General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kellock Pharmacy, Unit 17, The Braes Shopping Centre, Dougrie Drive, Glasgow, G45 9AA

Pharmacy reference: 9011804

Type of pharmacy: Community

Date of inspection: 09/03/2023

Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS and private prescriptions and provides a substance misuse service. 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

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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 mostly identifies and manages the risks associated with its services appropriately. It suitably protects people's private information and keeps the records it needs to by law. Team members recognise and appropriately respond to safeguarding concerns about vulnerable people. And they engage in some learning following the mistakes they make during the dispensing process to help reduce the risk of similar mistakes occurring.

Inspector's evidence

The pharmacy had control measures in place to manage the risks and help prevent the spread of infections. This included a plastic screen at the medicines counter which faced onto the waiting area. The pharmacy used 'standard operating procedures' (SOPs) which defined the pharmacy's working practices. SOPs included 'responsible pharmacist' and 'controlled drugs' procedures. It also included 'accuracy checking' procedures to support the 'accuracy checking technician' (ACT) conduct final accuracy checks on prescriptions that a pharmacist had approved and annotated. The dates on the SOPs showed they had expired. And a review was overdue to ensure that the SOPs remained relevant and reflected the safe working practices at the pharmacy. The signatures on the SOPs showed that not all team members had signed to confirm they had read and understood them. This meant there was a risk of team members not always following safe working practices. A new superintendent pharmacist (SI) had taken up post in February 2023. And there was evidence to show they were in the process of conducting reviews to identify any risks and implement the necessary control measures. Team members signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist and the ACT were able to help individuals learn from their dispensing mistakes. Team members did not always keep records of near misses. And this meant the pharmacy might be missing dispensing risks and opportunities for learning and improvement. Team members had implemented some safety improvements such as separating propranolol and prednisone to manage the risk of selection errors. The pharmacy did not provide contact information to encourage people to provide feedback about the services they received. Team members knew to report mistakes that people identified after receiving their medicine. And an incident report template was available for the pharmacist to document their findings and any improvements they had made.

Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place which were valid until 30 April 2023. The pharmacist displayed an RP notice which was visible from the waiting area. And they kept an RP record to show when their duties began and ended. Team members maintained electronic 'controlled drug'(CD) registers and kept them up to date. They checked the balance of most of the stock CDs each time they made a supply. But they did not regularly check and verify the balance of methadone. This meant there was a risk of balance discrepancies due to the manufacturer's overage not being accounted for. There was also a risk that slow-moving stock was not checked or verified on a regular basis and a risk of unresolved discrepancies.

People returned CDs they no longer needed for safe disposal. Team members recorded CD destructions in a register and the pharmacist annotated records to evidence that items had been disposed of safely. Team members filed prescriptions so they could easily retrieve them if needed. The pharmacy kept

records of private prescription supplies. And records complied with legal requirements. They were clear and legible, and they kept the associated paper prescriptions in a folder in date order. Team members kept certificates of conformity for unlicensed medicines, but they did not keep an audit trail to show supplies in the event of a product recall.

Team members understood data protection requirements and how to protect people's privacy. And they used a shredder to dispose of confidential waste. Team members understood their obligations to refer safeguarding concerns. And they knew to discuss their concerns about vulnerable people with the pharmacist. Team members provided examples of when they made referrals, such as using an electronic system to report missed doses of some medications to the health board. This information helped prescribers consider if they needed to pay particular attention to some people’s doses depending on the number of days missed.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members mostly have the necessary qualifications and skills for their roles and the services they provide. And they work together to suitably manage the workload. The pharmacy supports team members to develop in their roles. And they continue to learn to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's prescription workload had increased over the past year. And the owner had arranged for a new dispenser to increase their hours to help manage the increased dispensing workload. A new superintendent pharmacist (SI) had recently taken up post in February 2023 and worked on-site. The other team members were well-established and experienced in their roles and responsibilities. The pharmacy team included a full-time SI who was the responsible pharmacist, one full-time accredited checking technician (ACT), one full-time trainee pharmacy technician, one full-time dispenser, one part time dispenser, two part-time medicine counter assistants and a delivery driver. The pharmacist owner worked at a nearby branch, and they provided cover and extra support when necessary. They also arranged for other pharmacy team members to provide cover due to planned and unplanned leave. The pharmacy provided trainees with protected time in the workplace to support their learning. But one of the medicines counter assistants, who had worked at the pharmacy for many years, had not completed the necessary qualification training. They followed the relevant pharmacy SOPs for their roles and responsibilities. This included asking people to confirm their address before handing out prescriptions. It also included providing advice and highlighting the risk of addiction when making over-the-counter (OTC) sales of codeine containing medications.

The pharmacist had delegated responsibilities to certain team members. For example, the ACT managed multi-compartment compliance pack dispensing. This included re-ordering prescriptions and ensuring team members dispensed and supplied packs when they were due. They knew they were unable to both dispense and conduct final accuracy checks on the same prescriptions to keep the activities separate. A trainee pharmacy technician was responsible for organising serial prescription dispensing. This included ordering new prescriptions and planning the dispensing workload so that medications were available for collection when they were due. Most team members had signed to show they understood and followed the 'standard operating procedures' (SOPs) relevant to their role. And the new SI updated the team whenever there were service changes. One of the team members provided an example and explained recent eligibility changes for access to UTI treatments. This included people aged 16 years of age and over. They also knew about changes to a scheme for people eligible to access COPD rescue medication from participating community pharmacies. They knew that the authorisation cards now lasted for one year.

