General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M & D Green Dispensing Chemist Ltd, Great Glen Pharmacy, Lewiston, Drumnadrochit, Inverness, Highland, IV63 6UL

Pharmacy reference: 9011181

Type of pharmacy: Community

Date of inspection: 04/11/2024

Pharmacy context

This is a community pharmacy in the small village of Drumnadrochit on the north-western shore of Loch Ness. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. It provides medicines in multi-compartment compliance packs to people who need help to take their medicines at the right time. And it supplies medicines to people living in nursing homes. The pharmacy provides a medicines delivery service over a vast area. And team members provide advice on medicines' use.

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 suitably identifies and manages the risks with the services it provides. Team members record and discuss mistakes made during the dispensing process, and they make changes to mitigate the risk of the same mistake happening again. And they understand their role in helping to protect vulnerable people. The pharmacy keeps the records it needs to by law, accurate and up to date.

Inspector's evidence

The pharmacy had a comprehensive set of standard operating procedures (SOPs) available to support its team members to work safely and effectively. SOPs were paper-based and easily accessible. Some SOPs were overdue their review date, this included SOPs about supplying medicines in multi-compartment compliance packs, supplying medicines to people living in prisons and the responsible pharmacist (RP) regulations. SOPs were reviewed every two years by the superintendent pharmacist (SI). The responsible pharmacist (RP) explained some SOPs had recently been reviewed and they reflected the current working practices. But the documentation had not yet been updated to reflect the updated review dates. There was no signature sheet attached to SOPs to show team members had read and understood them. But team members spoken to at the time of inspection confirmed they had read them and regularly refer to them as needed. And they were observed to be working within processes detailed in SOPs. This was discussed at the time of inspection and the RP provided assurances they would implement a signature sheet to evidence team members had read the SOPs. Team members described their roles and responsibilities within the pharmacy and accurately described what activities they could or couldn’t undertake in the absence of the RP.

A signature audit trail on medicines labels showed who had dispensed and checked each medicine. This meant the RP was able to help team members learn from dispensing mistakes identified within the pharmacy, known as near misses. The pharmacy kept electronic records of near misses and included details such as the date and time the near misses happened, and any contributing factors. Team members were encouraged to record the near miss when it happened as a method of reflection following a mistake. Mistakes that were identified after a person received their prescription, known as dispensing incidents, were recorded on the same online system. All near misses and dispensing incidents recorded were sent to the head office team to be reviewed monthly. Team members discussed dispensing mistakes and agreed actions they then put in place to manage the risk of a same or a similar mistake happening again. This included separating stock of medicines which had similar sounding names or packaging to avoid selection errors. The pharmacy completed three monthly audits on prescriptions it dispensed for people living in a prison. This involved selecting a random sample of prescription records held at the prison and checking the accuracy against the pharmacy records, to ensure there were no discrepancies in the transfer of data between the two systems used.

The pharmacy had a complaints procedure and welcomed feedback. It advertised information on a television in the retail area, so people could submit feedback about the service they had received. Team members were trained to handle complaints and aimed to do so informally. If they could not resolve the complaint, they would refer to the RP who would initiate the formal complaints procedure.

The pharmacy had current professional indemnity and liability insurance. It displayed an RP notice that was visible from the retail area and reflected the correct details of the pharmacist on duty. The RP log

held electronically was complete. Team members maintained complete electronic controlled drug (CD) registers, any amendments to the registers were recorded appropriately. CD balance checks against the physical stock were conducted weekly. A random balance check on the physical quantity of three CDs matched the balances recorded in the registers. The pharmacy had records of CDs people had returned for safe disposal. And CDs awaiting destruction were stored appropriately, segregated from other stock. Records relating to private prescriptions and emergency supplies of medicines were mostly accurate. There was a duplicate entry for one private prescription seen, this was discussed at the time of inspection. The RP explained there had been a fault with the software used to record private prescriptions. When entering private prescription data, it would appear to have failed and required re-entry. However, it would then record a duplicate entry. This had been reported to the software provider and was being investigated. The pharmacy had records of unlicensed medicines. And details of supply were included to provide an audit trail.

