General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Houlihan Pharmacy, 15 Lorne Road, Hillington Park, Glasgow, Renfrewshire, G52 4HG

Pharmacy reference: 9012294

Type of pharmacy: Dispensing hub

Date of inspection: 03/12/2024

Pharmacy context

This is a hub pharmacy in the city of Glasgow. Its main activities are dispensing NHS prescriptions for other pharmacies within the company. And team members prepare medicines for further supply to people from a second hub pharmacy within the company.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.2	Standard not met	The pharmacy does not routinely record near miss errors identified during the dispensing process. And there are no arrangements in place to learn from things that go wrong.
		1.3	Standard not met	Team members are not fully clear on their roles and responsibilities, or what activities they can undertake in the absence of the responsible pharmacist. There is no responsible pharmacist notice displayed to show who is responsible for the safe and effective running of the pharmacy.
		1.6	Standard not met	The pharmacy does not maintain all the records as required by law, such as responsible pharmacist records.
2. Staff	Standards not all met	2.2	Standard not met	Team members do not have the appropriate qualification training for the activities they undertake.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not manage some its medicines safely, including effectively checking medicines' expiry dates, recording fridge temperatures and ensuring medicines which it removes from the manufacturer's original packaging are labelled appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not keep the records as required by law. And it does not make it clear who is responsible for the safe and effective running of the pharmacy. Team members assess the risks with the services the pharmacy provides. And implement changes to mitigate risk. But they do not routinely keep records of dispensing mistakes and there is no evidence of learning from these. The pharmacy has formal procedures to support its team members to work safely and effectively. And it keeps people's confidential information safe.

Inspector's evidence

The pharmacy had been operational since February 2024. It acted as a hub pharmacy and had been dispensing medicines for NHS prescriptions for nine pharmacies within the same company, known as spoke pharmacies. The pharmacy had a written set of standard operating procedures (SOPs) to support its team members to work safely and effectively. The sample of SOPs seen included responsible pharmacist (RP) regulations and the safe ordering of medicines. SOPs were reviewed by the superintendent pharmacist (SI) every two years. There were SOPs that defined the responsibilities of the spoke pharmacies against the hub pharmacy. The RP explained SOPs were currently under review and this was evident from observation as one of the SOPs had still to be officially standardised. The pharmacy used two machines to assist team members in removing medicines from the manufacturers original packaging. There was an aide-memoire that covered tasks such as cleaning instructions and the process to follow when using the machine. But this wasn’t officially documented in an SOP. There was a signature sheet attached to each individual SOP, but these had only been signed by the RP. A team member explained they thought they had read them when they commenced employment around four months prior to inspection. Team members described the tasks they were involved in within the pharmacy. But they did not recognise dispensing tasks should only be completed by team members with dispensing qualifications. And they were not clear of the RP regulations. A team member described what activities they would and wouldn’t undertake in the absence of the RP on the premises. And although they would not dispense medicines against prescriptions, they would prepare medicines for further supply to people by removing medicines from the manufacturers original packaging which would be used in an automated dispensing machine for multi-compartment compliance packs. This was discussed at the time of inspection as the RP raised the question if an RP was required to be present during these activities. And this was communicated further following the inspection.

There were no records of dispensing mistakes identified within the pharmacy known as near misses. The pharmacy used an automated dispensing machine to assist team members in the dispensing of medicines in original packs. The RP explained the software of the automated dispensing machine was not integrated with the patient medication record (PMR). So, medicine boxes had to be manually outputted from the automated machine against each prescription. There was a risk the wrong medicine could be selected from the automated dispensing machine when actioned manually and this was observed to happen during the inspection. This was not recorded as a near miss at the time it happened. Team members used barcode scanning technology to manage the risk of selection errors. The software alerted team members if they selected the incorrect medicine during the dispensing process. The system would not allow them to continue the dispensing process until the correct medicine had been scanned. The RP described how the software had significantly reduced the risk of the incorrect medicine being dispensed. The benefits of the regular recording of dispensing mistakes

were discussed during the inspection and that the lack of recording may mean missed learning opportunities for team members. Before the hub pharmacy was in operation the RP had visited other pharmacy sites with the same operation model as a proactive approach to identify any potential risks. Following this research, they had limited the number of prescriptions assembled at any one time to ten people. And they only dispensed serial prescriptions from spoke pharmacies. This helped manage workload in the pharmacy with plans to increase prescription volume further when software issues had been resolved.

The pharmacy had current professional indemnity and liability insurance. It did not maintain the records as required by law. There was not an RP notice on display and the pharmacy did not maintain an RP record to show who was responsible for the safe and effective running of the pharmacy.

The pharmacy was closed and not accessible to the public. There was a General Data Protection Regulation (GDPR) policy and team members were aware of the need to protect people's confidential information. Confidential waste was segregated and collected by a third-party contractor to be securely destroyed off-site. There was a safeguarding policy in place. The RP explained team members had not completed any official training relating to the safeguarding of vulnerable people or protecting peoples' confidentiality, although it was available from the company.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not enrol its team members on the appropriate qualification training for their roles. And so, they carry out tasks for which they are not appropriately qualified for. Team members work well together to manage the workload and they feel supported in their roles.

