General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gilmerton Pharmacy, 2 Ferniehill Road, Gilmerton, EDINBURGH, Midlothian, EH17 7AB

Pharmacy reference: 1042665

Type of pharmacy: Community

Date of inspection: 26/01/2024

Pharmacy context

This is a community pharmacy in a residential area of Edinburgh that changed ownership in September 2023. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It delivers medicines for some people to their homes and supplies some people with their medicines in multi-compartment compliance packs to help them with taking their medicines. The pharmacy team advises on minor ailments and provides 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 appropriately manages the risks associated with the services it provides for people. It has a complete set of written procedures which help the team carry out tasks consistently and safely. Team members record and learn from the mistakes they make when dispensing. And they keep the records they need to by law. Team members have knowledge and experience to help support vulnerable people.

Inspector's evidence

The pharmacy had a comprehensive set of standard operating procedures (SOPs) to help team members manage risks. The SOPs had been recently reviewed by the superintendent pharmacist (SI) in September 2023 when the pharmacy changed ownership. Team members signed a record of competence to confirm their understanding of SOPs. They were observed working within the scope of their roles. And they were aware of the responsible pharmacist (RP) regulations and of what tasks they could and couldn't do in the absence of an RP.

Pharmacy team members recorded mistakes they identified during the dispensing process, known as near misses, on a paper record. They explained errors were highlighted to them by the pharmacist, and they would enter it onto the record after discussion with the pharmacist. This allowed them to reflect on the mistake. Team members explained that after an error, they would implement actions to reduce the likelihood of a similar error happening again. Recently there had been an increase in the incorrect quantity of medicines from bulk packs being dispensed into multi-compartment compliance packs. The team had modified the dispensing process following the increase in errors and dispensed the exact quantities of medicines into amber bottles rather than dispensing straight from the bulk packs into the compliance packs. This had reduced the recurrence of this type of error. Team members also recorded details of any errors which were identified after the person had received their medicines, known as dispensing incidents. These incidents were recorded and then reviewed by the SI. The pharmacy team aimed to resolve any complaints or concerns informally. But if they were not able to resolve the complaint, they would escalate to the SI. Team members advised that following the change of ownership, the volume of complaints received had significantly reduced. They had also viewed online reviews of the pharmacy which had improved since the change of ownership.

The pharmacy had current indemnity insurance. The RP notice displayed contained the correct details of the RP on duty, and it could be seen clearly from the retail area. The RP record was generally compliant but there were some missed sign-out entries on the record observed. The pharmacy had recently transferred from a paper-based controlled drug (CD) register to an electronic register and the entries checked were in order. Team members checked the physical stock levels of CDs against the balances recorded in the CD register on each dispensing and on receipt of CDs. And this was recorded on the register. The pharmacist advised that they checked the balance of all CDs on a weekly basis. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. Accurate records of private prescriptions were maintained electronically.

Team members were aware of the need to keep people's confidential information safe. And they were observed separating confidential waste to be shredded. The pharmacy stored confidential information

in staff-only areas. Pharmacy team members had completed learning associated with their role in protecting vulnerable people. And they had access to contact details to relevant local agencies. The pharmacist was a member of the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has sufficient team members with the right qualifications and knowledge to manage its workload and provide its services. The pharmacy team supports its members to complete appropriate training for their roles and keep their skills up to date. Members of the team work well together and communicate effectively. And they are comfortable raising concerns should they need to.

Inspector's evidence

The pharmacy had a full-time pharmacist who was also the SI. The pharmacist was currently completing their independent prescribing qualification. Other team members who worked in the pharmacy included a full-time dispenser, a part-time dispenser, a part-time medicines counter assistant and a part-time trainee dispenser. There was also a part-time delivery driver who had recently been enrolled on an accredited training course. Team members enrolled on registered training courses received regular protected learning time. And all team members completed regular training relating to their roles. Recently they had completed shadowing of the pharmacist utilising the new pharmacy computer system before using it under supervision. Team members had found this an effective learning technique. They had also completed training relating to the NHS Pharmacy First scheme.

Team members were observed working well together and managing the workload. Recently the staffing levels had been reviewed by the SI following an increase in workload. The pharmacy had employed an additional full-time dispenser who was due to start the following week. Planned leave requests were managed by the SI and only one team member was allowed to have planned annual leave at any time. Part-time staff supported by working additional hours during periods of planned leave. The team felt comfortable to raise any concerns with their SI. Members of the team received regular feedback as they worked and had documented appraisals with the SI on an ongoing basis.

Team members were observed asking appropriate questions when selling medicines over the counter and referring to the pharmacist when necessary. They explained how they would identify repeated requests from people for medicines subject to misuse, for example, codeine-containing medicines. And that they would refer them to the pharmacist. There were no targets set for pharmacy services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and the team maintains them to a high standard. The pharmacy has private consultation facilities where people can have confidential conversations with a pharmacy team member if needed. The pharmacy is secure when closed.

