General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lindsay & Gilmour Pharmacy, 32 -34 Main Street, West Calder, West Lothian, EH55 8DR

Pharmacy reference: 9011872

Type of pharmacy: Community

Date of inspection: 21/09/2023

Pharmacy context

This is a community pharmacy in the town of West Calder in Lothian. Its main services include dispensing of NHS prescriptions, and it acts as a hub pharmacy, dispensing some medicines in multi-compartment compliance packs for other pharmacies in the company. The pharmacy has a 24-hour collection point which allows people to collect their dispensed 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 suitably manages risk to help its team provide safe services. Members of the team keep the records that are needed by law. They keep people's private information safe. And they know what to do to help protect the health of vulnerable people. They discuss mistakes they make when dispensing so that they can learn from them.

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. These were recorded 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 centrally by the SI. A common trend found from this analysis included an increase in the incorrect dispensing of medicines which looked or sounded alike (LASA). The team had attached ‘caution’ stickers to the most common LASAs, for example to propranolol and prednisolone, to reduce the recurrence of this type of error. 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. 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, some missed sign-out entries were observed 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. It 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.

A privacy notice and an NHS Pharmacy First privacy notice were displayed in the retail area. Team members were aware of the need to keep people’s information confidential. Team members were

observed separating confidential waste for collection by a third-party contractor for secure destruction. The pharmacy stored confidential information in staff-only areas and in secure locked cupboards within the consultation room. Pharmacy team members had completed learning associated with their role in protecting vulnerable people. The pharmacist was a member of the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has sufficient team members with the right qualifications and knowledge to manage its workload and provide its services. The pharmacy supports its team members to complete appropriate training for their role and keep their skills up to date. Members of the team work well together and communicate effectively. And they are comfortable providing feedback and raising concerns should they need to.

Inspector's evidence

The pharmacy employed a full-time pharmacist manager. There was a large, experienced pharmacy team that included an accuracy checking technician (ACT) who was also the manager of the multi-compartment compliance pack hub which operated within the pharmacy premises. Team members had all completed accredited training or were enrolled on accredited training courses. They were observed working well together and managing the workload. Planned leave requests were managed so that only two team members were absent at a time. Part-time staff supported by working additional hours during periods of planned leave. And there was additional relief dispenser support available.

All team members received thirty minutes of protected learning time per week. And those enrolled on accredited training courses received additional learning time. They had access to an online learning platform where they completed additional training relevant to their roles. Team members had recently completed training on safeguarding and child protection. The pharmacy manager held weekly meetings with all staff members where they discussed any learnings from near misses or dispensing incidents and alerts from head office. The team felt comfortable to raise any concerns to their manager or area manager. The area manager and area operations support manager visited the pharmacy regularly. The pharmacy had a whistleblowing policy which team members could access. Team members received a formal appraisal every six months.

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 from people for medicines subject to misuse, for example, codeine containing medicines. And that they would refer repeated requests to the pharmacist.

The team were set some targets to achieve by the company. These included prescription items and pharmacy services. Team members felt they were achievable and allowed them to continue providing a safe service to people.

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 a private consultation room where people can have confidential conversations with a pharmacy team member.

Inspector's evidence

The large premises were secure, modern, and provided a professional image. They had recently been extended to include an additional storage room and dispensary area where multi-compartment compliance packs were prepared using automated dispensing machines. The pharmacy workspaces were well organised with designated areas for completion of pharmacy tasks and suitable storage for prescriptions. The main dispensary area had a separate area at the rear where team members could work if required to reduce distractions. A central bench used by the RP to complete the final checking process was in the main dispensary near the retail counter. The medicines counter could be clearly seen from the checking area which enabled the pharmacist to intervene in a sale when necessary. A good-sized consultation room was available which was kept locked when not in use. And there was a hatch area at the retail counter where team members could have more private conversations with people.

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.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to support people's health needs. It manages it services well and they are easily accessible to people. The pharmacy receives its medicines from reputable sources and stores them appropriately. 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 a semi-automatic door with touch pad. It 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 main 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. These were colour coded to enable the team to identify the type of prescription stored within and to manage workload. Team members signed dispensing labels to maintain an audit trail. They provided owings slips to people when the pharmacy 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 using a handheld device. Team members were able to track progress of deliveries using an electronic platform so could answer queries from people expecting deliveries.

Team members demonstrated a good awareness of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to avoid covering up written warnings on the packs with dispensing labels. The pharmacy supplied patient information leaflets and patient cards with every supply. A review had recently been completed and no people currently prescribed valproate were identified as being in the at-risk group. Team members attached various alert stickers to dispensed medicines awaiting collection. They used these as a prompt before they handed out medicines to people who may require further intervention from the pharmacist.

The pharmacy provided medicines in multi-compartment compliance packs to a large number of people to help them take their medication correctly. And it provided the service as a hub dispensary for the other pharmacies in the company, known as the spoke pharmacies. A dedicated team member managed this service and used two automated dispensing systems to assemble the majority of the packs. The manager had visited all spoke pharmacies to provide training to team members on the process and to help identify suitable patients whose packs could be dispensed at the hub pharmacy. Team members at the spoke pharmacies used medication record cards that contained each person’s medication and dosage times. They ordered peoples repeat prescriptions and reconciled these against the medication record card. The prescription data was entered into the patient medication record (PMR) by a dispenser, it was clinically checked and accuracy checked by the RP at the spoke pharmacy. The prescription was stamped to confirm it had been accuracy checked and clinically checked. The data was then electronically transferred to the hub pharmacy where it was accuracy checked by an ACT prior to the data being inputted into the automated dispensing machine for assembly of the medicines. The

computer system that accompanied the dispensing machine took photographs of each pack. If any errors were found, the pack was rejected and required to be manually checked. And a photograph of each medication was printed onto the labels and attached to the packs so people could differentiate between the different medicines in the pack. A description of each medicine was also added by the dispenser. A sample of dispensed compliance packs were seen to have been labelled with descriptions and photographs of the medication. Patient information leaflets were supplied so people had access to up-to-date information about their medicines. Photographs of the packs were stored on the PMR and able to be recalled in the event of any queries. The completed packs were accuracy checked by the ACTs in the hub prior to delivery to the spoke pharmacies.

The team used barcodes to manage stock in the automated dispensing machine. The stock was de-blistered and placed into canisters and each canister contained the same batch number and expiry date so that there were no mixed batches. Barcodes were used to manage the stock and the barcodes from the canister and the stock boxes were scanned before as an accuracy check. A dispensing assistant kept additional paper records of when the stock had been removed from its original packaging and which members of the team had been involved in the process. A pharmacist or ACT performed a second check before the canisters were authorised to be loaded into the dispensing machine. The team also kept a record of all batch number and expiry dates of stock in the cannister so that medicines could be identified in the event a product recall.

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 screen 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 and had an audit trail to demonstrate completion. A random selection of medicines were checked and all were found to be within their expiry date. 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. It maintains its equipment to ensure it remains 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. The automated dispensing machines for multi-compartment compliance packs and the automated 24-hour collection point were serviced regularly by the external providers. And engineer support was available via telephone and in person 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.