General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Eildon Pharmacy, The Gatehouse, Mart Road, Newtown St Boswells, Scottish Borders, TD6 0PP

Pharmacy reference: 9011711

Type of pharmacy: Community

Date of inspection: 24/10/2024

Pharmacy context

This is a community pharmacy in the village of Newton St Boswells in the Scottish Borders. Its main activities are dispensing NHS prescriptions and providing people with their medicines in multi-compartment compliance packs to help them take their medicines safely. It provides services including NHS Pharmacy First and Pharmacy First Plus. And it delivers medicines to people in their homes.

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 manages the risk with its services to help team members deliver services safely and effectively. Team members record mistakes made during the dispensing process to learn from them. And they make changes to help prevent the same or a similar mistake from occurring. They keep the records required by law. And they keep people's private information secure. They know how to respond appropriately to concerns about the welfare of vulnerable adults and children. The pharmacy has written procedures for team members to follow. But some are overdue a review and others are incomplete and so they may not reflect current practice.

Inspector's evidence

The pharmacy had paper based standard operating procedures (SOPs) which were designed to help team members provide services safely. A sample of SOPs seen showed they were produced by the pharmacist owner or accuracy checking pharmacy technician. And they had been updated at different times with some having been updated in 2023 and others in 2018. So, some were overdue a review. There were SOPs about the dispensing processes, controlled drugs (CDs) and date checking. SOPs about responsible pharmacist (RP) regulations were incomplete. There was a SOP which explained what pharmacists needed to do to sign in as the RP, but no SOP about absence procedures. Team members knew what tasks they could and could not complete in the absence of the RP. The company's SOP for the delivery process was about delivering medicines to people safely during the covid pandemic and did not reflect current practices. There were sheets for team members to sign to say they had read and understood them, but records showed that not all team members had signed the SOPs. Team members were experienced in their roles and completed tasks such as date checking according to the SOP. The accuracy checking technician (ACPT) felt comfortable to check all medicines and was mostly responsible for checking multi-compartment compliance packs. The pharmacist signed the prescriptions which had been clinically checked which meant the ACPT knew they could complete the final accuracy check.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. The pharmacist recorded the details about the near misses and discussed it with the team member involved. Records showed that learning points and action taken were generally not recorded which means that opportunities to learn from the near misses may be missed. The pharmacist had informal discussions with the team about the mistake and they made suggestions for change to help prevent a recurrence of the mistake. For example, they had separated different strengths of sertraline from each other on the shelves to help prevent selection mistakes. The pharmacist highlighted common mistakes made in a monthly bulletin which was printed and displayed in the dispensary for team members to be aware of. The pharmacy recorded errors that were identified after a person had received their medicines known as dispensing incidents. The incidents were recorded on the patient medication record (PMR) and included actions taken to help prevent a recurrence of the incident. The pharmacist explained that they had changed their processes for preparing multi-compartment compliance packs for delivery which now involved two team members checking that packs were placed in a bag with the correct person's bag label.

The pharmacy had a procedure for dealing with complaints and concerns from people using the services. Team members aimed to resolve complaints informally. The pharmacy's superintendent (SI) pharmacist worked frequently in the pharmacy so was available to assist with any concerns. If the

pharmacy was unable to resolve the complaint, it could be escalated to the Health Board, but this had not been required. The pharmacy received positive feedback which was shared with team members. And people had been very positive about the pharmacy's relocation to a bigger premises. Team members frequently received thank you cards from people using the pharmacy.

