General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M & D Green Dispensing Chemist Ltd, Antonine Centre Pharmacy, Unit 26 Antonine Centre, Cumbernauld, GLASGOW, G67 1JW

Pharmacy reference: 9011765

Type of pharmacy: Community

Date of inspection: 09/05/2024

Pharmacy context

This is a busy community pharmacy in a shopping centre in Cumbernauld, Glasgow. Its main activities are dispensing NHS prescriptions and providing some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. It provides both NHS services and private services. And it delivers medicines to people in their homes

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's written procedures help manage risk so that team members can provide services safely and effectively. Team members record mistakes made during the dispensing process and make changes to help prevent the same or a similar mistake occurring. They keep all the necessary records required by law and know to keep people's private information secure. They have the necessary training to respond effectively to concerns for the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to manage risks and guide team members to work safely and effectively. They included SOPs about the responsible pharmacist (RP), controlled drug (CD) management and dispensing activities. A sample of SOPs seen showed they had been reviewed by the pharmacist manager in 2023. Team members signed to say they understood and would comply with them. They were observed working within the scope of their roles. The pharmacist manager was a pharmacist independent prescriber (PIP) and ensured they were using up-to-date guidelines including local Health Board prescribing guidelines and the National Institute for Health and Clinical Excellence (NICE) guidelines to support the delivery of the NHS Pharmacy First Plus service.

The pharmacy recorded mistakes identified and corrected during the dispensing process, known as near misses. The pharmacists recorded the details of the near miss and any identified learnings after discussing it with the person responsible for the mistake. They had reviewed the data from near misses in April to help identify trends. The review included what type of near miss errors were most common but did not include why the errors may have happened. This may mean that opportunities to learn from the near misses may be missed. Team members had highlighted areas in the dispensary where medicines that looked-alike or sounded-alike (LASA) were kept, alerting the dispenser to take extra care when selecting these medicines. The pharmacy completed incident reports for mistakes that were not identified until after a person had received their medicines, known as dispensing errors. These were recorded and shared with the area manager. A recent dispensing error involved a LASA medication and team members subsequently separated the medicines involved on the shelves where they were kept to help prevent the same error occurring. The pharmacy displayed a complaints procedure in the retail area of the pharmacy which informed people of how to raise any concerns or complaints. Team members aimed to resolve these informally. If they were unable to resolve the complaint, they escalated it to the area manager. People could also submit concerns or complaints via the pharmacy's website. Team members encouraged people to fill out feedback forms and kept a record of the action that was taken from the feedback. This included signing people up to a text messaging service to alert them when their prescription was ready for collection.

The pharmacy had current professional indemnity insurance. Team members knew which tasks could and could not take place in the absence of the RP. The RP notice was prominently displayed in the retail area but did not reflect the correct details of the RP on duty. This was highlighted and changed to reflect the correct details. The RP record was completed correctly with some minor omissions of the time the RP ceased duty. The pharmacy recorded the receipt and supply of its CDs. The entries checked were in order. Team members checked the physical stock levels of medicines matched those in the CD register upon receipt and supply. And a check of all medicines was completed monthly. Records of

patient-returned CDs were captured upon receipt and the destruction was completed and witnessed by the pharmacy technician and pharmacist respectively. The pharmacy kept certificates of conformity for unlicensed medicines and full details of the supplies were kept providing an audit trail. It kept complete electronic records for supplies of medicines made against private prescriptions and retained the corresponding prescriptions. The PIP kept records of the consultations completed for the NHS Pharmacy First Plus service, and these were shared with the person's GP so their record could be updated.

Team members were aware of their responsibility to protect people's private information. The pharmacy kept confidential waste separately and shredded it on site. And it displayed a NHS data processing notice in the retail area informing people of how their data was used. Team members received annual training about safeguarding. They knew to refer any concerns to the pharmacist and had contact details for the relevant authorities available in the dispensary to refer to. The pharmacists were registered with the protecting vulnerable groups scheme. Chaperone policies were displayed on the door of each consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large team of suitably qualified or in training team members to help manage its workload safely. Pharmacists complete appropriate training for the services they provide. Team members undertaking accredited training are supported to complete their training. And all team members receive regular ongoing training to develop their skills and knowledge. They ask appropriate questions and give appropriate advice when assisting people with their healthcare needs.

Inspector's evidence

The pharmacy team at the time of the inspection included two pharmacists, one of whom was the RP and pharmacy manager. They were supported by a trainee pharmacist, an accuracy checking pharmacy technician (ACPT), a pharmacy technician, nine dispensers, a medicines counter assistant, a pharmacy student, and two delivery drivers. Other team members not present included a third delivery driver and four additional pharmacy students.

Team members had either completed accredited training or were completing accredited training for their roles. The delivery drivers were enrolled on accredited training and had shadowed other drivers in the company. Team members in training received learning time in the pharmacy when possible and completed some training at home. More experienced team members supported those in training by helping to answer any queries. The company provided frequent training sessions for all its team members out with business hours. The most recent training involving learning about a new medicine used for treatment of substance misuse and a newly launched pharmacy app. The PIP attended regular training events provided by the local Health Board which helped develop their skills and knowledge. The last training covered skin conditions and an upcoming event planned to cover ear conditions. The PIP practiced within the scope of their competency, for example they did not treat people presenting with chest infections and referred these people to the GP. The other pharmacist was completing the post registration foundation programme. They had read and signed patient group directions to allow them to treat conditions such as urinary tract infections and skin infections under the NHS Pharmacy First service.

