General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lindsay & Gilmour Pharmacy, 2 Pentland View Court, CURRIE, Midlothian, EH14 5NP

Pharmacy reference: 1042614

Type of pharmacy: Community

Date of inspection: 26/09/2022

Pharmacy context

This community pharmacy is amongst a small parade of shops in the town of Currie. The pharmacy's main activities are dispensing NHS prescriptions and delivering medication to people's homes. The pharmacy provides the seasonal flu vaccination service and 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

The pharmacy generally identifies and manages the risks associated with its services. It mostly completes the records it needs to by law and it largely protects people's private information. The pharmacy provides its team members with training and guidance to help them respond to safeguarding concerns. They act appropriately when mistakes happen. But they don't fully complete records to help prevent future mistakes and improve the safety of services.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically. These provided the team with information to perform tasks supporting the delivery of services. Each team member had their own log in number to access the SOPs to read them and indicate when they had read them. The head office team monitored this and alerted the team to new SOPs or when changes were made to existing ones. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure for managing errors that occurred during the dispensing of prescriptions, known as near misses. The procedure included the team member involved capturing the error on an electronic record. A sample of errors found few entries had been made in the last three months. The pharmacy had a procedure for managing errors that were identified after the person had received their medicine, known as dispensing incidents. This included the team completing an electronic dispensing incident report. All team members were informed of the incident so they could learn from it and be aware of any changes made following the incident. The last report was completed in June 2022 and captured the learning from the error. This included to check the person's date of birth to ensure the correct person was selected when generating a dispensing label. And to add a record of the incident to the pharmacy's patient medication record (PMR) for that person. The pharmacy had a template to record when a review of the near miss errors and dispensing incidents had taken place. This helped the team to identify patterns and take appropriate action to prevent similar errors from happening again.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. The pharmacy didn't display any information on how to raise a concern with the team but the website had details on how to do this. The pharmacy was installing a voicemail facility on its external phone line to provide people with information and different options to help manage their call.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers mostly met legal requirements. Some entries in the RP records didn't capture the time the pharmacist ceased to be the RP. The electronic CD registers system prompted the team to complete balance checks of CDs to help spot errors such as missed entries. A recent CD balance check had found some discrepancies. The pharmacist had reported the discrepancies but had not completed an investigation. The team members had completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding on and offsite. The pharmacy website displayed a privacy notice that provided people with information on the personal data the pharmacy kept and how it was protected.

However, a few documents containing people's identifiable information were found on open display in the consultation room.

The pharmacy had safeguarding procedures, training and guidance for the team to follow. The RP was registered with the protecting vulnerable group (PVG) scheme. The pharmacy displayed a poster advising people that it provided a safe space for people to use. The delivery driver reported concerns about people they delivered to, back to the pharmacy team who took appropriate action such as contacting the person's GP or the police.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the appropriate range of experience and skills to safely provide its services. Team members work well together and are good at supporting each other in their day-to-day work. They discuss ideas and implement new processes to help with the delivery of the pharmacy's services. And they have some opportunities to receive feedback and complete training so they can suitably develop their knowledge and skills.

Inspector's evidence

A full-time pharmacist who had been in post a few weeks covered the opening hours with locum pharmacist support when required. The pharmacy team consisted of a full-time accuracy checking technician (ACT), a part-time dispenser, a full-time new member of the team, part-time pharmacy students and a part-time delivery driver. At the time of the inspection a relief dispenser was providing support to the team.

The pharmacy reported facing some staffing challenges in the last 12 months after several experienced team members left the business. The remaining team members supported each other but were often not advised of any relief cover until the day and when the dispenser arrived. This meant it was sometimes difficult for the team to plan its workload. During this time team members reported to have struggled to manage the workload and often they were several days behind with the processing of prescriptions. Team members described how they were regularly subjected to concerns directed towards them from people when there were delays to the supply of their medication. The team reported the pressures had eased since the full-time pharmacist and new team members had come into post. The ACT had also taken on managerial responsibilities. The team worked together to get ahead with the dispensing of prescriptions and had made changes to help them work efficiently. This included working extra hours and reorganising where the instalment prescriptions were stored so they could be easily found when the person presented.