Inspector's evidence

The pharmacy employed one full-time pharmacist who had the role of operations manager for the company, a delivery driver who worked every day and three full-time team members who were involved in dispensing activities and preparation of medicines for further supply to people. Two of the team members had commenced employment in February of 2024 and one four months prior to inspection, around July 2024 but they had not been enrolled on the necessary qualification training. Although they were observed to be competent, they were not accredited to carry out the dispensing activities they performed, such as selecting medicines and attaching dispensing labels. The pharmacy manager managed annual leave requests, so staffing levels remained sufficient to manage the workload safely. And they regularly assessed the level of workload to ensure it remained at a safe and manageable level. There was a vacancy for a qualified dispenser or accuracy checking pharmacy technician (ACPT).

Team members received training during their induction period. This included shadowing an experienced team member to become familiar with the daily activities within the pharmacy and how to operate the equipment. They received appraisals annually to review progress and identify any individual learning needs. And a team member explained they received regular feedback about their performance from the RP throughout their induction period. Team members were observed managing the workload well and they provided support to each other as they worked. They described feeling well supported in their roles. And they were encouraged to make suggestions to improve their ways of working. For example, a team member who was mainly responsible for the process of removing medicines from the manufacturer’s original packing had implemented a record log following queries from the second hub pharmacy regarding deliveries. This record included delivery dates and medicines supplied that everyone could access easily. A team member explained this had helped make queries easier to answer when they received them.

The RP was in regular contact with the SI. Team members were aware of a whistle blowing policy. And they explained they would feel comfortable raising any professional concerns, should they need to. There were no targets set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. They are clean, hygienic and secure.

Inspector's evidence

The pharmacy was part of the same building as the company head office. It was large and provided ample space for its services. The dispensary accommodated the automated dispensing machine and three working stations. Two for removing medicines from the manufacturer’s original packs and one area for the dispensing and checking of prescriptions. There was adequate work bench space that was free from clutter. Most of the pharmacy medicines were stored inside the automated dispensing machine but some medicines were stored on shelves around the perimeter and throughout the dispensary.

Access to the building was via an access control button that office administration staff monitored to restrict unauthorised access. Team members cleaned and sanitised the pharmacy and its equipment on a regular basis. Staff facilities were hygienic with access to hot and cold water. Lighting and temperature were kept to an appropriate level throughout the premises. Cardboard boxes were stored in corridors and on the floor of the dispensary which limited floor space. But team members managed the space well to prevent the risk of a trip, slip or fall hazard.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always store and manage its medicines appropriately. It does not have robust processes to make sure its medicines are within their expiry dates or labelled in line with requirements when removed from original manufacturer's packaging. And it does not adequately monitor medicines requiring cold storage. This means it cannot always ensure the safety of its medicines. The pharmacy purchases medicines and medical devices from recognised wholesalers. And it generally manages and delivers its services safely.

Inspector's evidence

The pharmacy acted as a hub pharmacy and dispensed medicines against NHS prescriptions for nine other community pharmacies within the company, known as the spoke pharmacies. This service was conducted on two days per week. And the main activity, which was removing medicines from the manufacturer's original packaging to be transported to another hub pharmacy within the company was conducted on three days per week. Team members explained that people did not contact the hub pharmacy with queries relating to their medicines and knew to contact the spoke pharmacy directly. Details about the spoke pharmacies were provided on medicines labels such as the postal address. The spoke pharmacies contacted the hub pharmacy via telephone with any queries relating to people's medicines. And the RP would contact the spoke pharmacies with any queries in the same manner. The pharmacy had one fridge, they used it infrequently in response to prescription requests. But they did not monitor or record the temperature to show it remained within the accepted limits of between 2 and 8 degrees Celsius. At the time of inspection, the temperature was slightly above the recommended limit. There were no medicines stored in the fridge on the day of the inspection.

The pharmacy purchased medicines and medical devices from recognised suppliers. A team member explained how the pharmacy managed the date checking of medicines stored within the automated dispensing machine. Medicines that had an expiry date of longer that three months were entered into the machine using barcode technology to record the batch number and expiry date of the medicine. Medicines that had an expiry date of less than three months were not stored within the automated machine. The electronic software produced a list of medicines due to expire and team members manually outputted these medicines monthly and disposed of them safely. They did not keep records of this. Team members did not always conduct the appropriate checks for medicines stored out with the automated machine. The RP explained they conduct a full date check of all medicines annually. However, at the time of inspection following a sample of 60 medicines, 27 were identified to have expired with some dates of expiry showing the year of 2023. Several inhalers were later highlighted as approaching their expiry date of December 2024 and were removed from the shelves. The RP agreed there had been a failure in the process of managing medicines stored out with the automated dispensing machine. The pharmacy received Medicines Healthcare and Products Regulatory Agency patient safety alerts and medicines recalls via email. The emails were delivered to the administration team within the head office who would distribute the alerts to the RP. The RP was responsible for actioning the recalls within the pharmacy. They described the process they would follow but they did not keep records of this. And they could not provide examples of recent recalls actioned.

