General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gillbrae Pharmacy, Pharmacy Unit At The New, Gillbrae Medical Practice, Gillbrae Road, DUMFRIES, Dumfriesshire, DG1 4EJ

Pharmacy reference: 1100088

Type of pharmacy: Community

Date of inspection: 31/07/2023

Pharmacy context

This is a pharmacy next to a doctor's surgery in Dumfries. Its main activities are dispensing NHS prescriptions and supplying medicines in multi-compartment compliance packs to people so they can take their medicine safely and effectively. It provides a range of services including advice and treatment under the NHS Pharmacy First Scheme and it delivers medicines to people in their homes. This pharmacy recently changed ownership and the same team members work in the pharmacy as before.

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 follows written procedures to help ensure it delivers its services safely and effectively. It generally keeps the records that are needed by law. But some records are incomplete so the pharmacy may not always be able to show that it has acted appropriately. Team members discuss their mistakes and record them so that they can learn from them. They keep people's private information secure, and they know how to protect vulnerable people and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) that were relevant to its practice and included controlled drug (CD) and responsible pharmacist (RP) SOPs. They helped inform team members how to complete tasks safely and effectively and they were available in paper form for easy referencing. They had been written and authorised by the superintendent pharmacist (SI) and were annotated with the date of review in two years' time. The SOPs had been entirely replaced when the pharmacy recently changed ownership and not all team members had read and signed to say they understood and would comply with them. However, the area manager explained that it would take time to work through the SOPs and that team members were focussing on one SOP a week.

The pharmacy recorded errors identified during the dispensing process so that the team could learn from them. The team member who made the error was responsbile for recording the details when identified by the pharmacist. The errors were recorded on paper and the records showed errors had been recorded for each month since the pharmacy changed ownership. The supervisor explained that she used the information from these near miss records to identify trends. She admitted no analysis had been carried out since the pharmacy had changed ownership approximately eight weeks previously, but she planned to review the records in the near future. However, she confirmed near misses were always discussed at the time they came to light with the team member who made the error. Team members had previously taken steps help prevent similar errors being repeated. For example, they had identified repeated near misses involving some medicines that looked-alike and sounded-alike (LASA), so these had been separated to help reduce selection errors. And they kept a sheet detailing various examples of common LASAs for team members to be aware of when dispensing. There was also a procedure in place to record dispensing errors that were not identified until after a person had received their medication. They confirmed the process was to complete an investigation and root cause analysis and record the incident on the patient's record. But there were no records available, and the team confirmed there had been no such dispensing errors since the pharmacy had changed ownership. Due to this, and the fact the incidents were recorded on paper, they were unsure whether these incidents would be shared with the SI.

Team members were experienced in their roles and were able to describe the tasks that they were responsible for. They knew what could and could not take place in the absence of the RP. The RP notice was displayed prominently in the retail area and reflected the details of the pharmacist on duty. The pharmacy did not have a formal complaints policy that team members were aware of, and nothing was displayed to advise people how they could make complaints or give feedback. However, the supervisor explained how she would attempt to resolve any complaints and, if unresolved, that she was able to contact the area manager for further advice. She confirmed this process had not needed to be engaged since the takeover. And feedback since the takeover had been positive. Team members had asked

people using the pharmacy about the products they would like to see in stock. And they had acted on this by ordering in products for people to purchase. Current professional indemnity insurance had recently been purchased and a copy of the certificate was provided.

The pharmacy kept mainly paper records, except for the record of its RP, fridge temperatures and for medicine used in the provision of the substance misuse service, which were kept electronically. Both the paper and electronic controlled drug (CD) registers recorded all required details. Running balances were recorded and team members checked CD stock against the running balance weekly. A check on a randomly selected CD matched the recorded balance. Records of patient returned CDs were made at the time they were returned, and the medicines were destroyed in a timely manner. RP records for July showed ten instances were the RP had not annotated the record to confirm when they ceased being the RP. And no record of the RP had been made on two days. Records of unlicensed medicines were generally in order. Private prescription records mostly captured the required details, but one entry was missing the dates of the prescription and supply.

Team members were aware of their responsibilities to ensure that people's private information was kept secure. They had been given training on information governance (IG) and General Data Protection Regulation (GDPR) by their previous employer. And they had completed refresher training annually. But they were unsure as to the training requirements of their new employer and had not received any training since the takeover. Confidential waste was separated for destruction and kept in bags, but they were not yet sure whether it was going to be destroyed in the pharmacy using a shredder or by a third-party company.