The team members accessed e-learning modules to keep their knowledge and training up to date. They had protected time at work to complete the training. This included the new team member who was supported by the other team members. Team members received informal feedback about their performance and had received positive comments about the work they'd done to ensure people received their medication.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were tidy and hygienic. In response to the COVID-19 pandemic the pharmacy team wore face masks and the pharmacy had installed clear plastic screens on the pharmacy counter. The team used separate sinks for the preparation of medicines and hand washing and they kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. And it had a defined professional area where items for sale were healthcare related. The pharmacy had a soundproof consultation room that the team used for private conversations with people and when providing pharmacy services. The pharmacy also had a separate, cordoned off area at the pharmacy counter area that provided privacy. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are accessible for people. And it adequately manages its services to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and it mostly stores them properly. The team carries out checks to make sure medicines are in good condition and appropriate to supply. But sometimes its processes are not robust and so it has a few medicines on its shelves past their expiry date.

Inspector's evidence

People accessed the pharmacy via a small step. The pharmacy had an automatic door operated with a press pad but this was not working at the time of the inspection. The window displays detailed the opening times and the services offered. Sometimes the pharmacy closed for an hour at 1pm, a poster was clearly displayed informing people of this. The team members provided people with information on how to access other healthcare services when required and they kept a small range of healthcare information leaflets. Team asked an appropriate range of questions and provided clear advice when selling over-the-counter products. The pharmacy had up-to-date patient group directions (PGDs) which gave the pharmacist the legal authority to supply certain prescription only medicines (POMs) within the criteria of the NHS Pharmacy First service.

The pharmacy provided multi-compartment compliance packs to help around 12 people take their medicines. The team had transferred, with their consent, the dispensing of many people's prescriptions to another pharmacy in the company who had the capacity to efficiently provide this service. This helped the team during its time of working under pressure to safely provide the service for the remaining people that received the packs. And it helped with the efficient delivery of other pharmacy services. The team usually ordered prescriptions in advance to allow time to deal with issues such as missing items and for the dispensing of the medication into the packs. The team recorded the descriptions of the products within the packs and supplied the manufacturer’s packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. At the time of the inspection the doses were stored in a basket in the area where the pharmacist worked. These were moved to the CD cabinet during the inspection and there was adequate separation of people’s doses to reduce the risk of the wrong dose being selected.

The pharmacy provided several people with their medicines from NHS instalment prescriptions. The team dispensed the instalments in advance and stored them in baskets labelled with the person’s name. The team marked the bag with the date of supply and how many weeks dispensing from the instalment prescription were left so they could advise the person when a new prescription was required. The team provided people with clear advice on how to use their medicines and team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The team members were aware of one person who met the criteria and that they had been provided with PPP information. The team usually highlighted the prescriptions for people prescribed high-risk medicines such as valproate so everyone was aware and appropriate counselling could be provided to the person. But a recent prescription for the person prescribed valproate who met the PPP criteria was found

without such markings. This meant the person may not receive appropriate counselling or advice when they receive their medicine. This was highlighted to the team members during the inspection who discussed amongst themselves the importance of always following their process. This would ensure, when required, people had appropriate PPP in place and understood the risks.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The team used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample found that the team completed the boxes. The pharmacy used fridge and CD stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The pharmacy had a text messaging service to inform people when their repeat prescriptions were ready. The pharmacy kept a record of the delivery of medicines to people. If the person was not at home the delivery driver left a note informing the person of the failed delivery.

The pharmacy obtained medication from several reputable sources. The pharmacy had a procedure for the team members to check the expiry dates on stock. This included a record of when the date checking had taken place but this was not available at the time of the inspection. The team generally marked medicines with a short expiry date to prompt them to check the medicine was still in date. However, some medicines were found on the shelves with expiry dates of April 2022 and October 2022 that had not been marked. The team members recorded the dates of opening on medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day. A sample of these records found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient-returned medication. And it stored out-of-date and patient-returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It makes sure it uses its equipment appropriately to protect people’s confidential information.

Inspector's evidence

The pharmacy had reference resources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. The pharmacy computers were password protected and the computer on the pharmacy counter was situated in a way to prevent disclosure of confidential information. The pharmacy had cordless telephones to help the team ensure telephone conversations were not overheard by people in the retail area. The pharmacy stored completed prescriptions away from public view.

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.