General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Balerno Pharmacy, 24 Main Street, BALERNO, Midlothian, EH14 7EH

Pharmacy reference: 1085731

Type of pharmacy: Community

Date of inspection: 13/09/2024

Pharmacy context

This is a community pharmacy in Balerno village in Midlothian. Its main activity is dispensing NHS prescriptions. And it supplies medicines in multi-compartment compliance packs to some people who need help remembering to take their medicines at the right times. The pharmacy offers a medicines delivery service. And it supplies a range of over-the-counter medicines. The pharmacy team advises on minor ailments and medicines' use.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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 identifies and manages the risks with its services. Pharmacy team members follow written procedures to help them safely carry out tasks. They keep the records they need to by law, and keep people's private information safe. The team is adequately equipped to manage any safeguarding concerns. Team members record and review details of mistakes they make while dispensing and learn from these to reduce the risk of further mistakes.

Inspector's evidence

The pharmacy had a set of electronic standard operating procedures (SOPs), and records showed that team members had read and agreed to follow them. The SOPs covered tasks such as the dispensing process, dealing with dispensing errors and the sale of pharmacy medicines. Team members described their roles within the pharmacy and the processes they were involved in and accurately explained which activities could not be undertaken in the absence of the responsible pharmacist. The pharmacy employed a pharmacy technician who carried out accuracy checks (ACPT). Team members demonstrated the process of prescriptions being clinically checked by the pharmacist prior to dispensing and how this was clearly marked on the prescriptions. This enabled the ACPT to complete the accuracy check. The pharmacy had a business continuity plan to address disruption to services or unexpected closure. Team members described the process for branch closure when there was no responsible pharmacist available.

Team members kept records about dispensing mistakes that were identified in the pharmacy, known as near misses. And they recorded errors that had been identified after people received their medicines. They occasionally reviewed all near misses and errors to learn from them and they introduced strategies to minimise the chances of the same error happening again. For example, a white board in the dispensary detailed the medicines the team were not reordering due to excess stock taking up too much space in the pharmacy. And team members separated some higher risk medicines into baskets on the shelves to prevent them being mixed up. Team members demonstrated how mistakes were recorded using mobile devices and a quick access (QR) code in the dispensary. This made it easier for them to record mistakes when they happened. The pharmacy had a complaints procedure and welcomed feedback. An electronic device next to the healthcare counter allowed people to provide feedback on the service they had received. And responses were sent to the pharmacy's head office team to review. Team members tried to manage complaints informally within the pharmacy and they knew to provide the contact details for the Superintendent pharmacist's (SI) office if people wished to escalate the complaint.

The pharmacy had current professional indemnity insurance. It displayed the correct responsible pharmacist notice and had an accurate responsible pharmacist record. From the records seen, it had accurate private prescription records including records about emergency supplies and veterinary prescriptions. It kept complete records for unlicensed medicines. The pharmacy kept digital controlled drug (CD) records with running balances. A random balance check of the physical stock of three controlled drugs matched the balance recorded in the register. Stock balances were observed to be checked against the balances in the CD register on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy and team members recorded entries on receipt.

Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste and securely shredded it. No person-identifiable information was visible to the public. A privacy notice on the waiting room wall provided assurance that the pharmacy protected people's personal information. The pharmacy had a documented procedure to help its team members raise any concerns they may have about the safeguarding of vulnerable adults and children. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. A team member discussed the safeguarding training they had received. And explained the process they would follow if they had concerns and would raise concerns to the RP. Team members were aware of national schemes to help people suffering domestic abuse access a safe place. They knew how to raise a concern locally and had access to contact details and processes. The pharmacy had a chaperone policy in place and displayed a notice of this on the door to the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the necessary qualifications and skills to safely provide the pharmacy's services. They manage their workload well and support each other as they work. They feel comfortable raising concerns, giving feedback and suggesting improvements to provide a more effective service. And the pharmacy has adequate procedures in place to help its team manage the workload in the event of unplanned staff absence.

Inspector's evidence

The pharmacy employed one full-time pharmacist manager, a full-time ACPT, three part-time dispensers, a part-time medicines counter assistant and a part-time delivery driver. The pharmacy displayed their certificates of qualification. The pharmacy reviewed staffing levels regularly. It used rotas to manage staff levels depending on workload. Part-time team members had some scope to work flexibly providing contingency for absence. And the company employed relief team members who provided cover when required. On the day of the inspection, a locum pharmacist was the responsible pharmacist, and the team were supported by a relief dispenser who was covering planned annual leave. The team communicated openly throughout the inspection and were seen to be managing the workload.

