General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kennyhill Pharmacy, 398-400 Cumbernauld Road, Glasgow, G31 3NN

Pharmacy reference: 9012240

Type of pharmacy: Community

Date of inspection: 15/08/2024

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).

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 team members work to professional standards to help keep services safe and effective. They discuss mistakes that happen when dispensing. And they keep records to identify patterns in the mistakes and reduce the risk of errors. The pharmacy keeps the records it needs to by law, and it protects confidential information to keep it safe and secure. Team members understand their roles in protecting vulnerable people.

Inspector's evidence

The pharmacy defined its working practices in a range of relevant standard operating procedures (SOPs) and they were readily available for team members to read whenever they needed to refer to them. The superintendent pharmacist (SI) had approved and issued a new set of pharmacy SOPs in November 2023 and team members had read and signed them to confirm their understanding and ongoing compliance. The pharmacy employed an accuracy checking pharmacy technician (ACPT) and a documented SOP defined the final accuracy checking procedure which required pharmacists to use a checking stamp and annotate the prescriptions they deemed suitable for the ACPT to accuracy check.

A signature audit trail on medicine labels showed who was responsible for dispensing each prescription. This helped the pharmacists and the ACPT identify and help team members learn from their dispensing mistakes. This included monitoring mistakes identified before they reached people, known as near miss errors. Team members recorded errors to help them identify patterns and trends and make safety improvements. And the pharmacist used a near miss record tool to carry out regular reviews which they discussed with the pharmacy team. The review records were comprehensive and showed the agreed actions and safety improvements to manage dispensing risks. This included obtaining a second accuracy check when dispensing high-risk medicines. It also included separating medicines with similar names, such as gabapentin and pregabalin to manage selection risks. Team members refreshed their knowledge of the pharmacy's procedures through the reading of SOPs. A notice in the waiting area informed people of the pharmacy's complaints handling procedure. Team members knew how to manage complaints and knew to escalate dispensing mistakes that people reported after they left the pharmacy. The pharmacist discussed the incidents with team members, so they learned about the risks in the pharmacy and how to manage them to keep dispensing safe.

Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed a responsible pharmacist (RP) notice which was visible from the waiting area and the RP record was mostly up to date. Team members maintained controlled drug (CD) registers and they checked the balance recorded in the register matched the physical stock, once a week. The pharmacy kept records of CDs that people returned for disposal which contained signatures to provide an audit trail when destructions had taken place. Team members filed prescriptions so they could easily retrieve them if needed and they kept records of supplies of unlicensed medicines and private prescriptions that were up to date. A notice in the waiting area provided assurance that the pharmacy protected people's confidential information and the pharmacy trained its team members to safeguard sensitive information. This included the use of a shredder to dispose of confidential waste safely and securely. The pharmacy trained its team members to identify vulnerable adults and children and they knew to escalate safeguarding concerns and to discuss them with the pharmacist to protect people. For example, when some people did not collect

their medication on time, and when the driver was unable to complete deliveries that had been previously arranged.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy reviews its staffing levels to ensure it has the right number of suitably skilled pharmacy team members working when it needs them. Team members have the right qualifications and skills for their roles and the services they provide. And the pharmacy supports team members to learn and develop.

Inspector's evidence

The following team members were in post; one full-time pharmacist and one part-time second pharmacist, one part-time ACPT, two full-time trainee ACPTs, one part-time trainee dispenser, four full-time trainee dispensers, one part-time medicines counter assistant (MCA), one part-time trainee MCA, two part-time pharmacy students, one full-time and one part-time delivery driver. The pharmacy had contingency arrangements in place to manage team members leave and the pharmacy students worked extra to help maintain adequate staffing levels. A second pharmacist worked at the pharmacy two days a week. This helped the full-time pharmacist, who was an independent prescriber (PIP), provide the NHS Pharmacy First Plus service. The company arranged cover and provided backfill when the pharmacists were on leave. For example, a pharmacist from another branch and the area pharmacist manager were providing cover at the time of the inspection.

The pharmacy regularly reviewed its staffing levels and skill mix arrangements and made improvements when there were shortfalls. The pharmacy recruited new team members to replace individuals that left. And the pharmacists and the other team members supported them whilst they underwent induction which included reading the pharmacy SOPs to confirm they understood and would adhere to them. The company enrolled new team members onto qualification training within the necessary timescales and the pharmacy provided protected learning time in the workplace. This ensured they were supported in their studies and made satisfactory progress with training. The pharmacist recently qualified as a PIP and had completed training to carry out clinical examinations. They followed a national service specification and prescribed according to a local formulary. They had reflected and identified further training needs to enable them to expand their prescribing and provide more treatments via the NHS Pharmacy First Plus service.

The pharmacist arranged ongoing training for the team members, so they had the necessary knowledge and skills to provide the services the pharmacy offered. Recent examples included training to provide an ear wax removal service. And training to provide a new blood borne virus service. Team members documented their training in individual records, and these were comprehensive and showed they kept up to date and developed in their roles. Some team members had learned more about a mobile Application that people had been using to re-order their medication. And the pharmacy had recently started promoting the use of the Application to make appointments such as for ear wax removal.