Inspector's evidence

The premises were secure and provided a professional image. The average-sized premises incorporated a retail area, dispensary, and a separate area to the rear of the pharmacy including storage space and staff facilities. The premises were clean and well maintained. There were sinks in the dispensary, staff room and toilet facilities. These had hot and cold running water, soap, and clean hand towels. The pharmacy had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions. This bench overlooked the medicines counter which enabled the pharmacist to intervene in a sale where necessary.

The pharmacy had a consultation room with a desk, chairs, sink and computer. The room was clean and tidy, and the door closed which provided privacy. Storage in the consultation room was kept locked to prevent unauthorised access. There was an additional consultation room which could be accessed directly from the dispensary area which was used to supervise a substance misuse service. Temperature and lighting were kept to an appropriate level throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to support people's health needs. It manages its services well and they are easily accessible to people. The pharmacy receives its medicines from reputable sources and stores them appropriately. The team carries out checks to help ensure the medicines are kept in good condition.

Inspector's evidence

The pharmacy had good physical access with a level entrance and a manual door to the main retail store. The pharmacy displayed its opening hours and some pharmacy services in the window. The team also kept a range of healthcare information leaflets for people to read or take away, these included information on depression and smoking cessation services.

Team members used dispensing baskets to safely store medicines and prescriptions throughout the dispensing process. This helped manage the risk of medicines becoming mixed-up. Team members signed dispensing labels to maintain an audit trail. The audit trail helped to identify which team member had dispensed and checked the medicine. The pharmacy offered a delivery service and kept records of completed deliveries including CDs.

Team members demonstrated a good awareness of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate, and of the associated risks. And they were aware of the most recent patient safety alert relating to valproate. Team members attached various alert stickers to prescriptions. They used these as a prompt before they handed out medicines to people who may require further intervention from the pharmacist.

A proportion of the pharmacy’s workload involved supplying people’s medicines in multi- compartment compliance packs. This helped people better manage their medicines. Team members used medication record sheets that contained each person’s medication and dosage times. They ordered people’s repeat prescriptions and reconciled these against the medication record sheet. They documented any changes to people’s medication on the record sheets and who had initiated the change. This ensured there was a full audit trail should the need arise to deal with any future queries. The packs were annotated with detailed descriptions of medicines in the pack, which allowed people to identify their medicines. The pharmacy supplied people with patient information leaflets. The compliance packs were signed by the dispenser and RP so there was an audit trail of who had been involved in the dispensing process.

Team members managed the dispensing of serial prescriptions as part of the Medicines: Care and Review (MCR) service. The prescriptions were stored alphabetically, and the team dispensed these when people requested them. They kept a record of the collection due date and supply date which allowed the team to monitor compliance. The team intended to begin to dispense serial prescriptions in advance of people collecting to help manage workload in the pharmacy. But there had been a delay to this starting as people using the service did not fully understand the prescription collection timeframes. This had improved following a period of patient education from the pharmacy team. The NHS Pharmacy first service was popular. This involved supplying medicines for common clinical conditions such as urinary tract infections under a patient group direction (PGD). The pharmacist could access the PGDs electronically and had printed copies to refer to. And they retained a copy of the consultation forms.

The medicines counter assistant asked people relevant consultation questions and referred to the pharmacy first formulary. They then suggested a treatment option to the pharmacist who completed the consultation. The regular pharmacist provided a private vaccination service. They had completed face-to-face vaccination training, basic life support training and an online training module prior to providing the service. And they had read the patient group directions (PGD).

The pharmacy obtained its stock medicines from licensed wholesalers and stored them tidily on shelves and in drawers. Team members had a process for checking expiry dates of the pharmacy's medicines. Short-dated stock which was due to expire soon was highlighted and rotated to the front of the shelf, so it was selected first. The team advised that they were up to date with the process and a random selection of medicines were checked and no out-of-date medicines were found to be present. The pharmacy had two medical grade fridges to store medicines that required cold storage. The team recorded daily checks of the maximum and minimum temperatures. A sample of the records seen showed the fridges were operating within the correct range of between two and eight degrees Celsius. The pharmacy received notifications of drug alerts and recalls via email. The team actioned the alerts and kept a printed record of the action taken. And they carried out the necessary checks and knew to remove and quarantine affected stock. The pharmacy had medical waste bins and CD denaturing kits to manage pharmaceutical waste.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to support the safe delivery of its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources including the British National Formulary (BNF), the BNF for children and the NHS Lothian Pharmacy First Formulary. And there was access to internet services. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. And it had a set of clean, well-maintained tablet counters. The pharmacy used an automated measuring pump for dispensing of some CD liquids that was calibrated before use and regularly cleaned. The pharmacy stored dispensed medicines awaiting collection, in a way that prevented members of the public seeing people's confidential information.

The dispensary was screened, and computer screens were positioned to ensure people couldn't see any confidential information. The computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones so team members could move to a quiet area to have private conversations with people.

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.