There was an open and honest culture amongst the team and team members were observed supporting each other to complete the workload. And they were enthusiastic and engaged in their roles and the operation of the pharmacy. They felt comfortable to raise professional concerns with the pharmacist manger, area manager or superintendent (SI) pharmacist if necessary. Annual leave was planned in advance for all team members. The company arranged for relief pharmacists or locums to cover pharmacist absences. And part-time team members could increase their hours and team members from other pharmacies in the company supported periods of absence for other team members. The pharmacy had an annual performance review process for its team members and pharmacists. The pharmacist manager was relatively new to post and had not yet completed performance reviews for team members. And the pharmacist manager had not yet received a performance review. Team members were set targets by the company but did not feel under pressure to achieve them.

Team members asked appropriate questions when selling medicines over the counter. They knew to be vigilant about repeated requests for medicines liable to misuse, for example medicines containing

codeine. Some team members felt confident to have supportive conversations with people, and other team members referred such requests to the pharmacist. The pharmacist had supportive conversations with people or referred them to their GP.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, secure and suitable for the services it provides. It has suitable facilities for people requiring privacy when accessing the pharmacy’s services.

Inspector's evidence

The pharmacy was a large modern premises which had both access from the shopping centre and at the rear. It had a large front retail space, with an area for people to wait for their prescriptions or after accessing services. The dispensary and medicines counter were situated together behind partitions separating pharmacy activities from the retail area. The dispensary comprised of a front area where most of the dispensing activity took place, and a rear area where assembly of multi-compartment compliance packs and care homes took place. Both dispensaries had separate bench spaces for the completion of different tasks. Some areas of medicines storage were untidy. Both pharmacist’s checking benches were situated centrally, which allowed for effective supervision of the dispensaries and medicines counter. The main dispensary had a sink which provided hot and cold water for handwashing and professional use. There were toilets and a staff kitchen area which provided separate facilities for hand washing. Team members cleaned the pharmacy daily and more thoroughly at the weekend and maintained a record of this. The lighting throughout the pharmacy provided good visibility and the temperature was comfortable.

The pharmacy had two lockable soundproofed consultation rooms where people could have private conversations with team members and access services. One of the consultation rooms was not currently in use. The consultation rooms were spacious, and each had a desk, chairs and a sink which provided hot and cold water for handwashing.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services well. And it makes them accessible to people. Team members provide people with the necessary information to help them take their medicines safely. They complete checks on medicines to ensure they remain fit for supply. And they respond appropriately when they receive alerts about the safety of medicines.

Inspector's evidence

The pharmacy had level access at both the front and rear of the premises. The main doors to the pharmacy were open during opening hours and there was an automatic door to the rear which provided ease of access to those using wheelchairs or with prams. The pharmacy advertised the services it provided in the retail area and team members signposted people to other pharmacies for services they did not provide, such as yellow fever vaccinations. Team members provided some people with large print labels to help them take their medicines safely and effectively. The pharmacy displayed healthcare leaflets for people to read.

Team members used baskets to keep people's prescriptions and medicines together and prevent them becoming mixed-up. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Team members highlighted the inclusion of a CD, fridge line or if the pharmacist wanted to speak to people when their medicines were handed out. Team members were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicines safely. Team members had completed risk assessments for all people who received valproate, including those who received it in multi-compartment compliance packs as per recently updated guidance. And the pharmacist recorded the decisions taken for each person. Team members were observed making suitable checks when handing out medicines to people to ensure they were given to the correct person.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicine correctly. Team members ordered the prescriptions two weeks in advance to allow any queries to be resolved. Each person had a medication record that detailed the medicines taken and the dosage times. Changes to people's medication was communicated from their GP and recorded on their medication record. And it was dated to provide an audit trail. Team members provided descriptions of the medicines in the packs and provided patient information leaflets monthly so people had the necessary information to take their medicines effectively.

The pharmacy provided medicine as part of a substance misuse service. Team members prepared the doses using an automated machine when people presented in the pharmacy to collect their medicine. The pharmacy had a delivery service, taking medicines to people in their homes. The drivers used an electronic device to scan and record the deliveries that were to be made each day. Medicines that could not be delivered were generally returned to the pharmacy and a note of failed delivery was left. For a small number of people there was an agreement in place that allowed alternative delivery arrangements. Team members had sought verbal consent for this process from people, but this was not recorded. Delivery drivers referred to notes on people's bag labels which indicated if the alternative delivery arrangements had been agreed. The pharmacy's SOP said that medicines should not be put

through people's letterboxes, and this was highlighted to the pharmacist.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were stored behind the medicines counter which helped ensure the sales of these medicines were supervised by the pharmacists. Team members had a process for checking the expiry date of medicines and these were checked monthly. Medicines that were going out of date in the next six months were highlighted for use first. And team members checked the expiry date of medicines as part of their dispensing and checking processes. The pharmacy had two fridges and team members recorded the temperatures daily. Records showed that some days did not have a record of the fridge temperatures. The fridges on the day of the inspection showed current temperatures of between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls via email from the Medicines and Healthcare Regulatory Agency. These were printed and signed to say that action had been taken. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to up-to-date electronic reference sources including the British National Formulary (BNF), British National Formulary for children (BNFc) and NICE guidelines. It had equipment used for the NHS Pharmacy First Plus service including an otoscope, tongue depressors and a thermometer. Measuring cylinders were crown stamped and marked to show which were for liquid medicines and which were for water. An automated machine used for dispensing substance misuse medicines was calibrated and cleaned daily.

The pharmacy had a cordless telephone so that conversations could be kept private. It stored medicines awaiting collection away from public view to protect people's private information. Confidential information was secured on computers using passwords. And computer screens were positioned in the dispensary so prevented unauthorised access to 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.