General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lindsay & Gilmour Pharmacy, 18-20 Woodburn Avenue, DALKEITH, Midlothian, EH22 2BP

Pharmacy reference: 1085676

Type of pharmacy: Community

Date of inspection: 08/07/2019

Pharmacy context

This is a community pharmacy in a residential area beside other shops. People of all ages use the pharmacy. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs.

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 processes for all services to ensure that they are safe. They record most mistakes to learn from them. They review these and make changes to avoid the same mistake happening again. The pharmacy asks people for feedback. Pharmacy team members discuss this to make pharmacy services better. 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) in place and team members followed them for all activities/tasks. All team members had read and signed them. The deputy superintendent pharmacist reviewed the SOPs every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs.

Dispensing, a high-risk activity, was smooth and logical with coloured baskets in use for dispensing. There was an audit trail in place for most dispensed medicines in the form of dispensed and checked by signatures on labels. The pharmacy had business continuity planning in place to address maintenance issues or disruption to services.

The pharmacy team members recorded dispensing near miss errors in an electronic near miss log. They recorded most but not all near misses. They had recorded five and 11 incidents respectively during the previous two months. The pharmacist reviewed these on receipt of a monthly summary and the team discussed them. Team members made some changes to reduce the chance of the same error happening again e.g. separating items on the shelves and placing labels on the shelf edges to draw attention to certain items. They had lengthy discussions regarding similar items following two identical errors reaching patients. Four team members had been involved between the two incidents. The deputy superintendent pharmacist was aware and dealing with one incident. A dispenser explained that one item was used very infrequently, and when team members saw it arriving in a delivery, they checked with colleagues to ensure that the correct item had been supplied the previous day.

Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. All team members were clear about activities that could not yet be undertaken by an inexperienced dispenser.

The pharmacy had a complaints procedure in place and asked people for feedback using a tablet device at the medicines counter. It had introduced this recently and a monthly summary was automatically generated. The previous month there had been several responses resulting in a high overall satisfaction score. The pharmacy had received a complaint recently from a person who had to wait for a liquid medication to be reconstituted. The pharmacy usually reconstituted this type of medicine at the point of supply as these medicines had a short expiry date once made. Following this complaint, it was discussed within the team. The team decided to tell people who were prescribed these medicines that their medicine would be reconstituted when they collected it. The pharmacy displayed its indemnity insurance, 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 drug (CD) registers, with running balances maintained and regularly audited; controlled drug (CD) destruction register for patient returned medicines. Alterations to records were attributable, by pharmacist's name and registration number. The electronic patient medication record (PMR) was backed up each night to avoid data being lost. At the time of inspection, two discrepancies in the CD registers had just been discovered but not yet investigated. The pharmacist explained that she would be investigating these on the same day and the NHS controlled drug accountable officer would be notified if they were not resolved.

Team members were aware of the need for confidentiality and had undertaken training on GDPR (general data protection requirements). People were not able to see any personal information and the pharmacy team segregated confidential waste for secure destruction. The pharmacy was asking all 'prescription collection service' patients to give signed consent to the pharmacy to collect their prescriptions from GP practices and this was being recorded on their record. Team members were also aware of safeguarding issues and the topic had been covered in accredited courses. The pharmacy had local processes and contact details displayed on the dispensary wall to be used to raise concerns. Team member described a situation where there was concern for a patient's health and an immediate appointment was made for the patient at the out of hours service. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough qualified and experienced staff to safely provide services. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is. The pharmacy makes changes. Team members have access to training material to ensure that they have the skills they need. The pharmacy sometimes gives them time to do this training. Members can share information and raise concerns to keep the pharmacy safe. They discuss incidents and learn from them to avoid the same thing happening again. Team members are not incentivised by targets.

Inspector's evidence

The pharmacy was staffed by one full-time pharmacist manager; one full-time trainee pharmacy technician; two part-time dispensers (30 and 32 hours per week), one who had recently qualified and the other had just completed her training; one Saturday only dispenser who worked in another branch during the week; one Saturday only medicines' counter assistant who worked in another branch during the week; one part-time delivery driver. The pharmacy manager had recently reviewed staffing levels with the cluster manager. This had resulted in recruitment underway for a part-time dispenser and increasing the delivery driver's hours. Previously he had worked three part-days, now he worked five. At the time of inspection, there was an accuracy checking technician (ACT) from another branch (working as a dispenser), a relief dispenser, and the full-time trainee pharmacy technician. The ACT worked regularly one day per week due to the ongoing recruitment, and the relief dispenser was covering annual leave. There was scope to cover absence from relief dispensers, part-time team members working additional hours and sharing staff between branches. Team members were able to manage the workload.

The pharmacy tried to give all team members half an hour per week protected learning time. They used this for reading new standard operating procedures, mandatory training dictated from head office or choosing modules of interest and relevance from the Numark hub. Currently this was challenging and not all team members were getting this time each week. The pharmacy displayed a timetable of protected learning time on the wall of the dispensary. And mandatory topics to be covered each job role within the quarter were listed. The trainee pharmacy technician was undertaking her training at home in her own time as there was no time during the working week. The pharmacy had recently established staff development using the 'five conversations' model.

The team members were observed going about their tasks in a systematic and professional manner, acknowledging people as they entered the pharmacy. Team members shared information with colleagues, particularly after phone calls had been taken – records were made, and relevant other team members were informed. They demonstrated an openness when describing dispensing errors that had been made and understood the importance of reporting these and sharing the learning.

