General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lindsay & Gilmour Pharmacy, 11 Elm Row, EDINBURGH, Midlothian, EH7 4AA

Pharmacy reference: 1042661

Type of pharmacy: Community

Date of inspection: 15/10/2019

Pharmacy context

This is a community pharmacy beside other shops on a main road in a city centre. It dispenses NHS prescriptions including supplying medicines in multi-compartmental 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. And it offers flu vaccination and a private GP consultation service via Skype. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines.

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 they review these and make changes to avoid the same mistakes happening again. The pharmacy asks people for feedback. And team members use feedback to improve pharmacy services. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. 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. It had a list of other branch numbers and useful contacts on the dispensary wall.

Team members used electronic near miss logs to record dispensing errors that were identified in the pharmacy. They checked all their own dispensing before passing to the pharmacist, so sometimes identified their own errors. They only recorded errors reaching the pharmacist. So, there were not many incidents recorded e.g. four per month. The pharmacist and other team members explained that dispensing was very accurate with few mistakes made. But the pharmacist explained that it was possible that some incidents may not be recorded if the computer was being used. The team was planning to additionally use paper near miss logs, with one used in the main dispensary and one in the room where multi-compartmental compliance packs were managed. They planned to transfer these records to the electronic system to ensure all errorw were recorded. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. An error a few months previously had involved a date expired item. The team was surprised and disappointed as team members regularly undertook date checking. Following the incident, they checked all stock and found a further two date expired items. They removed items expiring over the following two months. Another incident was an allegation of the incorrect number of tablets being supplied. The team completed a fishbone analysis to identify potential causes and learn from the incident. But they could not find any evidence of this. The team reported both incidents following the SOP and reflected on how improvements could be made, such as improving date checking and double checking unusual quantities of tablets. The area manager carried out quarterly audits which helped to inform action plans for the pharmacist and pharmacy. The pharmacy team used weekly audits to scrutinise the premises and processes. It also looked at how the pharmacy met GPhC standards, covering all standards over a three-month period. And health and safety audits were completed. The pharmacy had a document with links to all audits and check-lists to ensure they were all done as intended.

The pharmacy had a complaints procedure and welcomed feedback. It used a tablet device to capture feedback from people as they left the pharmacy. Team members ordered appropriate items into the

pharmacy for people e.g. Oraldene. They kept a notebook for this purpose and phoned people when the stock arrived. They also used feedback to help inform items stocked e.g. essential oils.

The pharmacy displayed 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. Team members signed any alterations to records, so they were attributable. 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 training material on the general data protection regulations (GDPR) and kept records of this. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacist was PVG registered. The pharmacist had undertaken the NHS Education for Scotland (NES) child protection training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. The pharmacy replaces team members when they leave. All team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training. This ensures skilled and qualified staff provide pharmacy services. Pharmacy team members discuss incidents. And they learn from them to avoid the same thing happening again. They can share information and raise concerns to keep the pharmacy safe.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one full-time pharmacy technician, one full-time dispenser undertaking NVQ 3 training, one full-time medicines counter assistant, one part-time medicines counter/dispensary assistant working two mornings per week and Saturdays, and two part-time delivery drivers. Following a recent retirement, the pharmacy had reviewed staffing levels and decided to recruit for a team member who could be trained for medicines counter and dispensary. The new team member was expected to start over the next few weeks. The pharmacy displayed team members' certificates of qualification. They were able to manage the workload. The pharmacist had recently been in discussion with the company management about using this pharmacy as a training hub. He had decided this would not be appropriate as the staffing level was appropriate when there was no absence, but no extra. And the pharmacy was not large meaning that there was limited capacity for additional training activities.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development. Head office sent quarterly lists of training modules to be completed and these were displayed on the wall in the dispensary. Current topics included flu, and body language. The pharmacy tried to give all team members half an hour per week to undertake these. They could also undertake other modules of their choosing from a large selection. The pharmacy technician had recently completed her training and explained that she had usually done this in the pharmacy on Saturdays which were quieter than other days. The NVQ 3 trainee was using her lunch breaks to complete her training. The pharmacy manager met each team member every few months for a development meeting. These meetings were conversations rather than formal documented events. Training needs and aspirations were discussed. These were addressed by the pharmacist ensuring that protected learning time was available and team members accessing training modules on relevant topics. Team members 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. The pharmacy team discussed incidents and how to reduce risks. The team had regular team meetings, at least monthly. The pharmacist kept notes of these meetings which were short, focused and topical. And he sent these notes to head office. The experienced medicines counter assistant had some autonomy to run the retail area.