The pharmacy planned learning time during the working day for all team members to undertake regular training and development. And it provided team members undertaking accredited courses with additional time to complete coursework. But team members sometimes missed their training time if the pharmacy was particularly busy at that time. A trainee dispenser had recently completed their course and described the training plan that they had worked through. The ACPT had recently completed training to provide an ear-wax removal service using microsuction. Their training was supported by supervised consultations so that they could demonstrate they were providing the service safely. Team members had informal discussions with the pharmacy manager to identify their learning needs. They felt able to make suggestions and raise concerns to the manager or area manager. And they completed feedback forms that were returned to the pharmacy’s head office team. They were observed to work on their own initiative, for example to phone the GP practice to ask about missing prescription items. They asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The pharmacy team discussed incidents and how to reduce risks. The pharmacy had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides. And they are clean, secure, and well maintained. The pharmacy has an appropriate sound-proofed consultation room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was averaged-sized and included a retail area with a healthcare counter which led to a raised dispensary and back shop area. This included storage space and staff facilities. The premises were clean, hygienic and well maintained. There were sinks for professional use and hand washing. These had hot and cold running water, soap, and clean hand towels. The pharmacy’s overall appearance was professional. The pharmacy had clearly defined areas for dispensing and the RP and ACPT used separate benches to complete their final checks of prescriptions.

People in the retail area were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room which was clean and tidy with a desk, chairs and sink. And the door closed which provided privacy. It provided a suitable environment for the administration of vaccinations and other services. The door was kept locked to prevent unauthorised access. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which it makes accessible to people. And it manages its services well to help people look after their health. The pharmacy sources, stores and manages medicines safely. This ensures that the medicines it supplies are fit for purpose. And the pharmacy team provides appropriate advice to people about their medicines.

Inspector's evidence

The pharmacy had good physical access by a ramp from the pavement. The healthcare counter was positioned so that team members could assist people who required help with opening the door. The pharmacy advertised opening hours in the main window. And digital screens in the window and inside the pharmacy advertised its services. It had a hearing loop for people wearing hearing aids to use, but not all team members were aware of how to use it. Team members used online translation services to communicate with people who did not use English as their first language. The pharmacy provided a delivery service and maintained an electronic audit trail of the medicines it sent through its delivery service.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and to separate people's medicines and prescriptions. And they attached coloured labels to bags containing people's dispensed medicines to act as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line or a CD that needed handing out at the same time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked medicines. They also initialled prescriptions to provide an audit trail of personnel involved at every stage of the dispensing process including clinical checks.

Some people received medicines from Medicines, Care and Review serial prescriptions. The pharmacy prepared these in weekly batches in advance of when they were required. Team members maintained records of when people collected their medication. And they regularly checked for any prescriptions that had not been collected. This meant they could then identify any potential issues with people not taking their medication as they should. They then communicated with the GP practice to ensure the prescription remained appropriate. The pharmacy supplied medicines in multi-compartment compliance packs for people who needed extra support with their medicines. Pharmacy team members managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept master backing sheets for each person. These master sheets documented the person's current medicines and administration time. And there was a record of previous changes to medication, creating an audit trail. Packs were labelled so people had written instructions about how to take their medicines. These labels included descriptions of what the medicines looked like, so they could be identified in the pack. And team members provided people with patient information leaflets about their medicines each month. Shelving to store the packs was kept neat and tidy. The pharmacy sent some packs to be prepared using automation at another of the company's pharmacies, known as the hub pharmacy. The pharmacy team was responsible for the accuracy of the data entered into the computer for prescriptions dispensed at the hub pharmacy. And the pharmacist completed an accuracy and clinical check of the information before it was then sent electronically to the hub and used to prepare the packs offsite. Packs had an accuracy check completed at the hub pharmacy and they were then sent

back to the pharmacy for collection.

Team members had knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. And they always dispensed valproate in the original pack. The pharmacy supplied patient information leaflets and patient cards with every supply. The pharmacy had patient group directions (PGDs) for unscheduled care, treatment of urinary tract infections, emergency hormonal contraception, and treatment of skin infections. Paper copies of the PGDs were available in the pharmacy. And the locum pharmacist accessed the most recent resources for this service online. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They referred to the pharmacist as required. The regular pharmacist provided a private travel clinic using private PGDs. They maintained electronic and paper records of consultations and any vaccines administered or medication supplied.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves, in drawers and in cupboards. And team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. And team members followed the sale of medicines protocol when selling these. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy had disposal bins for expired and patient-returned stock. Team members appropriately separated returned medication during the inspection. The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records about what it had done. 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 to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had access to the internet and a range of further support tools. This included the British National Formulary (BNF) and local health board formulary. So the pharmacy team could refer to the most recent guidance and information on medicines. The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included equipment for ear wax removal, weighing scales and a carbon monoxide meter. Equipment was cleaned and maintained regularly. Equipment to support the team in completing dispensing tasks was readily available. This included clean counting and measuring equipment.

Information displayed on the pharmacy's computer monitors was protected from unauthorised view. The pharmacy stored paper records in the dispensary inaccessible to the public. And it stored bags of assembled medicines safely and in a way which meant details on bag labels and prescription forms could not be read from the public area. Team members used a cordless telephone handset when speaking on the telephone. This meant they could move to suitable areas of the pharmacy to protect people's confidentiality when speaking to them over the telephone.

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.