Team members were aware of their responsibilities for safeguarding vulnerable adults and children. They had been provided with a SOP detailing the processes to follow, but team members were still to read and sign this. However, they explained that they would refer any concerns they had to the RP. And the deliver driver confirmed he would also report back any concerns from the home deliveries. The locum pharmacist confirmed he was registered under the PVG scheme but had not completed any formal training regarding safeguarding.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to manage the workload and deliver its services safely and effectively. There is an open and honest culture within the team and team members discuss their mistakes together to learn from them. And they feel comfortable raising concerns if they need to.

Inspector's evidence

At the time of the inspection there was a regular locum, who was the RP, and five trained dispensers, one of whom was the supervisor. Additionally, there was one dispenser who, although having been employed for two years, had only recently returned from a period of absence, and was not enrolled on an accredited training course. The supervisor explained that she had originally been enrolled on a course, but it was stopped during the period of absence. The supervisor knew that the requirement was for the dispenser to be enrolled within three months of starting work. There were two part-time delivery drivers who were also still to be enrolled on accredited training for their roles, having only been employed since the new owners took over. Team members who had been employed by the previous owner had worked within the pharmacy for many years together and were experienced. They were observed working well together to manage the workload. Staff from other branches within the company covered absences and holidays if needed. And the supervisor ensured work rotas were in place which helped ensure that each task was included and completed in a timely manner by a named person.

Team members had not had the chance to undertake any ongoing training since the takeover. But they had received regular ongoing training under their previous employer. The supervisor explained they had recently received a training pack for a new medicine that could be sold at the medicines counter. And she planned to give it to one of the regular pharmacists to arrange training for the team. She explained that for most medicines which had been declassified as prescription only medicines (POM) it was the pharmacist who completed the consultation. The locum pharmacist was trained to provide services for the NHS Pharmacy First Scheme and had signed to say he was competent in the delivery of the services.

The pharmacist and team members were observed assisting each other with queries. The counter assistant described the questions people were asked when purchasing medicines over the counter. And team members knew to be vigilant for repeated requests for medicines liable to misuse. A dispenser explained this included people who received a specific quantity of medicines on prescription on a routine basis, and any such requests were referred to the person’s GP. Team members felt able to discuss their mistakes openly and felt comfortable to raise concerns. And they knew who to raise concerns with, although they had never needed to. They had not yet received any reviews or been set targets since the takeover.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy and provides suitable space for the services it delivers. It has an appropriately soundproofed room where people can access services and have private conversations with team members.

Inspector's evidence

The pharmacy was clean, tidy, and free from clutter. And it portrayed a professional appearance. The retail area and dispensary were spacious. Team members organised the dispensary well and medicines were stored alphabetically and neatly in drawers and on shelves. There was a good workflow with different bench spaces for team members to complete different tasks. The medicines counter acted as a barrier and allowed access to the dispensary for authorised people only. The dispensary was protected from view of people in the retail area so that dispensing tasks could take place without distraction. And the pharmacist's checking area was situated so that they were able to intervene in conversations at the medicines counter if necessary.

The pharmacy had a soundproofed consultation room where people could have private conversations with team members and access services from the pharmacist. The room had a desk and appropriate space to allow services to be carried out safely. There was a sink in the consultation room which provided hot and cold water. There were some totes containing pharmacy only (P) medicines and general sales list (GSL) medicines in the consultation room. But the counter assistant was unsure what the new owners were planning to do with them. The consultation room was not lockable, but the medicines counter assistant worked directly adjacent to it so was able to prevent unauthorised access. The pharmacy had a cleaning rota which detailed which tasks were to be completed and when. It was up to date and signed by team members to confirm that the various tasks had been completed. There was a sink in the dispensary for professional use and for handwashing. And the toilet facilities were clean, hygienic, and provided hot and cold water and soap for handwashing. The lighting was bright throughout the dispensary and the temperature was comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services well. It has appropriate procedures to ensure people receive their medicines when they need them. Team members store and manage medicines as they should. And they carry out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy had level access from outside. There was an automatic door which helped provide access to those with limited mobility and with pushchairs. The pharmacy delivered some people's medicines to their homes. The driver confirmed that people were asked to sign for their deliveries. Each person who was due to receive a delivery had their name printed on a delivery sheet, and this was handed to the person to sign. To avoid any risk of this breaching confidentiality, the driver agreed that in future he would fold the paper in half when asking people to sign so that other people's names and addresses were not visible. And the supervisor confirmed she would ask the other driver to also do this. Team members put stickers on bags with to alert the driver to the presence of a CD or fridge line. Fridge lines were priortised and delivered within a few hours because there was no fridge within the van.