Team members discussed near miss errors to identify learnings and to make improvements to keep dispensing safe and effective. They had also discussed legislative changes and team members knew only to dispense full packs of valproate-containing medication unless in exceptional circumstances. Team members attended a regular appraisal of performance and the pharmacy provided opportunities for role development such as enrolment on ACPT qualification training. The SI encouraged team members

to provide feedback and suggest service improvements. And the team had been consulted on the new pharmacy layout before relocating into the premises in October 2023. The PIPs that worked in the company's other pharmacies had collaborated and developed a standardised form to be used to record consultations. This ensured they obtained the necessary information that helped them with their prescribing decisions. The pharmacy trained team members so they understood their obligations to raise whistleblowing concerns. This ensured they knew when to refer concerns to the pharmacist or another team member.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean, and hygienic. The pharmacy has good facilities for people to have private conversations with pharmacy team members.

Inspector's evidence

The pharmacy was in modern purpose-built premises. Team members managed the available workspace well to ensure dispensing procedures were conducted safely and effectively. They had designated workstations depending on the various tasks they conducted. This included separate areas for the final accuracy checks that were carried out by pharmacists and the ACPT. An area at the rear of the pharmacy was used to assemble and label multi-compartment compliance packs and medications for care homes. This provided sufficient space for the prescriptions and the relevant documentation to keep dispensing safe. The pharmacists had good visibility of the medicines counter and could intervene when necessary.

The pharmacy had a well-equipped consultation room with hot and cold running water. And it also had a separate private booth. Both areas provided an environment for people to speak freely with the pharmacist and other team members during private consultations. There was a clean, well-maintained sink in the dispensary that was used for medicines preparation. And team members cleaned and sanitised all areas of the pharmacy on a regular basis. This ensured the pharmacy remained hygienic for its services. Lighting provided good visibility throughout. And the ambient temperature provided a suitable environment to store medicines and to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it provides its services safely. 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. And they identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy provided a ramped entrance and an automatic door for people with mobility difficulties. And it displayed its opening hours and its services in the main window. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were fit for purpose. These included checks of expiry dates which they carried out informally when they had time. They did not document the checks to show when they were next due, but they checked the expiry dates at the time of dispensing to ensure they were fit for purpose. A random check of dispensary stock found no out-of-date medicines. The pharmacy used two fridges to keep medicines at the manufacturers' recommended temperature. And team members read and recorded the temperature every day to show that fridges remained within the accepted range of between two and eight degrees Celsius. The fridge was organised with items safely segregated which helped team members manage the risk of selection errors. Team members used four secure cabinets for some of its items and medicines were organised with segregated items awaiting destruction. The pharmacy received drug alerts and recall notifications. Team members checked the notifications and acted on them when necessary. They kept audit trails to confirm they had conducted the necessary checks which included removing affected items and isolating them from stock. The pharmacy had medical waste bins and denaturing kits available to support the team in managing pharmaceutical waste.

Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so people were able to read the relevant information. They also knew about recent legislative changes which required them to provide supplies in the original manufacturer's pack unless in exceptional circumstances. The pharmacist had carried out individual risk assessments for people who received valproate in a multi-compartment compliance pack to confirm it was appropriate to continue to do so. The pharmacy used containers to keep individual prescriptions and medicines together during the dispensing process. This helped team members manage the risk of items becoming mixed-up. The pharmacy dispensed a considerable number of multi-compartment compliance packs. Team members managed the ordering and receipt of the prescriptions to ensure people received their medication when it was due. They dispensed the packs over a four-week period, and they used supplementary pharmacy records to document the person's current medicines and administration times. This allowed them to carry out checks and identify any changes that they queried with the GP surgery. They used a designated book to record any changes that the GP surgery communicated. This provided an audit trail and team members referred to the records on receipt of new prescriptions before they dispensed them. A white board showed people that had been admitted to hospital and team members knew not to deliver their packs until they were notified of their hospital discharge. Team members supplied patient information leaflets (PILs) with the first pack of the

four-week cycle. And they provided descriptions of individual medicines to help identify them in their packs. The pharmacy kept records to show the packs that people collected and those the pharmacy had delivered. This provided confirmation that people had received their medicines and prompted team members to act when there were failed collections or deliveries.

Care homes establishments sent prescriptions to the pharmacy on a regular basis for dispensing. The pharmacy dispensed the prescriptions according to an agreed schedule, so people received their medication when it was due. Team members checked the prescriptions against records of previous supplies, and they spoke to care home team members to confirm any changes. They provided medicine administration record (MAR) charts to help care home team members with the administration of medicines.

The pharmacist was an independent prescriber (PIP) and provided a limited service within the scope of the NHS Pharmacy First Plus service. The GP surgeries were aware of the service and signposted people to the pharmacy. They only provided the service when the second pharmacist was on duty and people were advised to phone in advance before attending the pharmacy to access the service. The PIP used NHS prescriptions with a unique prescriber number so their prescribing activity could be reviewed and audited. All consultations were documented including those where no prescribing decisions had been made. But the form did not include a section for consent or pregnancy. And it did not always include information about whether prescribing decisions had been shared with the person's GP surgery. The PIP referred people to the relevant health care professional when necessary, such as when decisions were out with their area of competence. Consultation records were saved on a computer which was kept in a locked consultation room and a password ensured access was restricted to a pharmacist. The PIP did not self-check their own prescriptions, and checks were completed by the second pharmacist.

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 a separate measure for substance misuse medicines. They had highlighted the measure, so it was used exclusively for this purpose. 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 an automated dispensing machine to dispense a high-risk medicine. And team members calibrated the machine to confirm it was measuring accurately. The pharmacy used a blood pressure machine, but team members had not considered the need for recalibrations and there was no record of when it had been first used.

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.