General Pharmaceutical Council

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: 06/08/2020

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. 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. The pharmacy was inspected during the Covid-19 pandemic.

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 regularly updates its working instructions to keep its processes and procedures safe and effective. The team members read and sign the instructions to show they follow them. They record and discuss their dispensing mistakes, and regularly review the information to learn and manage risks. Pharmacy team members keep the records they need to by law up to date. They protect people's personal information and prevent sensitive information being seen by people who are not authorised to do so. And they know the importance of their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had carried out risk assessments throughout the Covid-19 pandemic to manage the risk of virus transmission. A Perspex screen at the medicines counter created a barrier between the team members and people that visited the pharmacy. And the number of people in the waiting room at the one time was restricted to two. The team members had placed markings on the floor to show people where to stand to keep two metres apart. Notices in the window provided public health information about the transmission of the virus and how to protect themselves from it. This included social distancing and the wearing of masks. The pharmacy had hand sanitiser available at various locations in the dispensary, and it was used on a regular basis by the team members. The pharmacy team members were wearing appropriate face masks as personal protective equipment (PPE). They observed social distancing as far as possible while working in the dispensary.

The company had recently reviewed and updated its working instructions. The team members were in the process of reading them. They recorded their signatures to confirm their understanding. This ensured their learning was up-to-date, and services were safe and effective. The pharmacy displayed the responsible pharmacist notice. It showed the name and registration number of the pharmacist in charge.

The pharmacy team members signed dispensing labels to show they had completed a dispensing task. This helped the pharmacist and the accuracy checking technician (ACT) support individual team members improve their accuracy and manage risks. And it acted as an audit trail of who had been involved in the dispensing process. The team members recorded their errors, and the pharmacist reviewed all the errors at the end of the month. This ensured they identified patterns and trends and areas for improvement. The pharmacy's workload had increased at the start of the Covid-19 pandemic, and the team members had not been able to record all the near miss errors due to workplace pressures. But, they had discussed the errors in the moment and they continued to learn and improve. The pharmacy's workload had since stabilised, and the team members had been able to improve record keeping and document the errors they made.

The pharmacist used monthly team meetings to discuss areas for improvement. A recent discussion had resulted in the team members 'ticking' key information on the dispensing labels. This showed they had checked the information and confirmed it corresponded with the prescription's instructions. An area manager was on-site at the time of the inspection to provide support. They had also re-introduced audits to provide assurance that the pharmacy complied with professional standards. For example, making sure the team members had signed the company's policies and procedures.

The pharmacist managed the incident reporting process, and they used the company's on-line report

form to document the root cause and the improvement action taken. The pharmacy did not display a complaint notice, but the team members had been trained to handle complaints in a sensitive manner. They also knew to refer dispensing incidents to the pharmacist. The pharmacist had been proactive at managing people's expectations throughout the pandemic. And the team members had been providing realistic timescales about the prescription turnaround time to avoid frustration. The pharmacy normally used a ‘buzz-box’ at the medicines counter to gather feedback about its services. But the team members had removed it at the start of the pandemic to manage the risk of cross-infection. People had been providing verbal feedback that they appreciated the pharmacy service. They valued the support they had received during the pandemic.

The pharmacy maintained the records it needed to by law. The pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity insurances in place, and they were valid until 30 April 2021. The pharmacy team members kept the electronic controlled drug (CD) registers up to date. They recorded controlled drugs that people returned for destruction, and the pharmacist and a team member recorded their name and signature against each destruction. The pharmacy recorded private prescriptions and records met legal requirements. Specials records were kept up to date with details of each person who had received a supply.

The pharmacy had been inspected in February 2020 and an action plan issued to improve its data protection arrangements. The company carried out a risk assessment and arranged for new shelving to be installed in a rear store-room. The team members had moved prescriptions away from the medicines counter, and this managed the risk of names and addresses being seen by people in the waiting area. The pharmacy displayed information about its data protection arrangements. The notice provided assurance that it safeguarded personal information. The company trained its team members to protect confidential information. They knew to follow the company's processes and procedures. The team members used designated bags to dispose of personal information. An authorised company uplifted the bags for off-site shredding.

The pharmacy used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. It used a flowchart and contact details to support the team members whenever they had concerns about safeguarding vulnerable people. This ensured they were able to contact the relevant agency in a timely manner. The pharmacy displayed information about the Safe Space initiative, and the team members knew to refer concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members are qualified and accredited for their roles and the services they provide. They have protected learning time to keep their knowledge up to date and they complete training on a regular basis. The pharmacist supports individuals to develop their knowledge and skills. The team members support each other in their day-to-day work. They are enthusiastic and knowledgeable in their roles, and they suggest improvements to make services safer and more effective.

Inspector's evidence

The pharmacy's workload had increased over the past six months, and the pharmacy's footfall had decreased at the same time. This was due to the Covid-19 pandemic and the necessary service changes that had been implemented to manage the risk of infection. The pharmacy team had remained mostly the same over the past six months. It had become more effective at managing the workload as a result of the service changes. And the reduced footfall had reduced the number of interruptions to the work-flow. They had been able to introduce new working practices. For example, they were manually checking computer generated orders at the end of the day to manage the risk of over-ordering.

The company kept copies of qualifications and training certificates at its head office. 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. This ensured they maintained minimum levels by authorising only one team member to take leave at any one time.

