

Registered pharmacy inspection report

Pharmacy Name: Lindsay & Gilmour Pharmacy, 81 Main Street,
Sauchie, ALLOA, Clackmannanshire, FK10 3JT

Pharmacy reference: 1041951

Type of pharmacy: Community

Date of inspection: 10/02/2020

Pharmacy context

This is a community pharmacy in the village of Sauchie. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. And it provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers a smoking cessation and flu vaccination service.

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	1.7	Standard not met	The pharmacy keeps prescriptions beside the medicine counter. And people's names and addresses can be easily read from the waiting area. The pharmacy does not always keep information safe. And people's personal information is not always protected.
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 not all met

Summary findings

The pharmacy uses working instructions to define its processes and procedures. But the team members do not always follow them to keep services safe and effective. They do not protect personal information to the standard expected of them. And there is an increased risk of a data breach. The pharmacy team follow the company's complaints handling procedure. And people using the pharmacy can provide feedback about the services they receive. The pharmacy team members record and discuss some mistakes that happen whilst dispensing. They use this information to learn and reduce the risk of further errors. But they do not always collect detailed information about the causes of mistakes to help inform the changes they make. The pharmacy keeps the records it needs to by law. And the team members keep them up to date.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. The team members had not signed all the working instructions that were relevant to their role. And the pharmacy was not able to provide assurance that they always followed safe working practices. The pharmacy team members signed dispensing labels to show they had completed a dispensing task. And the pharmacist and the accuracy checking technician (ACT) checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The team members had not signed the near-miss procedure to confirm they followed it. And since the last inspection in July 2019 they had recorded some errors, but some months they had not recorded any. A sample review was selected for August 2019. And the pharmacist had instructed the team members to slow down during dispensing to manage the risk of dispensing errors. The team members were aware of look-alike and sound-alike medication. And on the day of the inspection one of the dispensers had tidied the drawer used for sodium cromoglycate and sodium chloride due to a selection error.

The pharmacist managed the incident reporting process. And they documented incidents to show what the root cause had been and the remedial action they had taken. The pharmacy team had discussed a recent incident when someone with the same name as another person's had been handed the wrong medication. The pharmacist had reminded the team members to confirm each person's date of birth before handing out prescriptions. And they had agreed an extra step which involved circling the address on the prescription/bag label to confirm they had carried out the necessary checks. The pharmacy used a complaints policy. And this ensured that team members handled complaints in a consistent manner. The pharmacy did not display a complaint notice to encourage people to discuss their concerns. But it provided a 'buzz-box' to encourage people to provide feedback about the services they received. The feedback had been mostly positive with no areas for improvement identified. The pharmacist had changed the two-queue system that was in place when they took up their post. And this was due to people not understanding how the queuing system worked and the risk of confrontation if they served people in the wrong order. Some-one how sometimes people were not seen to in the order they arrived at the pharmacy. And this had managed people's expectations and improved the way the pharmacy team provided their services.

The pharmacy maintained the records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity

insurance in place. And it was valid until 30 April 2020. The pharmacy team members kept the electronic controlled drug registers up to date. And they checked the balances at the time of dispensing, with a full balance check carried out each month. The pharmacy team kept the methadone registers up to date. But they had not checked and verified the balance for a significant period of time. The pharmacy team recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. And they referred to the 'pharmacy first' PGDs on the Health Board website when they needed to.

The pharmacy did not display information about its data protection arrangements. And it did not tell people how it safeguarded their personal information. The pharmacy regularly trained the team members to comply with its confidentiality arrangements. But at the time of the inspection they were not complying with the pharmacy's arrangements. The pharmacy had been inspected on 3 July 2019 when a 'standards not all met' outcome had been recorded. This was due to the pharmacy storing prescriptions beside the medicines counter. And not concealing people's names and addresses which could be easily read from the medicines counter. The pharmacy had installed a vertical blind as an interim protective measure. But during the follow-up inspection the blind had not been drawn and people's names and addresses could still be seen. The team members had disposed of dispensing labels alongside the general waste. And the pharmacist removed a repeat slip that had also been placed in the bin and which contained patient identifiable information. The pharmacy team archived spent records for the standard retention period. The pharmacy used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. And it used a flowchart and contact details to support the team members whenever they had concerns. The team members knew to refer concerns to the pharmacist. And they provided examples of when they had spoken to surgery staff about vulnerable people when they had not arrived to collect their medication on time.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. Pharmacy trainees have protected learning. And they are supported to learn and develop in their roles. The pharmacy team complete ad-hoc training. And, they learn from the pharmacist to keep their knowledge and skills up to date. The pharmacy team members support each other in their day-to-day work. And they can speak up and make suggestions to improve services. The team members speak about mistakes that happen. But they do not always discuss the reasons for the mistakes. And this prevents them from learning from each other.

Inspector's evidence

The pharmacy workload had remained mostly the same over the past six months. And the company had reduced the levels of team members at the pharmacy over the past year. For example, the accuracy checking technician (ACT) and a dispenser had reduced their hours. The pharmacy was working below its agreed capacity due to a team member being on long-term absence. And the pharmacist had recently discussed capacity with a new area manager who had arranged for a second pharmacist to work the following Friday. A new extra team member had been recruited. And the company was 'fast-tracking' them to complete the dispenser's course within six months.