Baskets were used during the dispensing process to separate people's prescriptions and prevent medicines from becoming mixed up. The software system did not process prescriptions on an individual

person basis. This meant there could be multiple baskets for one person. The RP explained they recorded on the name and address bag label on the outside of the prescription bag how many packs of medicines were expected to be inside. This was used as an accuracy check during the final check of the prescriptions. And the pharmacy requested team members from the spoke pharmacies to check this on receipt. This helped ensure medicines for the same person were not split over several different supplies. The pharmacists working at the spoke pharmacies were responsible for counselling people on specific instructions on how to use their medicines, including for higher-risk medicines. And they were responsible for conducting clinical checks and accuracy checks on prescriptions before the prescription data was transferred to the hub pharmacy. This provided assurances that prescription requirements and the directions on the medicines label were clinically appropriate. The RP was aware of the Pregnancy Prevention Programme and the risks associated with supplying valproate-containing medicines. But not all team members were aware. The inspector highlighted how to apply medicines labels so not to cover the warning cards on valproate-containing medicines.

Team members assembled and dispensed original packs using barcode technology. Once they received the prescription data electronically, the software produced a picking list of medicines required for the selected batch of prescriptions. Team members manually outputted medicines from the automated dispensing machine or collected them from dispensary shelves. They then used barcode technology to match the medicines against the prescriptions. Prescription labels were printed and applied to the medicines. The medicines stock and labels were scanned again to ensure the correct medicine was put in the correct person's basket. A final accuracy check was performed by the RP before medicines were placed in bags to allow delivery to the spoke pharmacies. If there was an error at any point, the barcode technology would alert a team member that a mistake had been made and it would not allow further progress. These instances were not recorded as near misses. Some medicines were not suitable to be assembled this way, this included CDs and medicines that were removed from the manufacturer's original packaging. A team member explained they were trained to operate the barcode technology and knew how to re-set the software following an error alert. It was not typical for them to receive an accuracy check from the RP at the point of an error alert but in certain circumstances they would alert the RP. For example, if a medicine was not in stock in the pharmacy the whole prescription had to be suspended and the system re-set to proceed. The RP described how they managed prescriptions where the full quantity of a prescription could not be supplied. Team members worked a week in advance, so they had sufficient time to order stock to fulfil the prescriptions. Owings were marked as high priority on the electronic system, to be actioned when they received the medicines. For medicines that could not be sourced from a manufacturer, they would contact other pharmacies within the company and request a transfer of stock or alert the spoke pharmacies who would request an alternative treatment from the person's GP. Team members did not use individual log in credentials to access the software. So, there was no audit trail to identify who was involved in the dispensing process should any queries arise. The RP explained how they could access this information. Prescription data was stored on an electronic system, so they could access this information and identify which date the medicines were dispensed. They would then be able to identify who was present in the pharmacy and which tasks they were involved in on that day. The benefits of having a robust audit trail were discussed during inspection and the RP confirmed this is something they planned to implement in the future.

The pharmacy delivered medicines to the spoke pharmacies for further supply to people. The same barcode technology was used to assign prescriptions to a specific tote for delivery to a pharmacy. The barcode on the bag labels were scanned against the barcode on a specific tote. If a prescription was scanned against a tote for the incorrect pharmacy, it would highlight an error and would not allow team members to proceed until the correct tote was scanned. The spoke pharmacies accepted the delivery by using similar barcode technology. This provided an audit trail of deliveries.

The second part of the pharmacy business was removing medicines from the manufacturer's original packaging to support a second hub pharmacy within the company. These medicines were used to assemble multi-compartment compliance packs via an automated dispensing machine. A team member explained how this service was managed. The pharmacy received an order form via email which listed the medicines required and the quantity. The pharmacy would then order the medicines ensuring the batch number and expiry date were the same. A team member then used a machine to remove the medicines from the manufacturer's original packing. Medicines were placed into large clear bags that were sealed, ready for transport. For the sample seen, the original pack was kept inside the sealed bag so the second hub pharmacy could confirm the expiry date and batch number of the medicines. But the bags were not labelled with what the medicine was, the batch number, expiry and quantity and so did not adhere to labelling requirements. Team members kept paper-based records of the medicines supplied. Details recorded included the medicine, the batch number, expiry date, the person involved in the process and the date it was delivered to the second hub pharmacy. As stock medicines were transferred between pharmacies and on a regular basis the pharmacy was advised to contact the MHRA.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment required to provide safe services. And it suitably protects people's confidential information.

Inspector's evidence

The pharmacy had access to up-to-date electronic resources such as the British National Formulary (BNF).

The pharmacy had a service contract in place for the automated dispensing machine. And they had contact details for a quick response service engineer. They were able to solve some problems remotely or they would attend the pharmacy if appropriate. Cleaning was a priority for the machines used to remove medicines from the manufacturer's original packaging. And team members were aware this was to limit contamination and ensure the safety and stability of medicines.

Confidential information was stored securely. Although individual log in credentials were not in use but the risk of unauthorised access was minimal.

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.