The pharmacist carried out individual performance reviews throughout the year. They were about to have a review meeting with the team members. The pharmacist supported trainees to learn and develop. They had allocated four hours training time per week to ‘fast-track’ the trainee dispenser. This had supported the trainee to qualify in only six months. The company allocated 30 minutes per week to the other team members. This provided protected learning time to complete structured on-line training, and to read the company policies and procedures. The team members had recently completed training about the seasonal flu vaccination service. They had also learned about the new 'NHS Pharmacy First' service that launched at the end of July 2020.

The company did not use numerical targets to grow the services it provided. The team members were currently promoting the free delivery service and the 'NHS Pharmacy First' service. They knew this was for the benefit of vulnerable people and people who needed treatment for minor ailments.

The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had introduced one basket for multiple prescriptions for the same person instead of a basket for each prescription. This managed the risk of prescriptions getting separated and missed at the point of collection or delivery.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and hygienic and has appropriate infection control arrangements in place. It has consultation facilities to meet the needs of the services it provides, and people can speak with team members in private.

Inspector's evidence

The pharmacy is clean and hygienic, with infection control measures such as an automatic door and a Perspex screen at the medicines counter. The consultation room was out of use due to the pandemic, but the pharmacist spoke to people at a small hatch at the rear of the waiting area. This ensured people's privacy and dignity was protected.

The pharmacy had allocated areas and benches for the different dispensing tasks. The team members used separate benches for dispensing. For example, they used a rear bench to dispense and check multi-compartment compliance packs. The pharmacist supervised the medicines counter from the checking bench. This meant they could make interventions when necessary. The pharmacy had effective lighting, and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays information about its services and opening times so people can easily see them. It provides public health information and it keeps people up to date with safety messages. The pharmacy reviews its working arrangements when there are changes, this helps keep its processes safe and effective. The pharmacy sources, stores and manages its medicines appropriately. It receives safety information about medicines. And it updates team members so they know to only supply medicines that are safe to use.

Inspector's evidence

The pharmacy had step free access. This provided unrestricted access for people with mobility difficulties. The pharmacy displayed information about its services and opening hours. It also provided public health information and safety messages to protect people from the coronavirus. The team members displayed healthcare information leaflets on the medicines counter. This included information about the new 'NHS Pharmacy First Service' and the 'NHS Care and Review Service'. The company used an NHS approved app for people to order and track repeat prescriptions.The app could also be used to communicate with the pharmacy. This had been beneficial when the pharmacy's phone-line had gone out of service. And the team members had placed a message on the app to inform people about the issue. The pharmacy provided a delivery service. A relief driver was providing cover for the regular driver who was on annual leave. The pharmacy had carried out a review of the delivery service in light of the coronavirus pandemic to identify infection risks. The pharmacist had discussed the new arrangements with the driver. This included staying two metres apart from people, placing items at the person's door until they were taken inside, and not collecting signatures. The drivers used an electronic system to record the prescriptions for delivery. This provided an audit trail of deliveries that had been completed.

The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. They had printed the new 'NHS Pharmacy First' PGDs, and they referred to the Forth Valley Health Board website to confirm PGDs were up-to-date. The pharmacy team members knew about 'high-risk' medicines. They knew to look for information stickers on prescriptions bags and to act accordingly. They knew to check that people were up to date with blood tests. A ‘pharmacist’ sticker meant calling on the pharmacist to provide extra advice, such as for new medicines. A ‘fridge’ sticker meant they had to retrieve extra items from the fridge.

The pharmacy team members used dispensing baskets. They kept prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 140 people. This had increased slightly over the previous six months. And the company had authorised the pharmacy to send around half of the prescriptions for compliance packs to its hub for off-site dispensing. The company had issued a set of new working instructions for the team members to read. They had been trained to process the prescriptions to be sent to the hub for dispensing. The team members used a separate bench in a rear room to assemble, check and store the packs. They used supplementary records to support the dispensing process. And they updated the records following prescription changes to keep an audit trail of changes. The team members supplied patient information leaflets with the packs. They also provided descriptions of medicines on the packs to support people to take their medicines.

The team members used a MethaMeasure to dispense methadone doses for around 23 people. They obtained an accuracy check when they entered new prescriptions for the first time. They also 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. They highlighted short-dated stock and split packs during regular checks. The team members monitored and recorded the fridge temperature. They showed the temperature had remained between two and eight degrees Celsius. The team members kept controlled drugs in two separate cabinets. This managed the risk of selection errors, for example, they kept multi-compartment compliance packs in a separate cabinet to avoid congestion. The team members acted on drug alerts and recalls. They recorded the date they checked for affected stock and what the outcome had been. For example, they had checked for digoxin tablets in August 2020 with affected stock placed in quarantined.

The pharmacist had trained the team members about the valproate pregnancy protection programme. The team members knew about the initiative. But they were not expected to know where the safety leaflets and cards were kept as these were added by the pharmacist at the time of checking. The pharmacist had provided training about the Falsified Medicines Directive (FMD). The pharmacy had the necessary resources to meet the system's requirements. But the team members had stopped using it during the pandemic.

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 checks 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 kept a blood pressure monitor, but the team members had not used it since the start of the Covid-19 pandemic. The pharmacy had not carried out checks, and the team members could not confirm when it had last been replaced or re-calibrated.

The pharmacy kept cleaning materials for hard surface and equipment cleaning. The pharmacy sink was clean and suitable for dispensing purposes. The pharmacy team members kept computer screens out of sight of people in the waiting area. They used a portable phone to keep personal conversations private. The team members were wearing face masks. They washed and sanitised their hands on a regular basis.

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.