The deputy superintendent had recently started sending monthly newsletters covering topics such as near misses, dispensing errors and similar sounding and looking medicines. All team members read and discussed this. The company had a staff forum with an appointed contact in each branch. The cluster representative attended meetings and cascaded information to the team member in this pharmacy. She followed this up with a phone call to ensure that all team members had been involved and informed. The pharmacy did not set targets. But the superintendent pharmacist sent data regularly so that the

team knew how it performed compared with others.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for its services. The pharmacy team members use a private room for some conversations with people. People cannot hear private conversations. The pharmacy is secure when locked.

Inspector's evidence

These were small premises with an adequately sized dispensary, small retail area and a very small back shop area with 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. Temperature and lighting were comfortable.

People were not usually able to see activities being undertaken in the dispensary. The pharmacy previously had an area where prescriptions were handed in straight to the dispensary, but a Perspex screen had been installed and there was a notice asking people to hand prescriptions in at the medicines counter. This prevented people seeing into the dispensary and minimised distraction. The pharmacy stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people.

The pharmacy had a consultation room with a desk, chairs, and sink which was clean and tidy and the door closed providing privacy. The door was kept locked to prevent unauthorised access. The pharmacist supervised some people with their medicine in this room.

The pharmacy was alarmed, had CCTV, and panic alarms. It had shutters protecting the front door and windows when the pharmacy was closed. A back door could only be opened from the interior. And rear windows were protected by bars.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps and advises people to ensure that they can all use its services. 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 mostly stores them properly.

Inspector's evidence

The pharmacy had good physical access by means of a gentle slope at the entrance and an automatic door. It displayed a list of its services. Pharmacy team members could signpost people to other services – there was a list on the dispensary wall of relevant services and agencies e.g. stop smoking, and services for young people and pregnant women.

The pharmacy had a good relationship with the local community, and recently the pharmacist had been invited to talk to a community group about pharmacy services. This had mostly been elderly people who were not regular patients of this pharmacy and they were had asked a lot of questions. The pharmacist was undertaking the independent prescribing qualification, specialising in substance misuse prescribing as she had identified a requirement for this.

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. The driver stored items requiring cold storage in a cool bag containing ice blocks during transport.

The pharmacy had a defined workflow for dispensing using coloured baskets to separate people's medicines and define prescription types. It had designated areas for dispensing and checking. Team members used pharmacist information forms (PIFs) to share information such as new medication or change in dose with the pharmacist. The patient medication record flagged changes. This enabled the pharmacist to undertake clinical assessments.

The pharmacy had dispensing audit trails in place in terms of initials on dispensing labels of personnel who had dispensed and checked medicines, except sugar free methadone instalments. Owings were usually assembled later the same day or the following day.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. It usually assembled these about a week in advance of the first supply, but at the time of inspection packs were being assembled for supply two days later. Team members acknowledged that this increased pressure. The pharmacist checked medicines after they had been gathered before they were placed into the compliance packs. The pharmacist sealed the packs while carrying out a final accuracy check after medication was fully dispensed. Team members attached backing sheets firmly to packs and put tablet descriptions on these. Patient information leaflets (PILs) were supplied with the first pack of each prescription. The pharmacy kept thorough records of any changes or other clinical information, including dates and prescriber or other personnel involved. It kept a diary listing which trays were due for assembly and team members worked through this in chronological order.

Dispensers poured methadone instalments using the 'methameasure' device. Most instalments were supervised, and the pharmacist checked these and then undertook the supervision. Dispensers input the data onto the computer system when prescriptions were received, and the pharmacist checked this for accuracy. The pharmacy supplied several people with a variety of other medicines by instalment. It assembled these weekly at the weekend for the following week.

The pharmacist undertook clinical checks and counselled people as required but especially people receiving high risk medicines including valproate, methotrexate, lithium, and warfarin. Written information and record books were provided if required. The valproate pregnancy prevention programme was in place. The pharmacy had identified one person in the at-risk group and the pharmacist had given appropriate counselling. The non-steroidal anti-inflammatory drug (NSAID) care bundle had been implemented and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. 'Sick day rules' were also discussed with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacist kept all this literature in one place and all team members knew where it was.

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, chloramphenicol ophthalmic products and chlamydia treatment. The pharmacy provided medicines prescribed on chronic medication service (CMS) prescriptions to two people. It was sometimes registering people for the service, with people completing their own questionnaire and few pharmaceutical care issues identified. Sometimes people asked the pharmacist questions about the service, but there was little uptake from local GP practices. Team members were empowered to deliver the minor ailments service (eMAS) within their competence. They described symptoms that they could deal with and others that they referred to the pharmacist. The pharmacist delivered the smoking cessation service.

The pharmacy obtained medicines from reputable suppliers such as Alliance and AAH. It was compliant with the requirements of the Falsified Medicines Directive (FMD). Medicines were scanned (commissioned) when stock arrived then decommissioned at the point of supply. All team members were trained and competent – they had undertaken training and the system had been demonstrated to them a few months previously. Pharmacy team members checked expiry dates of medicines, keeping records of this and marking short dated items. They stored most medicines in original packaging on shelves/in drawers and cupboards. A few medicines were observed incompletely labelled in bottles on shelves. And some shelves were untidy, increasing the risk of the wrong item being selected. Items requiring cold storage were stored in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. The pharmacy protected pharmacy (P) medicines from self-selection. And 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 a patient level recall. Items received damaged or faulty were returned to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for 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.

It kept equipment required to deliver pharmacy services in the consultation room where it was used with patients accessing these services. This included a carbon monoxide monitor maintained by the health board. The pharmacy had Crown stamped measures including separate marked ones for methadone solutions. It had a 'Methameasure' pump device for methadone. A team member cleaned this each day after use and poured test volumes each morning when it was set up.

Clean tablet and capsule counters were available, and a separate marked one was used for cytotoxic tablets. The pharmacy kept paper records in the dispensary inaccessible to the public. Team members did not leave computers unattended and used passwords.

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.