General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lindsay & Gilmour Pharmacy Alderston, 6 Alderston Drive, DUNFERMLINE, Fife, KY12 0XU

Pharmacy reference: 1042066

Type of pharmacy: Community

Date of inspection: 25/11/2019

Pharmacy context

This is a community pharmacy beside other shops in a residential area. 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 also 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 offers the smoking cessation service, seasonal flu vaccination and runs anti-coagulant clinics. It had changed ownership four weeks previously.

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

The pharmacy team members follow written processes for all services to ensure that they are safe. They record mistakes to learn from them and make changes to avoid the same mistakes happening again. Team members use people's feedback to improve pharmacy services. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Team members know how to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which the new owner had recently introduced. The deputy pharmacy superintendent reviewed them every year and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members were referring to them frequently. And the folder was kept on the pharmacist's checking bench for ease of access. Team members were gradually reading and signing them, taking a risk-based approach. Team members who had worked for the company in other branches had read and signed SOPs in their previous/usual branch. The pharmacy kept records of who had read each SOP. The pharmacy was systematically changing processes to follow the new SOPs. The superintendent and deputy superintendent pharmacists were supporting this. Some processes involved major change, such as the prescription collection service management and dispensing, and the dispensed medicines retrieval system. All processes were being reviewed and changes implemented, and training and coaching provided. For example, the pharmacy had recently introduced a 'methameasure' pump device for dispensing methadone. All team members had received basic training but so far only one was fully competent. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. Team members were very clear regarding which activities they were competent in and able to undertake. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members had recently started to use near miss logs to record dispensing errors that were identified in the pharmacy. But they were not yet used consistently. The process for recording was electronic and had recently been changed. There had been no reviews so far. Team members could describe examples of rearranging stock and separating high-risk items. They were clear that this process must be followed and described it as 'work-in-progress'. They also recorded errors reaching patients to learn from them.

The pharmacy had a complaints procedure and welcomed feedback. A medicines counter assistant explained that recently there had been several complaints about the pharmacy delivery service. This was due to the change in computer system, and data had not been transferred from the old system to the new system. She explained that she apologised to people and arranged the deliveries. The team now ensured that any items for delivery were transferred from the old computer system onto the new system rather than rely on this happening automatically. The team member explained that people were understanding when an explanation and apology was given.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. The pharmacy displayed the

responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read information in the staff handbook and had training on general data protection regulations (GDPR). They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read safeguarding information and the local process for raising concerns was available on the internet. The pharmacy was in the process of registering the locum pharmacist with Disclosure Scotland as part of the PVG scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. It compares numbers and qualifications to how busy the pharmacy is. And then it makes changes to ensure that there are always enough team members. They can share information and raise concerns to keep the pharmacy safe.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacy technician/manager; one full-time trainee pharmacy technician; one full-time dispenser; three part-time medicines counter assistants and two part-time delivery drivers. There was currently no regular pharmacist and the pharmacy was using a variety of locum pharmacists. A regular pharmacist was starting in around two months' time working four days per week. She was currently working as a locum pharmacist including some days in this pharmacy. And another regular pharmacist was going to be working two days per week, giving a day of double cover. Locum pharmacists would continue to work Saturdays. The pharmacy technician was training to be an accuracy checking pharmacy technician (ACT). The pharmacy displayed their certificates of qualification. Typically, there were now two medicine counter assistants, two dispensers and a pharmacy technician working at most times. The pharmacy had recently reviewed staffing levels when ownership had changed. Two team members and the pharmacist had left following the change of ownership. A trainee pharmacy technician had relocated from another branch and following recruitment, a new team member with pharmacy experience had started on the day of inspection. And a relief dispenser was currently working for one or more days per week. She was assisting with the transition of multicompartment compliance packs to a new process. The pharmacy was relocating many of these to a central hub. The relief dispenser was coaching other team members in the process to ensure that others were competent. One team member managed substance misuse services. She had been fully trained when the 'methameasure' pump device had been introduced into the pharmacy. She was in the process of coaching colleagues to ensure that others could do this. Over coming weeks all team members were going to be trained and coached in all services to ensure that all team members could undertake all activities. Most team members had worked in this pharmacy for several years. They described the challenge of new owners and processes but were working well with team members who already worked for this organisation. They were able to manage the workload. The pharmacy head office was supporting with the challenges and at the time of inspection the deputy superintendent pharmacist was working in the pharmacy. He was very aware of the challenges of staff leaving, new staff and new processes.