The pharmacy provided treatment and advice for a range of conditions under the NHS Pharmacy First Scheme. This included urinary tract infections, shingles, and impetigo. The service was underpinned by patient group directions (PGDs) and the pharmacy had the most up-to-date copies for the pharmacists to refer to. Consultation forms were retained.

When dispensing, team members kept people's prescription forms and medicines together in baskets to help prevent errors. And they used stickers to highlight actions needed, such as an intervention by the pharmacist or the need to add a fridge line or controlled drug at the time of supply. Team members signed dispensing labels to indicate who had dispensed and item and who had checked it. They were aware of their additional responsibilities to ensure that people were counselled appropriately when they received higher-risk medicines. They were aware of the patient safety cards to be given to people in the at-risk category taking valproate. A dispenser explained they had one patient who was in the at-risk category and had been previously counselled and was aware of the requirements, but she was not sure if the person was counselled and given a card every time the medicines were supplied.

The pharmacy dispensed some medicines into multi-compartment compliance packs to help people take them at the right times. A dispenser was the main person responsible for managing the service, but each team member was trained to dispense the packs so that holidays and absences could be covered. The dispenser explained that prescriptions were ordered ahead of time so any queries could be resolved by the GP. Communications regarding changes to a person's pack or information about early collections was kept in a communications book. Each person had a record of their medicines to be supplied in the packs and the times of day each medicine should be taken. Packs that included CDs or medicines that may lose stability when dispensed from the original pack had these added to the pack the day before they were due to be supplied. Team members provided patient information leaflets with the packs, so people had the necessary information to take their medicines. And they added descriptions to the backing sheets provided with the packs to help people identify the individual medicines.

Team members completed checks on the expiry dates of stock medicines. They highlighted medicines that were going out of date in six months with a 'short dated' sticker for use first. And they recorded these on a sheet which showed they had identified medicines as going out of date within the next six months. Liquid medicines with a short expiry date on opening were marked with the date of opening. The pharmacy's SOP stated that date checking was to be completed weekly, but the records showed that it was being done monthly. However, the supervisor and a dispenser confirmed the entire dispensary had been date checked within the last month due to the takeover. A random sample of dispensary stock was checked, and the medicines were all found to be in date. Medicines in the fridge were kept neatly and well organised. Team members recorded daily fridge temperatures electronically. The records for July showed that on a few occasions the fridge temperature had not been recorded, but all records were within the appropriate temperature range. Team members understood the process for managing drug alerts and medicines recalls. These were received via NHS email. They were to print, sign, and stamp the alerts to confirm the action was taken. But they had received no alerts since they had been taken over. Medicines that were returned by people were kept separately and collected for disposal by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses the equipment and facilities in a way that protects people’s private information.

Inspector's evidence

The pharmacy had access to both paper and electronic copies of the British National Formulary (BNF) and British National Formulary for children (BNFc). It used stamped measuring cylinders that were marked for measuring water and liquid medicines. And there were brushes used for cleaning the cylinders. The cylinders were dirty, but the team gave assurance that they were normally cleaned after use and would be cleaned before next use. There were clean triangles used to count medicines and a separate one was marked for use for cytotoxic medicines. An automated machine was used to measure liquid medicines for the substance misuse service, and it was calibrated and cleaned daily. There were kits used for the destruction of controlled drugs.

Team members used a cordless telephone so that conversations could be kept private. Computers were protected against unauthorised access as they were password protected. The PMR system did not log off after a period of inactivity, increasing the risk of staff utilising each other's log in details. Some team members had not been provided with a password to access the system. Screens were positioned so that only team members could see them. Prescription forms were stored within the dispensary in a way that prevented people in the retail area from seeing any private information. The pharmacist was seen to be using the consultation room during the inspection 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.