General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Greenlaw Pharmacy, 4 The Square, Greenlaw, DUNS, Berwickshire, TD10 6UD

Pharmacy reference: 1041938

Type of pharmacy: Community

Date of inspection: 22/06/2023

Pharmacy context

This is a pharmacy located in the small village of Duns in the Scottish Borders. Its main activities are dispensing NHS prescriptions and providing multi-compartment compliance packs to people to help them take their medicines safely and effectively. It delivers medicines to people and provides advice and treatment for a range of conditions as part of the NHS Pharmacy First Service.

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

Overall the pharmacy manages the risks with providing its services. It mostly keeps the records it must by law. And it keeps people's personal information secure. Team members know their role in protecting vulnerable people. And they learn from mistakes to reduce the risk of similar mistakes happening again. They have written procedures to help provide services safely, but the team cannot easily access the most recent versions to make sure their processes are up to date.

Inspector's evidence

The pharmacy had access to paper copies of standard operating procedures (SOPs). And they had been prepared in March 2019 but did not include the details of who had written and authorised them. Some SOPs required additional information adding that was relevant to the pharmacy. For example, the controlled drug (CD) SOP was to be annotated to reflect the frequency of stock checks completed. But this had not been completed. The superintendent pharmacist (SI) had introduced updated electronic SOPs in 2022. These were supplied to the pharmacy via a USB device but the responsible pharmacist (RP) was unable to gain access to these during the inspection.

Team members recorded errors identified during the dispensing process known as near misses. The pharmacist who identifed the error recorded the details of the error. The pharmacist explained how they had informal discussions at the time with team members to identify any potential reasons for the error occuring. And team members made suggestions for improvements to help mitigate the risk of the same or a similar error occuring in the future. For example, team members marked on shelves to highlight different pack sizes of the same medicine. The small number of errors recorded on the near miss log made it more difficult to identify trends in near misses. However the RP described the actions taken after identifying some repeated mistakes. The pharmacy recorded errors highlighted after a person had received their medicines, known as dispensing incidents. And the process was to share these reports with the SI. The pharmacist showed an example of the most recent dispensing incident report but was unable to confirm if it had been shared with the SI. Action had been taken following the incident to learn from the error.

A team member described the tasks they completed and these were within their role and competency. They knew what activities could and could not take place in the absence of the RP. The RP notice had details of the pharmacist on duty, but their name needed updating on it. The notice could not easily be seen by people in the retail area. There was a current certificate of indemnity insurance available.

The pharmacy had a complaints policy which was on display for people in the pharmacy to see. The pharmacist explained they rarely had any complaints as they had developed good relationships with the local community and surgeries. If any complaints were raised, they would initially be resolved in the pharmacy, where possible. And escalated to the company's head office if this was needed.

The pharmacy kept an electronic CD register, except for patient-returned CDs which were recorded on paper. The CD registers checked were up-to-date and running balances were recorded. Random sampling of two CDs confirmed the stock held reflected the register running balance. And the record of patient-returned CDs was in order. Not all private prescriptons dispensed were recorded in the electronic private prescription register. This was discussed with the RP. Some of the RP records seen

were incomplete, as the record did not capture the time the RP signed out. The pharmacy dispensed some unlicensed medicines known as "specials". And it retained copies of the "certificates of conformity" but details of who was prescribed the medicine were not captured in case of queries.

Team members were aware of their responsibilites to keep people's personal information secure and had received information about the importance of confidentiality when they commenced employment. There had been no formal ongoing training since. Confidential waste was kept separately and sent to another pharmacy within the company for shredding. A privacy notice was displayed in the retail area giving people information about how their personal information was used. The team had received no formal training about their role in safeguarding vulnerable people and children. A dispenser explained how they would report any concerns to the RP. The availability of training modules for all team members was discussed with the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small and suitably skilled team, who manage the workload well. Team members receive appropriate training and development relevant to their roles. They use their professional judgement to ensure people receive medicines appropriate to their healthcare needs. And they feel comfortable raising concerns if they need to.

Inspector's evidence

The pharmacy team at the time of the inspection included a pharmacy manager, who was the RP, and a dispenser. Additionally there was another dispenser. The two dispensers worked part time and covered the opening hours working on different days. And they made use of additional team members from other pharmacies within the company to cover absences and holidays if needed. The pharmacist and dispenser were seen to be working well together to manage the workload. The dispenser confirmed that development opportunities were encourage by the company's head office for those interested. And dispensers received notification of training from the company's main branch. For example, health and safety training was repeated annually. And they received training packages for new over-the-counter medicines.

Team members were aware of the need to be vigilant to repeated requests of purchases for medicines liable to misuse and would refer these to the pharmacist. The pharmacist gave an example of using her professional judgement to refuse a sale and referring the person to their GP for their healthcare needs. The dispensers received yearly performance reviews which were recorded formally by the head office team. But the pharmacist didn't receive a formal review. Team members felt comfortable raising concerns if they needed to. And there was a whistleblowing procedure in place, but they had never needed to engage this procedure.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure, clean and generally tidy. The premises are relatively small for the services provided. The team manages the space well to provide services safely. And the team suitably manages people's need for privacy in the absence of a dedicated consultation room.

