General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lindsay & Gilmour Pharmacy, 37-39 Moredun Park Road, Edinburgh, Midlothian, EH17 7ES

Pharmacy reference: 9011753

Type of pharmacy: Community

Date of inspection: 18/10/2023

Pharmacy context

This is a community pharmacy in a residential area in the city of Edinburgh. Its main services include dispensing NHS prescriptions, and it provides some people with their medicines in multi-compartment compliance packs. The pharmacy has a 24-hour collection point which allows people to collect their medicines at any time, including outside of the pharmacy's opening hours.

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 appropriately manages the risks associated with the services it provides for people. It has a complete set of written procedures which help the team carry out tasks consistently and safely. Team members record and learn from the mistakes they make when dispensing. And they keep the records they need to by law. Team members have knowledge and experience to help support vulnerable people.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) to help team members manage risks. The SOPs were all kept electronically, and each team member had an individual login to the electronic platform to access them. The pharmacy superintendent (SI) reviewed the SOPs on a regular basis. Team members read the SOPs relevant to their role and completed a short assessment to confirm their understanding of them. They were observed working within the scope of their roles. Team members were aware of the responsible pharmacist (RP) regulations and of what tasks they could and couldn't do in the absence of an RP.

Pharmacy team members recorded any mistakes they identified during the dispensing process, known as near misses, on an electronic near miss record. They explained that an error would be highlighted to them by the pharmacist, and it was their responsibility to enter it onto the record. This allowed them to reflect on the mistake. The pharmacy manager reviewed the near miss record monthly to identify any trends and patterns. This was recorded on a patient safety report which was reviewed by the SI. Team members also recorded details of any errors which were identified after the person had received their medicines, known as dispensing incidents. These incidents were recorded on an electronic platform and were then reviewed by the SI. The individuals involved in the error completed a root cause analysis form and reflective statement to determine how the error may have happened. A recent dispensing incident involved the incorrect quantity of co-codamol being dispensed. After completion of a root cause analysis, a determining factor was found to be that the packaging for the 100 pack and 50 pack of the medicine were the same size. This was highlighted to all team members to reduce the recurrence of the same error happening again. An electronic tablet device had recently been installed in the retail area for people to provide feedback and to rate their experience of pharmacy services. The feedback was reviewed by head office. The team aimed to resolve any complaints or concerns informally. But if they were not able to resolve the complaint, they would escalate to the manager or SI office.

The pharmacy had current professional indemnity insurance. The RP notice displayed contained the correct details of the RP on duty, and it could be seen clearly from the retail area. The RP record was generally in order, although the RP had sometimes forgotten to sign-out on the sample of the record examined. The pharmacy held its controlled drug (CD) register electronically. And from the entries checked, it appeared to be in order. The team checked the physical stock levels of CDs against the balances recorded in the CD register every week. There was a record of patient returned CDs in an electronic register and this was maintained to date. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. Accurate records of private prescriptions were maintained.

Team members were aware of the need to keep people's information confidential. They were observed

separating confidential waste in dedicated bags which were collected periodically by a specialist contractor for secure destruction. The pharmacy stored confidential information in staff-only areas. Pharmacy team members had completed learning associated with their role in protecting vulnerable people. They understood their obligations to manage safeguarding concerns. And they knew to discuss any concerns with the pharmacist and had access to contact details for relevant local agencies. The pharmacist was a member of the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled team members to manage its workload. And it is actively recruiting for additional team members. Team members receive the correct training for their roles and they complete some additional regular training to maintain their knowledge and skills. And they receive some feedback about how they are performing.

Inspector's evidence

The pharmacy employed a full-time pharmacist who was also the manager. And it had additional pharmacist cover to support when the usual pharmacist had vaccination clinics. The pharmacy team included two pharmacy technicians, one of whom was enrolled on an accuracy checking pharmacy technician course. Team members had all completed accredited training or were enrolled on an accredited training course for their role. They were observed working well together and managing the workload on the day of the inspection. There were currently two vacancies advertised for dispensary team members and a medicines counter assistant had recently started in role. The pharmacy company had a defined induction plan, but the new team member had not yet started this. Team members explained that they sometimes did not get additional cover during periods of annual leave or sickness. The SI advised that the pharmacy company was currently recruiting for additional relief dispensary support staff to enable more cover during periods of absence.

Team members who were enrolled on an accredited training course received protected learning time. And all team members had access to an electronic learning platform where they could complete additional learning relevant to their roles. They received some learning time during quieter periods. The pharmacist had monthly formal meetings with all staff members where they discussed any learnings from near misses or dispensing incidents and recent drug alerts. The meetings were minuted and distributed among all team members, including team members who were unable to attend. This ensured that the whole team received relevant notifications and learnings. Each member of the team received informal appraisals with the pharmacist where they had the opportunity to raise any individual learning needs. There were no targets set for pharmacy services.

Team members were observed asking appropriate questions when selling medicines over the counter and referring to the pharmacist when necessary. They explained how they would identify repeated requests for medicines subject to misuse, for example codeine containing medicines. And they would refer such requests to the RP.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and the team maintain them to a high standard. It has private consultation rooms where people can have confidential conversations with a pharmacy team member.

Inspector's evidence

The premises were secure, modern, and provided a professional image. They had recently been extended to include a dispensary area where multi-compartment compliance packs were prepared and an additional consultation room. The pharmacy workspaces were well organised with designated areas for completion of pharmacy tasks and suitable storage for prescriptions. The medicines counter could be clearly seen from the checking area via two hatches which enabled the pharmacist to intervene in a sale when necessary. Two good-sized consultation rooms were available which were kept locked when not in use. And there was a separate consultation room with a hatch to the dispensary area to enable team members to supervise a substance misuse service.