The pharmacy had current professional indemnity insurance. The RP notice was displayed prominently in the retail area of the pharmacy and identified the correct RP on duty. The RP record was completed correctly. The pharmacy recorded the receipt and supply of its CDs. Team members completed checks of the stock held against the CD register running balance when medicines were received from the wholesaler. And they completed weekly checks of liquid medicines used in the substance misuse service. A full balance check, including for medicines that were not regularly received by the pharmacy was completed in July 2024. The pharmacy didn't complete all relevant details about the returned medicines until destruction, which was discussed with the pharmacist. The destruction was witnessed by a registrant. The pharmacy kept certificates of compliance for unlicensed medicines known as "specials". Team members recorded the details about who the medicine was supplied to which provided an audit trail. The pharmacy kept complete records of the supply of medicines against private prescriptions and retained corresponding prescriptions.

The pharmacy displayed NHS and company privacy notices in the retail area informing people of how their data was used. Team members understood their responsibility to keep people's private information secure and some had completed additional training as part of their accredited training courses. They separated confidential waste for shredding on site. Team members were aware of their responsibility to safeguard vulnerable adults and children. Some team members felt comfortable to refer people to their GP and others referred in the first instance to the pharmacist. The pharmacy displayed contact details for relevant local authorities. The pharmacist was registered with the protecting vulnerable groups scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to deliver its services safely and effectively. Team members in training are appropriately supervised. And team members suitably support people with their healthcare needs.

Inspector's evidence

The pharmacy's two owners, one of whom was the SI, usually covered the pharmacy's opening hours. During the inspection the RP was supported by a pre-registration pharmacy technician who had recently passed their training course and was awaiting annotation on the register, an ACPT and two dispensers. Team members not present during the inspection included the SI, two medicines counter assistants (MCA), one of whom was a trainee, a dispenser, a trainee dispenser and a delivery driver. Team member's annual leave was planned in advance. Part-time team members could increase their hours to support periods of absence.

Team members had either completed or were in the process of completing accredited training for their roles, except the delivery driver. The owner pharmacist confirmed after the inspection the driver had been enrolled on accredited training. The trainee MCA was supervised by one of the owner pharmacists. And team members who had completed accredited training kept their skills and knowledge up to date by identifying areas which they could complete online training modules about. The owner pharmacist was a pharmacist independent prescriber (PIP) and assessed their own competency to treat certain conditions. They had regular meetings with other PIPs who worked within the same Health Board to discuss cases to help with development and had attended clinical training days. And they sought advice about cases and feedback about their prescribing from clinicians who worked in the nearby GP surgery.

Team members were observed to work well together to complete the workload. There was an open and honest culture and team members felt comfortable making suggestions for change. They knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. Team members had supportive conversations with people or referred them to the pharmacist to have supportive conversations with people. The pharmacist gave an example of making an intervention on a prescription that had been requested too early. Team members were given regular feedback about their performance and support was given to those who needed it. The pharmacy had a whistleblowing SOP for team members to refer to if needed. The pharmacy did not set targets for its team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services it provides. It has appropriate facilities for people requiring privacy when accessing services.

Inspector's evidence

The pharmacy had a small retail area which led through to the dispensary. Upstairs, there was a larger area where the dispensing of multi-compartment compliance packs took place. The dispensary, although small, had space for team members to move around freely and had different work benches for the completion of different tasks. And it was kept clean and was free from clutter. The pharmacist's checking bench allowed for effective supervision of the dispensary and medicines counter. The dispensary had a sink which provided hot and cold water for handwashing. Toilet facilities were clean and provided separate handwashing facilities. Lighting provided good visibility throughout and the temperature was comfortable.

The pharmacy had a large consultation room which had a desk, chairs and a computer for consultations to be completed comfortably.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. And it makes them accessible to people. Team members complete regular checks on medicines to ensure they remain fit for supply. They generally provide people with the necessary information to take their medicines safely. And they respond appropriately to alerts about the safety of medicines.

Inspector's evidence

The pharmacy had a very small step up from the street and team members confirmed that people with limited mobility using wheelchairs or prams were able to access the pharmacy. There was a doorbell for people who did require assistance at the front door, for example people using mobility scooters. Team members were able to communicate with people who had hearing difficulties if needed in writing. And they provided some people with visual difficulties with large print labels.