The pharmacy had issued all team members with a staff handbook when it had changed ownership four weeks previously. Team members had received training on the general data protection regulations (GDPR). A head office team member was due into the pharmacy later the day of inspection to complete induction training with the new team member. She would be issued with her staff handbook and health and safety, GDPR and safeguarding training delivered. The pharmacy did not currently provide learning time during the working day. It had recently provided team members with access to Numark training modules with a view to undertaking these regularly. Team members were aware of these but had not yet started them. The trainee accuracy checking technician (ACT) was about to commence her assessed checking and believed she would have time during the working day to do this. The trainee pharmacy technician did not have time at work to undertake any coursework but was doing this in her own time

at home. She was aware of the challenges having relocated to this branch and was keen to complete her course. A team member who had started in the pharmacy on the day of inspection was being supervised by pharmacist and pharmacy technician (manager). And all other team members were assisting her. The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the manager or area manager. The company had a whistleblowing policy. Team members explained how they would deal with any concerns and gave appropriate responses to scenarios posed.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean, and suitable for the pharmacy's services. The pharmacy team members use private rooms for some conversations with people. People cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were reasonably sized premises incorporating a retail area, dispensary and back shop area including storage space and staff facilities. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, and computer which was clean and tidy, and the door closed providing privacy. The pharmacy also had a separate area for specialist services such as substance misuse supervision. This was a small room with a hatch to the dispensary close to the 'meathameasure' pump. Temperature and lighting were comfortable.

The pharmacy was in the process of planning some adjustments and improvements to the premises. This included planning to install additional shelving, a large fridge and another controlled drug (CD) cabinet.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. And they provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and wide door. It listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order and could provide large print labels to help people with impaired vision. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. Team members labelled and dispensed prescriptions for people walking-in at a bench immediately behind the medicines counter and adjacent to the pharmacist's checking bench. They labelled prescriptions received from GP practices on another labeller to the rear of the dispensary. Then team members placed prescriptions and labels into individual baskets per person. Another team member assembled these on a dispensing bench at the rear dispensary where they were stacked up neatly for the pharmacist. The pharmacist selected baskets from this area to check in a methodical order. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. But some instalment prescriptions labels were not signed.

The pharmacy usually assembled owings later the same day or the following day using a documented owings system. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when people requested them. The team kept records electronically and on prescriptions of supply. The GP surgery had issued prescriptions a few months before they were due so there was some confusion about dates. Also, some information had not transferred from the old to new computer system. The team was aware that records may not be accurate currently and was working to resolve this. There was no evidence of poor compliance. The pharmacy was working with GP practices to increase serial prescriptions and manage these following the company SOP.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. It was reviewing and changing this process to comply with the company SOP. An experienced relief dispenser was assisting and helping to train other team members in the new process. The pharmacy was relocating the assembly process for some packs to another branch that operated as a 'hub'. Team members were notifying people that their medicines were now being assembled in another branch. People were satisfied with this arrangement. The process was robust and comprehensive records were kept. A team member checked prescriptions for completeness and entered the data onto the computer to share with the hub. The pharmacy scanned prescriptions and backing sheet templates, and these were sent to the hub for the ACT there to check against. The hub produced backing sheets with photographs of tablets which helped identification. It attached backing sheets firmly and included patient details and date of supply. The pharmacy still managed some of

these prescriptions in the pharmacy. These included prescriptions for controlled drugs, warfarin, complex dose regimes and prescriptions that often changed. Team members followed the SOP and the process in the pharmacy was also safe and robust. The pharmacy supplied patient information leaflets (PILs) to people with the first pack of each prescription. Team members recorded information and changes in a communications book and complete patient records were kept.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. A team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and the pharmacist at that time had counselled them appropriately. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, and supply of chloramphenicol ophthalmic products. It also followed private PGDs for flu vaccination. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required.

The pharmacy provided an anti-coagulant clinic when appropriately trained pharmacists were working. It was carefully managing this to ensure that personnel were available on the days people expected. The pharmacy had clinics on site one day per week, and from a hospital site another day. A pharmacist also undertook home visits to some people. The pharmacy also provided a flu vaccination service which was also carefully managed to ensure that people were only given appointments when a suitably trained and qualified pharmacist was available. These services were not available at the time of inspection.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). It had the scanning equipment, but this was not in use as team members were not yet trained. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in two fridges. Over the past few weeks fridge temperatures had not been monitored daily due to a change in computer software. This was resolved during inspection and a reminder setup on the system. The fridges' actual and minimum and maximum temperatures were within the recommended range at the time of inspection. Team members checked expiry dates of medicines and those inspected were found to be in date. Stocktakers had checked expiry dates of all medicines four weeks previously when ownership had changed. All team members checked expiry dates during the dispensing process. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. It looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board, a 'Coagucheck' device calibrated as per the manufacturer's guidance, and sundries such as gloves and sharps boxes. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy had recently obtained a 'methameasure' pump for methadone use. Team members cleaned it at the end of each day and poured test volumes each morning. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left them unattended unless they were locked.

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.