The pharmacy encouraged team members to make suggestions and improve the pharmacy's processes and procedures. Following a discussion, they updated the record sheets the pharmacy used to document prescription deliveries to people in their homes. And a new section provided the opportunity to provide notes or information for the driver to take into consideration whilst making deliveries. Team members had also changed the frequency by which they dispensed instalment prescriptions. And instead of dispensing them weekly, they dispensed them monthly which reduced the number of split

packs on the shelves. This had reduced waste and was helping to manage the risk of quantity errors. The pharmacist and the ACT did not keep records of near miss errors. But they had a general awareness and shared near miss information with the pharmacy team. This included information about any patterns and trends so the team could make improvements to manage dispensing risks. Team members were aware of the company's whistleblowing policy. And they felt empowered to speak up if they had concerns.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises support the safe delivery of services. And the pharmacy suitably manages the space for the storage of its medicines. It has appropriate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy had relocated in March 2022 and was in a new, purpose-built premises. Two sound-proofed consultation rooms were available for use. And a hatch in one of the rooms was used to provide supervised consumption services. The other consultation room had hot and cold running water and was used to provide other services. Both rooms provided a professional environment and people could speak privately with the pharmacist and the other team members during consultations.

The pharmacy had ample storage space and workstations for its services. And team members had organised the dispensary for different dispensing tasks. They used a separate bench for dispensing multi-compartment compliance packs. And it used separate shelves for storing them. A sink in the dispensary was available for hand washing and the preparation of medicines. And a dedicated area for comfort breaks was available for team members to use. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it 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 conducts checks to make sure medicines are in good condition and suitable to supply. But it cannot always evidence it removes medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy had a level entrance and an automatic door to provide unrestricted access for people with mobility difficulties. It advertised services and opening hours at the front of the pharmacy. And provided access to some health information leaflets which they displayed in the waiting area for self-selection. The pharmacy provided treatments via ‘patient group directions’ (PGDs). And the PGD for ‘urinary tract infections’ (UTIs) was valid until August 2024. Team members kept stock neat and tidy on a series of shelves. And they used secure cabinets to store some items. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members checked expiry dates for out-of-date medicines. They did not document the date of the checks, and there was a risk they did not check dates on a regular basis. Sampling showed stock items were in date. A large fridge kept medicines at the manufacturers' recommended temperature. And team members monitored and recorded the temperatures every day. This provided assurance that the fridges were operating within the accepted range. Team members received information about for drug alerts and recalls. One of the dispensers confirmed they had recently checked for levothyroxine medication with none found. But the pharmacy did not keep an audit trail to evidence they conducted the checks and had removed affected stock when they should have. The pharmacy used medical waste bins and CD denaturing kits. And this supported the pharmacy team to manage pharmaceutical waste.

Team members knew about valproate medication and the Pregnancy Prevention Programme for people at risk. The pharmacy technician had recently reminded colleagues to always supply patient information leaflets and patient cards with every supply after reading a bulletin in the pharmaceutical press. Team members had organised the dispensary to keep their working environment safe. The pharmacist positioned themselves so they could supervise the medicines counter. And team members worked at the various workstations depending on the tasks they were conducting. Dispensing baskets kept medicines and prescriptions safely contained during dispensing. And this managed the risk of items becoming mixed-up and the risk of dispensing mistakes. The pharmacist attached information stickers to some prescription bags. And team members responded to the information, such as retrieving and adding refrigerated medicines and alerting the pharmacist so they could provide extra counselling, such as for new medications.

The pharmacy dispensed medicines into multi-compartment compliance packs to help people with their medicines. And it had procedures in place to manage dispensing to keep services safe and effective. Team members referred to people’s medication records to check new prescriptions for accuracy. And they contacted the surgery to confirm any changes. The pharmacy technician had identified a change to a gliclazide dose. And they were about to contact the GP practice to check it was correct. They planned to record the outcome in a diary they used to keep an audit trail of changes. Team members retained

only the flaps from the original packs for the pharmacist and the ACT to refer to. This meant they were not always able to check the batch number or the expiry date at the time of the final accuracy checking procedure. This meant there was a risk of supplying out-of-date medication. Team members attached 'backing sheets' to the compliance packs. The sheets listed the medications inside and provided the necessary information to meet labelling regulations. They supplied patient information leaflets and annotated the PMR if people chose not to receive them.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses its facilities to suitably protect people's confidential information. It has the equipment it needs to provide safe services.

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 treatments. They had highlighted the measures, so they used them exclusively for this purpose. The pharmacy used an automated dispensing system to dispense methadone doses. The pharmacist or a senior team member calibrated the system each morning 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 conduct conversations in private if needed, using portable telephone handsets. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the sink was clean and suitable for dispensing purposes.

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.