Inspector's evidence

The pharmacy was small, and it was kept clean. There were separate bench areas for the completion of different tasks. One bench had medicines stored in baskets awaiting checks from the pharmacist. Due to the limited bench space, this appeared somewhat cluttered, and some baskets were piled on top of one another. The pharmacist ensured the risk of medicines becoming mixed was minimised by using baskets and keeping the space organised. The floor areas within the dispensary were small and some prescriptions awaiting collection with many items were being stored on the floor. This did not pose a trip hazard as there was space to walk around but floor areas gather more dirt and dust. The pharmacy had a separate small room to the rear of the dispensary where multi-compartment compliance packs were stored.

The pharmacy did not have a consultation room due to the size of the pharmacy. The pharmacist explained that people could choose to either wait until the shop was quiet or be referred to another local branch which did have a consultation room. The dispensary was protected from public view and allowed privacy for dispensing tasks to take place. And the medicines counter had a barrier across which restricted access for unauthorised people. The toilet facilities were clean and hygienic and had a sink with water and soap for handwashing. There was a sink within the dispensary which was used for professional use and handwashing. The dispensary was well lit, and the temperature was comfortable throughout.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy appropriately stores and manages its medicines. And it regularly checks its medicines are suitable to supply. People can access services to help meet their healthcare needs. And team members adequately manage and deliver the pharmacy's services.

Inspector's evidence

The pharmacy entrance was not completely level and there were two half doors to open, which meant that access for people with limited mobility or with pushchairs was more difficult. The pharmacist explained the half doors could be fully opened and people alerted team members to help. The pharmacy retained notes on some people's files to highlight they had some hearing difficulties so team members knew to communicate in a different way with these people. The pharmacy provided a range of services, including provision of advice and treatment for a range of conditions under the NHS Pharmacy First Scheme. It used patient group directions (PGDs) for this service. The most up-to-date copies of all PGDs were not available in the pharmacy, but the pharmacist knew where to access them electronically.

Pharmacy team members used baskets when dispensing to keep people's prescriptions and medications together to reduce the risk of an error occuring. And team members signed to confirm who had dispensed and who had checked an item. The pharmacist was observed to be dispensing and checking some prescriptions, even though there was a dispenser. No errors had been reported due to self-checking, and the risks associated with this practice were discussed. Team members were aware of their additional responsibilites to provide counselling for people taking higher-risk medicines. This included providing people prescribed valproate, in the at-risk category, with patient safety cards. And they highlighted on people's name and address labels that intervention by the pharmacist was required. Team members did not always confirm people's addresses when handing out mediciation when team members knew the person collecting their medicines. The risks of an error occuring with this practice were discussed.

The pharmacy dispensed medicines in multi-compartment compliance packs in an organised way to help ensure people received their medicines in a timely manner. It kept individual record sheets where the team recorded the medicines people were taking and communications regarding changes to their medicines. The pharmacist completed clinical checks on these prescriptions in the pharmacy and the packs were assembled using automation at another branch within the company, that acted as a hub pharmacy. The pharmacist explained the packs were checked for accuracy at the hub pharmacy by a qualified accuracy checking pharmacy technician and checked again by the pharmacist once received back in the pharmacy. The packs contained photographs and descriptions of the medicines so that people could easily identify their medicines. People had previously received patient information leaflets (PIL) with their packs, but these were not provided each month. There was an example of a PIL attached to a pack as a different brand had been dispensed. This helped reassure the person that their medicine was correct.

The pharmacy provided a delivery service three times a week and there was a collection point within a local village shop. The agreement for the collection service had been in place for approximately twenty years. The pharmacist confirmed people either chose to have their medication delivered to the village

shop or their house. Deliveries to people's homes were generally reserved for those who could not leave their homes and for some specific higher-risk medicines. However, on occasions some medicines that required storage in a fridge could be collected from the village shop. The medicines were stored in a fridge but the pharmacy had no assurances of records of the temperature of this fridge. This was discussed at the time with the pharmacist and subsequently with the SI. The SI explained it was not usual practice for fridge lines to be stored at the shop but it may have occurred occasionally. And he confirmed that there were planned changes to the collection point arrangement.

The pharmacy had one small fridge and temperatures were recorded electronically. From a sample checked, there were two occasions where the maximum temperature had been above the recommended maximum of eight degrees. The pharmacist reset the thermometer to monitor the temperature and make sure it stayed within range. The fridge was small and sometimes full of medicines and prescriptions awaiting collection. The pharmacist subsequently confirmed she had repositioned the thermometer within the fridge, and the temperatures had remained within recommended limits. The pharmacy kept up-to-date records of its expiry date checking process in line with the SOP. Team members highlighted medicines that were going out of date to use first. A sample of medicines checked were found to be within their expiry dates. The pharmacy had some excess stock stored above the dispensary shelves. This was being monitored by the pharmacist.

The pharmacy received information about drug alerts and medicine recalls via email. And team members printed these off and actioned them. But they did not keep records of what they had actioned so there was no audit trail in case of any queries.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has suitable equipment and facilities to help deliver its services safely and effectively. And it uses the equipement and facilities in a way that protects people's private information.

Inspector's evidence

The pharmacy had suitable equipment for dispensing, including different clean conical measures used for liquid medicines and water. And the team used brushes to clean them. Team members highlighted which were to be used for liquid medicines and which were for water.

The dispensary lay out was organised in such a way that meant that computer screens could not be seen by unauthorised people. And the computers were password protected, with each team member having their own password. There was a cordless telephone so that calls could be taken in private. The area where medicines and prescriptions awaiting collection were stored was positioned so that people's private information could not be seen in the retail area.

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.