Team members used baskets to keep people's prescriptions and medicines together and reduce the risk of errors. They used stickers or a stamp to highlight the inclusion of a CD, fridge line or higher-risk medicine. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Team members were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicines safely. They supplied some people with their valproate outside the manufacturer's original pack and had not completed risk assessments for this. The pharmacist subsequently confirmed these would be completed. Some team members were not aware of the recent update about a PPP for topiramate, and discussions were had about completing learning about this. Team members informed people if they were unable to be supplied with the full quantity of their prescription verbally, they did not provide them with a written note. The pharmacy kept a label detailing the owed medication and reviewed owings daily. For any medicines that could not be supplied, team members gave people options, such as sourcing the medicine from another pharmacy or obtained an alternative from the GP.

The NHS Pharmacy First service was underpinned by patient group directions (PGDs) which the pharmacist could access the most up to date copies of online. For the NHS Pharmacy First Plus service, the PIP recorded the details about the consultation and any prescribing decisions on the person's PMR and shared the details with the person's GP. The pharmacy supervised the administration of medicines for some people. It managed the service by preparing the doses weekly so that the medicine was ready for people to collect. And volumes of the medicine poured were double checked by either the pharmacist or ACPT. The pharmacy had a delivery service, taking medicines to people in their homes. The driver used a sheet with people's names and addresses to make their deliveries. And team members highlighted if a CD or fridge line was included. Any deliveries attempted when the person was not at home were returned to the pharmacy with a note left at the person's address about the failed delivery.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. The pharmacy ordered the prescriptions in advance so any queries about a person's medication could be resolved. Each person had a medication record sheet which detailed the medicines taken and when. Any changes to a person's medication were

communicated from the GP and their record was updated. Team members did not provide descriptions of the medicines in the pack unless requested by people, which meant individual medicines may not be identifiable in the case of a query. They provided people with patient information leaflets once a month, so they had the necessary information to take their medicines safely.

The pharmacy sourced its medicines from licensed wholesalers. Medicines were generally stored neatly on shelves in the dispensary. Team members had a process for checking the expiry date of medicines. The dispensary was separated into different sections and records showed that date checking had been completed regularly over the past few months with the most recent records showing checking of some sections of the dispensary completed in October 2024. Team members highlighted medicines that were going out of date in the next six months for use first. And these medicines were removed when the date checking was next completed. Team members checked the expiry dates of medicines when dispensing and checking and the pharmacist was observed completing these checks. A random selection of ten medicines found none past their expiry dates. Liquid medicines with a shortened expiry date on opening were marked with the date of opening. The pharmacy had a fridge used to store medicines that required cold storage. Team members recorded the temperatures daily and records showed the fridge was operating between the required two and eight degrees Celsius. The pharmacy received notifications about drug alerts and recalls via email. They printed relevant alerts and stamped and signed them to show they had been actioned. Alerts that were about medicines that were not relevant to the pharmacy were retained as read in the pharmacy's emails.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to electronic reference resources including the British National Formulary (BNF) and British National Formulary for children (BNFc), specialist pharmacy service and medicines complete. The PIP also accessed National Institute for Clinical Excellence (NICE) guidelines and the local Health Board formulary to help with their prescribing decisions. The pharmacy had crown stamped measuring cylinders which were marked to identify which were for water and which were for liquid medicines. And it had clean triangles used to count tablets for prescriptions.

The pharmacy had a cordless telephone so that conversations could be kept private. Due to the small size of the retail area, team members managed confidential conversations by offering people the use of the consultation room. Team members did not discuss medicines by name during conversations and instead pointed to the medicine on a prescription to maintain confidentiality. Confidential information was secured on computers using passwords and they were generally positioned in a way that ensured only authorised people could see them. There was one computer screen that faced towards people waiting at the retail area. Team members ensured that the screen was locked when it wasn't in use.

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.