Team members could make suggestions and raise concerns to the manager or superintendent

pharmacist. No examples were described but appropriate responses were given to scenarios posed. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

These were average sized premises incorporating a retail area, small dispensary and an additional dispensary used for manging multi-compartmental compliance packs. The premises included a large basement which provided staff facilities and storage. One area of the basement was damp, but this area was segregated and not used. Team members had asked for the staff area to be upgraded and improved and this had been done. The basement was also used as a repository for waste medicines' bins for the company. Company delivery drivers delivered these sealed bins and stored them in the basement until the NHS contractor uplifted them. 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, sink and computer which was clean and tidy, and the door closed providing privacy. It was a thoroughfare between the two dispensaries. When the pharmacist was using the room with people, he ensured doors to the dispensaries were closed. Sometimes people were in the consultation room unaccompanied when they were using the online GP consultations facility, 'Medicspot'. The pharmacist removed a sharps' bin and folders containing confidential information at these times. The door was kept locked to prevent unauthorised access. The pharmacy also had a discreet area with a hatch to the dispensary used for some consultations and delivery of substance misuse services. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. It gives access to a private GP service which helps visitors to the area. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as travel vaccination. Team members explained that there was some local demand for this service and there was hope but this could be implemented in the pharmacy in the future. The pharmacy could provide large print labels for people with impaired vision. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines. This was an electronic record and team members could view signatures and time of delivery if required.

Pharmacy team members followed a logical and methodical workflow for dispensing. But dispensing took place on a very small area adjacent to the medicines counter. Team members were frequently interrupted as they were public facing in this area. They also had very little space to work on. The pharmacist checked dispensed medicines on a dedicated bench with his back to the public which minimised his interruptions. He had the hatch used for consultations and supervision immediately behind him. Team members used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. They used pharmacist information forms (PIFs) to share information about new medicines or new patients with the pharmacist. They had stopped highlighting controlled drugs using these forms over the past few months. The used labels to highlight some information such as pharmacist intervention required, and storage in a fridge. But they did not use controlled drug (CD) labels so did not note expiry dates of controlled drugs prescriptions on standard retrieval shelves. There was no evidence of expired prescriptions in use. Team members initialled dispensing labels to provide an audit trail of who had dispensed and who had checked each item.

The pharmacy usually assembled owings later the same day or the following day using a documented owings system. A few people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy team dispensed these when people presented at the pharmacy. Team members had no evidence of poor compliance. But they were considering how to manage these as the service grew. They were reviewing their process, comparing it to others and considering what options would provide a continued safe service. The pharmacy was actively registering people for this service. The pharmacist acknowledged that this did not currently have a strong clinical focus. He was currently reviewing this process to improve how he might discover pharmaceutical care issues. He was considering targeting specific drug groups. He had worked in this way before with high risk medicines such as warfarin and this had been successful at identifying care issues.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. The pharmacy technician worked nearly full time on this activity. She ordered

prescriptions as the third pack was supplied. This gave her plenty of time to check prescriptions and deal with any queries before assembling in time for supply of the first pack. The pharmacy used a separate room for the management of multi-compartmental compliance packs. They were managed, assembled, checked and stored in this room. The pharmacy technician followed a robust and logical process with smooth workflow and designated areas for packs waiting to be checked. She included tablet descriptions on packaging and supplied patient information leaflets with the first pack of each prescription. The pharmacist sealed packs at the time of checking. He checked medicines for one or two people at a time then returned to the main dispensary. This ensured that he maintained his concentration. The pharmacy kept ring binders for each day of supply, and each person had their own file in the appropriate folder. The files contained a master dose regime template and comprehensive records of changes. The pharmacy had designed a bespoke form for changes to capture a range of information including date, prescriber, and the various changes to paperwork required in the pharmacy. The pharmacy technician and pharmacist signed and dated this form once all aspects of the change had been implemented.

The pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. He or 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 pharmacy did not supply valproate to anyone in this group. The pharmacist provided information to people but the dispenser and pharmacy technician were fully aware of the risks and information to be supplied. 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 medicines counter assistant was familiar with these and had information on the medicines counter to supply to relevant people. She confidently and appropriately described the information that she gave to people.

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, supply of chloramphenicol ophthalmic products and chlamydia treatment. It also followed private PGDs for 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 had the abbreviated formulary on the dispensary wall for reference.

The pharmacist was trained and competent to deliver flu vaccinations and followed the documented procedures. The pharmacy was part of an NHS pilot vaccinating people who met certain criteria. People had to be registered with a GP practice which was also part of the pilot. The main surgeries that this pharmacy dealt with were not part of the pilot, so the service was not very busy. During the inspection a person requested a private vaccination. The pharmacist spoke to him and ascertained that he was not feeling well. The pharmacist explained that it would be inappropriate to vaccinate him that day and requested that he returned when he was well. The pharmacist communicated this well and the person was satisfied. The pharmacist delivered the smoking cessation service although the medicines counter assistant promoted it. She was competent to sell nicotine replacement therapy products to people who did not want to engage with the NHS service. Foundation year one trainee doctors from a local GP practice spent short sessions in the pharmacy to understand pharmacy processes. The pharmacist explained that this was very useful and allowed these doctors to see first-hand how services such as

‘pharmacy first’ and the minor ailments’ service contributed to people’s care.

The pharmacy provided an online GP consultation service using ‘Medicspot’. The pharmacy had promoted the service to tour groups and hotels. It had seen a need for a service such as this as it was in an area popular with tourists. Usually people booked these appointments online although sometimes they could access the service by presenting at the pharmacy. So, the pharmacy could manage use of the consultation room around this. It usually required the pharmacy technician to stop assembling multi-compartmental compliance packs for the duration of the consultation due to the layout of these rooms. People were shown into the consultation room and shown the equipment. Then the consultation was carried out over Skype. The GP and the patient could see each other, and the GP explained to people how to use the equipment. GPs providing the service were based in London and most prescriptions were for antibiotics. Prescriptions were electronic token versions and the pharmacist was confident that they were legal and appropriate. Once the pharmacy had dispensed the medication, the prescription was completed, and the link was no longer available, so it could not be used anywhere else.

The pharmacy obtained medicines from licensed wholesalers such as alliance and AAH. It complied with the requirements of the Falsified Medicines Directive (FMD). Medicines were scanned on receipt. This process was quick because the company’s central buying team organised stock so that FMD compliant packs were all in one box. Team members scanned these items when they were dispensing which created a bag label with the barcode. They scanned the bag label as medicines were supplied to people which decommissioned the medicines. If people were waiting for their medicines, team members decommissioned them as they were dispensed. Team members marked split packs as they decommissioned them. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. 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. Team members raise concerns when equipment is not fit for purpose. And the pharmacy acts in a positive way to minimise any disruption to services.

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 blood pressure meter which was replaced as per the manufacturer's guidance, the 'Medicspot' kit which was around three months old, sharps' bin, gloves and sundries for vaccination and equipment required for emergencies during vaccination. The pharmacy team was able to call a technician if there were any problems with the 'Medicspot' equipment. The pulse oximeter was currently broken and had already been replaced. The pharmacy expected the technician to replace this again within the next few days. Team members kept ISO marked measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy had a 'Methameasure' pump available for methadone use and this was cleaned daily and test volumes poured twice a day. 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 consultation room and dispensary inaccessible to the public. It stored prescription medication waiting to be collected 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.