There was a clean, well-maintained sink in the dispensary used for medicines preparation and there were other facilities for hand washing. The pharmacy kept heating and lighting to an acceptable level in the dispensary and retail area. There were chairs in the retail area that provided a suitable waiting area for people receiving clinical services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to support people's health needs. It manages its services well and they are easy for people to access. The pharmacy obtains its medicines from reputable sources and stores them appropriately. And the team carries out checks to help ensure the medicines are kept in good condition.

Inspector's evidence

The pharmacy had good physical access with a level entrance and an automatic door. There was a sensor at the entrance to alert team members when people entered the pharmacy. The pharmacy displayed its opening hours and some pharmacy services in the window. The team also kept a range of healthcare information leaflets for people to read or take away, these included information on NHS Pharmacy First Service and Medicines: Care and Review Service (MCR).

The dispensary had separate areas for labelling, dispensing, and checking of prescriptions. Team members used baskets to store medicines and prescriptions during the dispensing process to prevent them becoming mixed-up. The baskets were stored on shelving whilst waiting to be checked by the pharmacist. This enabled the dispensary benches to remain clear. Team members signed dispensing labels to maintain an audit trail. The team provided owing's slips to people when it could not supply the full quantity prescribed. And they contacted the prescriber when a manufacturer was unable to supply a medicine. The pharmacy offered a delivery service and kept records of completed deliveries, including CDs.

Team members demonstrated a good awareness of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate, and of the associated risks. They explained they would highlight any prescriptions for valproate for the attention of the RP. They knew to apply dispensing labels to the packs in a way that prevented the written warnings on the packs from being covered up. The pharmacy supplied patient information leaflets and patient cards with every supply. And they always supplied valproate in the original manufacturer's pack.

A large proportion of the pharmacy's workload involved supplying some people's medicines in multi-compartment compliance packs. This helped people better manage their medicines. Team members used medication record sheets that contained a copy of each person's medication and dosage times. They were responsible for managing the ordering of people's repeat prescriptions and reconciled these against the medication record sheet. They documented any changes to people's medication on the record sheets and who had initiated the change. This ensured there was a full audit trail should the need arise to deal with any future queries. The packs were annotated with detailed descriptions and photographs of the medicines which allowed people to distinguish between the medicines within them. The pharmacy supplied people with patient information leaflets, so they had access to up-to-date information about their medicines. The compliance packs were signed by the dispenser and RP so there was an audit trail of who had been involved in the dispensing process. Around half of the compliance packs were dispensed at an offsite dispensing hub located at another pharmacy owned by the same company. The prescriptions were clinically checked by the pharmacist at the pharmacy, and this was confirmed with a stamp. The prescription and medication record sheets were sent to the hub for completion of the dispensing process. And the completed multi-compartment compliance packs were

then returned to the pharmacy.

The pharmacist and technician provided a private and NHS flu vaccination service. They had completed face to face vaccination training and on online training module prior to providing the service. And they had read the patient group direction (PGD). The service was managed via an appointment schedule and additional pharmacist cover was provided on days where clinics were held. Records of vaccinations were maintained.

The pharmacy had an automated 24-hour collection point. The collection point allowed people to collect their medicines at any time of day, including outside of the pharmacy's opening hours. Team members asked people for written consent to allow them to store their medicines in the collection point. If they agreed, they were sent a text message indicating their medicines were ready to collect with a pin code. The pin code was used to enter on the touch screen system and the prescription could be collected in the collection drawer.

Pharmacy-only (P) medicines were stored behind the pharmacy counter and Perspex screens to prevent unauthorised access. The pharmacy obtained medicines from licensed wholesalers and stored these tidily on shelves. And it used a medical grade fridge to keep medicines at the manufacturers' recommended temperature. Team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the required range of between two and eight degrees Celsius. Team members checked the expiry dates of medicines weekly. Short-dated stickers were used to highlight medicines which were due to expire soon. The team advised that they were up to date with the process. A random selection of medicines was checked and all were found to be within their expiry date. There were a small number of loose tablet and capsule strips stored in clear bags next to medicine packs containing the same medicines. These did not all have batch number or expiry dates. This meant that there was an increased risk of an out-of-date medicine being supplied or a medicine not being identified in the event of a drug recall. The RP removed these and advised he would speak to the pharmacy team. The pharmacy received notifications of drug alerts and recalls via email. Team members carried out checks and knew to remove and quarantine affected stock. They returned items received damaged or faulty to manufacturers as soon as possible. The pharmacy had medical waste bins for pharmaceutical waste.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to support the safe delivery of its services. Its equipment is fit for purpose and safe to use. And its team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources including the British National Formulary (BNF), the BNF for children and the NHS Lothian Pharmacy First Formulary. There was also access to internet services. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. And it had a set of well-maintained tablet and capsule counters. The automated dispensing machines for dispensing of liquid CDs and the automated 24-hour collection point were serviced regularly by the external providers. And engineer support was available via telephone if required for both machines.

The pharmacy stored dispensed medicines awaiting collection, in a way that prevented members of the public seeing people's confidential information. The dispensary was screened, and computer screens were positioned so that unauthorised people couldn't see any confidential information. The computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones so team members could move 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.