There was an information governance policy (IG). And team members understood the importance of protecting people's confidentiality. Confidential waste was segregated and shredded on-site. There was a protecting vulnerable groups (PVG) procedure. Team members provided examples of signs that would raise concerns and of interventions they had made to protect vulnerable people. And the pharmacy had details of local safeguarding agencies.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary skills and knowledge for their roles and the services they provide. They manage the workload effectively and provide support to each other as they work. And they feel comfortable raising professional concerns should they need to.

Inspector's evidence

The pharmacy employed a full-time pharmacist, who was the pharmacy manager, one full-time dispenser, three part-time dispensers, three full-time trainee dispensers, two part-time trainee dispensers and six part-time delivery drivers. A second pharmacist provided part-time cover regularly on days throughout the week. Team members were observed managing the busy workload well and in a calm manner. The pharmacy manager managed annual leave requests and skill mix arrangements within the pharmacy. This was to ensure staffing levels remain sufficient and continuity of work during periods of absence. And part-time team members provided contingency cover if needed.

Team members that had completed accredited qualification training displayed their certificates in the pharmacy that were visible from the retail area. Protected learning time was provided for team members undertaking accredited qualification training. And for the introduction of new services. For example, some team members had received specialist training to be able to provide a private microsuction ear wax removal service. Currently two team members were trained to provide this service.

There was no official appraisal process. The pharmacy manager explained team members had regular informal discussions to review progress and identify any individual learning needs. And they discussed ways to provide a more effective service. For example, to order medicines generically to improve cost saving within the pharmacy. Team members asked appropriate questions when selling over-the-counter medicines. And they explained how they would handle repeated requests for medicines liable to misuse, such as codeine-containing medicines. By referring to the RP or person’s GP for supportive discussions. The pharmacy had a close working relationship with the local GP practice. Due to the pharmacy being in a location where tourists visited, they had regular requests from people who do not live within the local area or country. The pharmacist would conduct a consultation and where appropriate, provided treatment on the NHS Pharmacy First service or recommended over-the-counter medicines. If anything was out with their competence, they would refer to the GP practice or signpost to other services available within the local area.

There was a supportive culture within the pharmacy team. There was a whistle bowling policy. And team members felt comfortable to raise concerns with the pharmacy manager, area manager or SI. The pharmacy manager was in regular contact with the area manager and SI, and they felt well supported in their role. There were targets set for team members. They felt these were appropriate for the services they provided, and they did not feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and provides a professional environment suitable for the services it delivers. It has a private consultation room where people can have confidential conversations with a member of the pharmacy team.

Inspector's evidence

The pharmacy premises were modern, clean, and provided a professional image. There was a large well-presented retail area which led to a healthcare counter, post office counter and a dispensary. Pharmacy-only-medicines were stored behind the healthcare counter which had a barrier to prevent unauthorised access to staff only areas. The dispensary was screened in a way that allowed the pharmacist to supervise activities within the retail area and intervene in a sale where necessary. The dispensary was of good size with three separate areas. One for the checking and dispensing of prescriptions, one for the assembly of multi-compartment compliance packs and one area for dispensing medicines related to nursing homes and prisons. The dispensary was well-organised with plenty of work bench space. Medicines were stored neatly on shelves around the perimeter and throughout the dispensary. It had a sink with access to hot and cold water for professional use and handwashing. Staff facilities were hygienic with access to hot and cold water.

There was a consultation room that was well advertised, lockable and fit for use. Lighting and temperature were kept to an appropriate level throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely and effectively. And they consider how to make services easily accessible to people who do not use English as their first language. The pharmacy sources its medicines from reputable suppliers and it stores them properly. And team members carry out the appropriate checks to ensure they keep medicines in good condition.

