTI infections under supervision. Team members understood the need for whistleblowing and felt empowered to raise concerns when they needed to. The pharmacist kept team members up to date with the relevant coronavirus initiatives and had recently trained team members to provide supplies of lateral flow tests. They were currently providing around 50 boxes of lateral flow tests per week. The manufacturer of the pharmacy's new collection point had delivered on-site training so that team members could effectively operate the system.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is modern, purpose-built, and professional in appearance. It has a large sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The dispensary was modern with ample space for dispensing. The space between the dispensing benches allowed team members to keep as far apart as possible for most of the day. The pharmacist and one dispenser worked at a large bench that looked out into the waiting area. It allowed the pharmacist to observe and supervise the main medicines counter and intervene and provide advice when necessary. Another bench was used to assemble multi-compartment compliance packs and a large room was fitted with a series of shelves to safely store the packs. Additional benches were available for dispensing and other activities. The driver used a dedicated bench in the dispensary to effectively organise prescriptions and other items for delivery.

Team members had access to a small kitchen area and rest room. Only one team member at a time used the room for comfort breaks. A sound-proofed consultation room was in use and provided a confidential environment to have private consultations. It was well-equipped with a sink and hot and cold running water. A sharps bin for clinical waste was used to dispose of the needles used to administer flu vaccinations. A sink was available for hand washing and the preparation of medicines. 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.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it generally manages its services well to help people receive appropriate care. 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.

Inspector's evidence

The pharmacy advertised its services and opening hours in the windows at the front of the pharmacy. The pharmacist had been responding to an increased demand for access to 'prescription only medicines' via 'patient group directions' (PGDs). This included trimethoprim to treat 'urinary tract infections' (UTIs). They had completed the necessary training to provide the company's private flu vaccination service and the PGD was valid until 31 March 2022. The pharmacy had recently extended its Saturday opening hours from 1pm to 5pm to improve access to services. A step-free entrance and an automatic door provided unrestricted access for people with mobility difficulties. Team members had organised the dispensing benches and they were clutter-free. They used dispensing baskets to manage the risk of items becoming mixed-up and they kept stock neat and tidy on a series of shelves. Two controlled drug cabinets were organised and provided good visibility to manage the risk of selection errors. The pharmacy purchased medicines and medical devices from recognised suppliers and team members checked expiry dates and kept a date checking matrix up to date. They had last checked the expiry dates in April 2021. Two glass-fronted medical fridges were in use. One was used for stock and the other for dispensed prescriptions awaiting collection or delivery. Team members monitored and documented the fridge temperatures which were within the accepted range at the time of the inspection. Team members knew about 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 if they received new prescriptions for people in the at-risk group. Team members only supplied original packs which contained patient information leaflets and warning cards.

The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people. And it had defined the assembly and dispensing process in a documented 'standard operating procedure' (SOP). Since the pharmacy's relocation, team members were dispensing packs for more people due to the available workspace which had increased in size. A separate area was used to assemble the packs. And a separate storage area was well-organised. An experienced dispenser was responsible for ordering the prescriptions. They ordered them when they issued the third pack to ensure that packs were assembled and supplied in good time. Supplementary records which contained a list of the person's current medication and dose times were kept up to date. And team members checked prescriptions against the master records for accuracy before they started dispensing packs. Queries were discussed with the relevant prescriber and they recorded changes on people's records. Team members supplied patient information leaflets with the first pack of the four-week cycle unless people had opted-out. They recorded this information on each person's record. Team members only annotated descriptions of medicines on the pack when people asked them to.

The pharmacy provided a prescription delivery service. The delivery driver wore a face mask and regularly sanitised their hands. This helped vulnerable people and those that were shielding to stay at

home. The delivery driver recorded deliveries on an electronic handheld device that connected to the pharmacy's PMR system. Team members could access the system to check the status of prescriptions and any notes the driver had added. Team members accepted unwanted medicines from people for disposal and donned disposable gloves before processing the waste for destruction. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Drug alerts were prioritised, and team members knew to check for affected stock so that it could be removed and quarantined straight away. One of the dispensers produced an alert they had just received for Mydrilate eye drops. They had checked for stock and when none was found they had signed, annotated, and retained the documentation to show their findings. The pharmacy used a collection point for prescriptions. The pharmacist had completed a documented risk assessment and had excluded medications that were unsuitable such as fridge items, controlled drugs, and bulky items. They also checked that people were suitable for the service, and they did not register those that were vulnerable. The pharmacy continued to provide a prescription delivery service when appropriate to keep vulnerable people safe.

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. A separate measure was used for methadone. The pharmacist had recently purchased a new blood pressure monitor due to an increase in demand for testing. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the 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 and gloves. A prescription collection point was in use and a service contract was in place to manage the risk of breakdowns. The engineer was available to resolve issues either remotely or through on-site visits.

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.