General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lingdale Pharmacy, 29 High Street, Lingdale, SALTBURN-BY-THE-SEA, Cleveland, TS12 3DZ

Pharmacy reference: 1107165

Type of pharmacy: Community

Date of inspection: 26/07/2023

Pharmacy context

This pharmacy is in the small rural village of Lingdale in Cleveland. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies several people with their medicines in multi-compartment compliance packs to help them take their medicines properly. And it delivers medicines to many people's homes. The pharmacy offers other NHS services including the Community Pharmacist Consultation Service (CPCS). And it holds a wholesale dealers' licence.

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 suitably identifies and manages the risks associated with its services. It has written procedures that the pharmacy team follows and it completes the records it needs to by law. Team members protect people's private information correctly and they understand their roles in safeguarding the safety and wellbeing of children and vulnerable adults. They respond suitably to errors by discussing what happened and taking appropriate action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. The SOPs had review dates of 2021 but there was no evidence this had happened. Team members had read and signed the SOPs signature sheets to show they understood and would follow them. They demonstrated a clear understanding of their roles and worked within the scope of their role.

The SOPs included details on how to record and learn from errors identified during the dispensing process, known as near misses. A sample of near miss records showed the details recorded by the team members enabled patterns to be identified. And the records captured the action taken by the team member involved to prevent the error from happening again. For example, one entry recorded the team member was to double check the quantity dispensed from partially used packs of medicines. The pharmacist manager completed a monthly review of near miss errors and discussed the outcome with team members, along with the actions they could take to prevent similar errors. These discussions had led to the team separating some medicines that looked alike, to help reduce picking errors. A procedure was in place for managing errors that were identified after the person received their medicines, known as dispensing incidents. This included recording the dispensing incident and making all team members aware of the incident. The team reported there had not been any recent dispensing incidents.

The pharmacy was given feedback from some people who had needed their medication urgently and were pleased with the help they received from the team. Team members explained they had a good working relationship with the pharmacist at the local GP surgery. And this enabled them to request prescriptions and dispense medicines for people who urgently needed them.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records, records of medicines supplied against private prescriptions and controlled drug (CD) registers met legal requirements. The correct RP notice was displayed. Appropriate records were kept of CDs returned by people for destruction. Team members understood their roles in protecting people's private information and the pharmacy displayed a privacy notice. Confidential waste was separated in clearly marked containers and shredded offsite.

Team members had safeguarding information and training appropriate to their role. And they had access to contact numbers for local safeguarding teams. The delivery driver reported concerns back to the team who took appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they discuss ideas to enhance the safe delivery of the pharmacy's services. Team members have opportunities to undertake some training so they can suitably develop their skills and knowledge. And they feel comfortable raising concerns and making suggestions.

Inspector's evidence

A full-time pharmacist manager and regular locum pharmacists covered the opening hours. The pharmacy team consisted of two full-time dispensers, two part-time dispensers and a part-time delivery driver. At the time of the inspection the pharmacist manager, and all team members were on duty. Team members had experienced an increase in their workload as people stopped using the services of a nearby pharmacy and relocated to this pharmacy. They worked very well together to manage the workload and they ensured people presenting at the pharmacy were promptly helped. This included working additional hours to support the increased volume of work. One of the full-time dispensers was leaving the pharmacy's employment. So, the pharmacy was in the process of recruiting for the post and for additional hours to support the team's increased workload.

Additional training for team members to keep their knowledge up to date was centred around that required for the NHS Pharmacy Quality Scheme such as infection prevention and control. Team members received feedback on their performance from the pharmacist manager who arranged for these sessions to be done during protected time. They used these one-to-one sessions to discuss opportunities to develop their knowledge and skills. For example, one of the dispensers had expressed interest in the accuracy checking course.

The team held regular meetings and team members shared ideas. One of the dispensers had suggested a new filing system for storing prescriptions for the medicines supplied in compliance packs. This was agreed with other team members who reported the new system had improved the efficient delivery of this service. Team members set themselves targets for services such as the NHS New Medicines Service and reviewed their progress with meeting the targets at team meetings.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy premises were tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, with hot and cold water available along with hand sanitising gel. In response to the COVID-19 pandemic the pharmacy had installed a clear plastic screen on the pharmacy counter. Heating and lighting were kept to an acceptable level in the dispensary and retail areas. The dispensary was small, but team members managed the space well and worked in a tidy and organised manner. There was enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a defined professional area and items for sale in this area were healthcare related. A small, soundproof consultation room enabled the team to have private conversations with people and to provide services such as the NHS COVID-19 booster vaccinations. The pharmacy prevented unauthorised access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which help people to meet their healthcare needs. Team members manage the pharmacy services well to help make sure people receive medicines when they need them. They store medicines properly and they complete regular checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via two small steps with a handrail located on one side of the entrance. A doorbell was available for people to alert the team when they needed help accessing the pharmacy. A defibrillator was located on the outside wall of the pharmacy. Team members wore name badges detailing their role so people using the pharmacy knew who they were speaking to. And they provided people with information on how to access other healthcare services when required. There was a range of healthcare information leaflets for people to read or take away. Team members asked appropriate questions when selling over-the-counter (OTC) medicines and they monitored people's requests for OTC medicines to ensure the supplies were suitable for the person.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. One team member managed this service with support from other team members when required. A list of people due their medication was kept so the team could plan the preparation of the packs. And prescriptions were requested in sufficient time to allow queries such as missing items to be managed. A room to the rear of the dispensary away from any distractions was used for dispensing and checking the packs. Team members labelled the packs with directions of when to take the medicines and they recorded the descriptions of the medication within the packs. But they rarely supplied the manufacturer's packaging leaflets. So, people could identify the medicines in the packs but had limited information about the medicines they were taking. The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. And they were stored separately and securely.

The team provided people with clear advice on how to use their medicines. The pharmacist held conversations with people on higher-risk medicines but didn't always record this on the pharmacy's patient medication record (PMR) for the team to refer to. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided. But occasionally the pharmacist missed the opportunity to speak to people prescribed valproate to provide them with the correct information.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Pharmacy team members initialled 'dispensed by' and 'checked by' boxes on dispensing labels, to record their actions in the dispensing process. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The pharmacy delivered medication to many people in the area as access to public transport was limited for several people. Team members kept a record of the deliveries to refer

to when queries arose.

The pharmacy obtained medication from several reputable sources and the team members followed the pharmacy's procedures to ensure medicines were safe to supply. They checked the expiry dates on stock and kept a record of this. Medicines with a short expiry date were marked to prompt the team members to check the medicine was still in date. And they kept a list of medicines due to expire each month. The dates of opening were recorded for medicines with altered shelf-lives after opening so the team could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And it stored out-of-date and returned CDs separate from in-date stock in CD cabinets that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. Team members printed off the alert, actioned it and kept a record. The pharmacist manager regularly checked the MHRA website to ensure they had not missed any alerts. The pharmacy's wholesaling activity was minimal and had little impact on the team's workload and the storage space in the pharmacy.

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 suitably to protect people's private information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And two fridges for holding medicines requiring storage at this temperature. The pharmacy completed safety checks on the electrical equipment.
Up-to-date adrenaline pens were available in the consultation room for the pharmacist to use in the event of a person having an anaphylactic reaction to the flu vaccine or the COVID-19 booster vaccine.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. Team members used cordless telephones to ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other private information in the dispensary and rear areas, which had restricted public access.

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.