Inspector's evidence

The pharmacy had good physical access by means of a small ramp that led to the main door. It advertised its opening hours and services it provided in the main windows. There was a range of healthcare leaflets available for people to read or takeaway including information on the NHS Pharmacy First service. And it advertised services available in the local community such as mental wellbeing support and help to stop smoking. Pharmacy team members provided large print labels to help people with visual impairments take their medicines safely. The pharmacy was in a rural location close to Loch Ness and so received many tourists throughout the year who didn't speak English as their first language. A team member explained they had access to an interpreter telephone service, but this wasn't always practical or efficient to use. So, team members had discussions on improvements they could make to help support these people accessing pharmacy services. A team member developed a set of quick reference guides in Spanish, German, French and Chinese. These were printed booklets separated into specific sections such as diabetes, pain, asthma, burns, eye and ear problems. The guides listed questions in English and the translation to the specific language. Questions or statements seen included 'I have a chesty cough', 'I have pain', 'Do you take regular medication' or 'What type of painkiller have you tried'. The team member explained they used these as quick reference guides and allowed people to read them and point to certain questions relating to their symptoms. This had been a more effective way of communicating quickly and allowed the pharmacist to select the appropriate treatment without accessing an interpreter service for each consultation.

The pharmacy purchased medicines and medical devices from recognised suppliers, and it stored them appropriately in the manufacturer's original packaging. Liquid medicines that were opened were marked with the date it should be safely disposed of. And medicine boxes that did not contain a patient information leaflet (PIL) had a sticker attached to the outside of the box, so team members new to print one so people had information relating to their medicines. The pharmacy checked the expiry dates of medicines and recorded their actions on a date checking matrix. Records seen showed date checking was up to date. And a random sample of 20 medicines showed none had expired. The pharmacy used two well-organised fridges to store its medicines and prescriptions awaiting collection that required cold storage. And team members recorded the temperatures daily to demonstrate they were working within the recommended limits of between 2 and 8 degrees Celsius. Records showed one of the fridges temperatures had exceeded the maximum temperature range on several occasions. This was discussed at the time of the inspection. The RP explained it was due to the storage area of the fridge, it had been reported and maintenance work had been carried out to regulate the temperature in the area where the fridge was located.

Team members used coloured baskets during the dispensing process to separate people's prescriptions and prevent medicines from becoming mixed up. This also helped prioritise prescriptions that required delivery to people's homes within the pharmacy. As each colour was related to a specific delivery route. They added coloured stickers to the outside of the bag of dispensed medicines to highlight it contained

a fridge line, CD or higher-risk medicine that required further counselling. Team members were aware of the Pregnancy Prevention Programme and the risks associated with supplying valproate-containing medicines. They supplied valproate-containing medicines out with the manufacturer's original packaging to some people in multi-compartment compliance packs. Risk assessments had been completed and found this was the most appropriate way for those people to receive their medicines. The pharmacy provided a delivery service that covered a vast area within the locality. Delivery drivers planned their route in advance, and they used paper-based delivery sheets to record the delivery of each prescription. Delivery of CDs were highlighted and recorded on a separate sheet. And they kept records of this. They had the appropriate equipment to maintain the cold chain for throughout the delivery process. Some people signed consent forms for their prescription to be left in a safe place if they were not home to receive their delivery. The pharmacy conducted a risk assessment on an individual basis, and they kept records of this. The pharmacy received Medicines Healthcare and Products Regulatory Agency (MHRA) patient safety alerts and product recalls via email and actioned these on receipt. A team member signed this to indicate the appropriate action had been taken. And they kept paper-based records of action taken for future reference.