The company kept copies of qualifications and training certificates at its head office. And this provided evidence of accreditation should it be needed. The following team members were in post; one full-time pharmacist, one x 27 hours accuracy checking technician (ACT), one full-time trainee pharmacy technician, one full-time dispenser, one x 36 hours dispenser, one x 16 hours dispenser, one full-time trainee dispenser, one Saturday dispenser and one delivery driver. The pharmacist managed annual leave requests. And they maintained minimum levels by authorising only one team member to take leave at any one time. The company employed a relief dispenser to provide essential cover. And they were covering for someone's annual leave at the time of the inspection.

The pharmacist was due to carry out performance reviews. And following the review the pharmacist continued to discuss the team member's developmental objectives throughout the year to ensure they met them. For example, correctly endorsing prescriptions before they sent them to the pricing agency. The pharmacist also identified when team members were performing well in their roles. For example, someone with good IT skills was encouraged to support the rest of the pharmacy team.

The pharmacist supported the trainees to learn and develop. And they allocated four hours training time to the 'fast-track' dispenser and two hours to the trainee pharmacy technician. The pharmacist met with the team members each morning. And they discussed service priorities and any other issues.

The pharmacy provided structured training via an on-line module. And this was monitored by a central office. For example, the team had completed information governance training in 2019. The medicines counter assistant (MCA) had not completed any training over the past six months. But they knew they were all due to have a performance review to identify areas for development. The pharmacist had completed the necessary training to provide the company's private flu vaccination service. And they had also been commissioned to provide the Health Board's service.

The company did not use numerical targets to grow the services it provided. And the team did not feel undue pressure in their day-to-day roles. The Health Board had contacted the pharmacist to ask them to offer flu vaccinations to people who had registered with supervised consumption services and this had been agreed. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had suggested/introduced one basket for multiple prescriptions for the same person instead of a basket for each prescription. And this had been due to prescriptions getting separated and missed at the point of collection or delivery.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises is clean and hygienic. It has consultation facilities to meet the needs of the services it provides. And it has an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

A well-kept waiting area presented a professional image to the public. The pharmacy provided seating. And it provided a few patient information leaflets for self-selection. The pharmacy had allocated areas and benches for the different dispensing tasks. And the team members used a separate rear area to dispense, check and store multi-compartment compliance packs. The pharmacist supervised the medicines counter from the checking bench. And they could make interventions when necessary. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy provided a well-equipped consultation room. And an integrated counter was used to provide supervised doses.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know what services are available to them. The pharmacy has working instructions in place for its services. But it does not always provide assurance that the team members have read them. This means that services are at risk of not being as safe as they need to be. The pharmacy sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information. The pharmacy demonstrates it removes faulty medicines when they are notified to do so. And this means that the medicines they use are fit for purpose.

Inspector's evidence

The pharmacy had step free access. And it provided unrestricted access for people with mobility difficulties. The pharmacy displayed some healthcare information leaflets on the medicines counter and in the waiting area. And it provided information about its opening hours in the window. The pharmacist had trained the pharmacy team to speak to people about their medicines. For example, they printed safety messages on prescriptions bag labels for people taking lithium medication. And the team members knew to check that people were up-to-date with blood tests.

The pharmacy team members used dispensing baskets. And they always kept prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 130 people. And this had increased slightly over the previous six months. The team members had read and signed the company's working instructions to confirm that dispensing was safe and effective. And they used a bench in a rear room to safely assemble, check and store the packs. The team members isolated packs when people's prescription needs changed/were changing. And when they went into hospital. The team members used supplementary records to support the dispensing process. And they updated the records following prescription changes and retained an audit trail of the changes. The team members carried out regular checks to ensure that people collected their medication on time. And this helped them to identify potential compliance issues which they then referred to the pharmacist. The team members supplied patient information leaflets. And they provided descriptions of medicines to support people to take their medicines. The team members used a MethaMeasure to dispense methadone for around 23 people. And they obtained an accuracy check at the time they entered new prescriptions. And they obtained an accuracy check at the time of supply.

The pharmacy purchased medicines and medical devices from recognised suppliers. The team members carried out regular stock management activities. And they highlighted short dated stock and split-packs during regular checks. The team members monitored and recorded the fridge temperature. And they demonstrated that the temperature had remained between two and eight degrees Celsius. The team members kept controlled drugs in two separate cabinets. And this managed the risk of selection errors, for example, they kept multi-compartment compliance packs in a dedicated cabinet to avoid congestion. The team members acted on drug alerts and recalls. And they recorded the date they checked for affected stock and what the outcome had been. For example, they had last checked for ranitidine in February 2020 with no stock found.

The pharmacist had trained the team members about the valproate pregnancy protection programme. The team members knew about the initiative. But they did not know where to find the safety leaflets and cards and said it was the pharmacist who issued them. The pharmacist monitored prescriptions for valproate. But they had not received any prescriptions from people that could be affected to confirm they knew about the risks. The pharmacist had provided training about the Falsified Medicines Directive (FMD). And the pharmacy had the necessary tools to meet the system's requirements. But the scanner had stopped working and they were not using the system.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. But it does not always carry out the necessary maintenance to provide assurance it is fit for purpose.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used crown-stamped measuring equipment. And the measure for methadone was highlighted, so it was used exclusively for this purpose. The pharmacy used a blood pressure monitor. But the pharmacy team were unable to confirm when it had last been replaced or re-calibrated. The pharmacy kept cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy arranged computer screens, so they were out of sight of people in the waiting area. And the pharmacy team members had access to a portable phone which they used at the rear of the pharmacy away from the waiting 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.