The pharmacy supplied medicines in multi-compartment compliance packs to help people take their medicines properly. Team members worked to a four-week cycle to allow them sufficient time to resolve any queries relating to people's medicines. The pharmacy used a notification form to record any changes to people's medicines supplied in packs. Such as if a strength of a medicine was increased or decreased. And they kept records of when a person was admitted to hospital, so they knew not to deliver their prescription. When the pharmacy received prescriptions, they were checked against the previous month's prescriptions as well as the notification form, to ensure the information was correct before it was processed for dispensing. Backing sheets were attached to each pack that included warning labels for each medicine, directions for use and a description of what each medicine looked like. PILs were supplied monthly so people had up to date information relating to their medicines. A team member explained higher risk medicines such as CDs or valproate-containing medicines were added to the compliance packs on weekly basis. This was to ensure the stability of medicines when they were removed from the manufacturer's original packaging.

The pharmacy supplied medicines to people living in nursing homes. The service was managed on a monthly cycle with paper-based administration charts provided for use by nursing home staff. The nursing home staff were responsible for ordering medication required and did so using an order form. Pharmacy team members provided an order prompt reminder sheet with medicines supplied to nursing homes. This included the date medicines should be ordered for the next cycle and the date they would be delivered. This helped the nursing staff manage their workload. And the pharmacy had received positive feedback since implementing the form.

The pharmacy provided medicines to people living in prisons. Each person was identified by an individual reference number. And team members used a separate computer solely for processing prescriptions for people living in a prison. Original prescriptions were held within the prison and prison staff transferred the prescription data electronically to the pharmacy. Team members kept copies of the prescriptions for each individual person which included the medicine prescribed, administration times and the date the medicine was commenced. And they received original copies for medicines such as CDs the same day the prescription was transferred electronically. Medicines were supplied on a daily, weekly or monthly basis. Team members removed medicines from their original packaging, placed them into sealed clear bags and they attached the dispensing label to the outside of the bags for each person. Team members communicated any queries relating to people's medicines via email so there was an audit trail for future reference. And the RP visited the prison every three months.

The NHS Pharmacy First service was popular. Team members used consultation forms to gather

relevant information before referring to the pharmacist for treatment. The pharmacist provided medicines for common conditions such as urinary tract infections or skin infections under a patient group direction (PGD). The pharmacy kept paper-based consultation records of treatment provided or referral decisions. And team members communicated these to the person's GP to ensure their medical records were kept up to date.

The pharmacy provided a private microsuction ear wax removal service. They used an electronic device to record consultations. A digital otoscope was used to capture high-definition images from inside the ear and assess if the person was suitable for wax removal. The same device enabled team members to deliver microsuction removal of ear wax. The RP explained the process team members would follow and how they referred people when needed. There was a specialist ear nose and throat consultant available for further referral or queries relating to treatment. The team member sent the images taken from within the ear on an electronic platform as well as sending consultation notes and referral decisions. There was a maximum 24 hour wait for a response, however they explained the response was usually much quicker. They received regular updated information and guidance from other healthcare professionals within the private company to continue to provide the service safely. And had plans for further training to be able to expand the service to allow for hearing consultations.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to the appropriate equipment which is fit for purpose and safe to use. And team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had internet services to allow team members to access current electronic resources to support them in their roles. Such as, the British National Formulary (BNF) and the local health board formulary.

The pharmacy had a set of clean tablet counters and CE-stamped cylinders. And they had highlighted specific measures to be used solely for the purpose of measuring substance misuse liquid medicines. There was a range of equipment available for use in the consultation room included a blood pressure monitor and in-ear thermometer. Electrical equipment was visibly free from wear and tear. And single use earpieces were available for each person. The pharmacy used a digital otoscope to conduct private consultations. It was visibly free from wear and tear. A team member explained how it is cleaned after each use. And individual suction tubes were available for each person.

Prescriptions awaiting collection were stored in drawers behind the healthcare counter. And confidential information was not visible to people in the retail area. Computers were password protected and positioned in a way that prevented unauthorised view. And cordless telephones were in use to allow private conversations in a quieter area.

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.