General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dickies Pharmacy, 96 Victoria Road, ABERDEEN, Aberdeenshire, AB11 9DU

Pharmacy reference: 1041643

Type of pharmacy: Community

Date of inspection: 28/05/2019

Pharmacy context

This is a community pharmacy beside other shops within a city. People of all ages use the pharmacy. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartment compliance packs. The pharmacy supplies medicines to a care home.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.2	Standard not met	The pharmacy does not routinely track and review dispensing accuracy. So it may miss learning opportunities and the chance to make improvements.
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 not all met	4.2	Standard not met	The pharmacy does not always manage instalment dispensing safely. And it does not always keep accurate records and audit trails of these supplies.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy team members follow processes for all services. They seldom record mistakes to learn from them. So, the team are missing learning opportunities. The pharmacy does not review these so cannot identify learning points. The pharmacy keeps the records that it needs to by law. It usually keeps people's information safe, but some personal information is disposed of with general waste.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place and these were followed for all activities/tasks. They had been read and signed by relevant pharmacy team members. They were reviewed every two years and were signed off by the pharmacy manager. At the time of inspection, they were in the consultation room as some new processes were being read by team members. Staff roles and responsibilities were recorded on individual SOPs. There was an index page with version number and renewal date which was useful for individuals using these as working documents. Dispensing, a high-risk activity, was observed to be methodical with coloured baskets in use for dispensing. There was an audit trail in place for dispensed medicines in the form of dispensed and checked by signatures on labels. The pharmacy had a business continuity plan in place to address maintenance issues or disruption to services. There were contact details for a variety of suppliers, GP practices and other pharmacies, and recent relevant letters regarding processes and services, at the pharmacist's checking bench for reference.

The pharmacy had near miss logs but team members did not often record mistakes. Some months they had not recorded any. The SI explained following the inspection that mistakes were not frequent. Team members did not record enough information with meaningful reasons for useful reflection to take place. The pharmacy also had error reporting in place, but this was also very brief. An error had been made a few months previously which had been reported. Part of the report stated that a voicemail had been left asking the patient to get in touch with the pharmacy. There was no further information, and no one was aware if this had ever been followed up. Team members did not give any examples of changes or improvements being made after incidents. Pharmacy team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist.

There was a complaints procedure in place. Team members described some recent complaints to the pharmacy and NHS regarding difficulty finding prescriptions and stock not always being available. They were addressing this by trying to better explain to people about external stock shortages. Indemnity insurance certificate was displayed, expiring March 2020.

The following records were maintained in compliance with relevant legislation: Responsible Pharmacist notice displayed; Responsible pharmacist log. All entries were from 9am, although the pharmacist was often on the premises and undertaking pharmacy activities before that; Private prescription records including records of emergency supplies and veterinary prescriptions; Unlicensed specials records; Controlled drugs registers, with running balances maintained and regularly audited. Entries were made twice daily, and these items were counted. A dispenser counted all stock monthly, and this was double checked. Controlled drug (CD) destruction register for patient returned medicines. The electronic patient medication record was backed up each night.

Team members were aware of the need for confidentiality. They generally segregated confidential waste for secure destruction, but at the time of inspection some labels were in general waste. They were also aware of safeguarding issues and had general information and contact details/local process available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained or training team members staff to safely provide its services. The pharmacy team do not have time routinely set aside to keep their knowledge and skills up-to-date. This could affect how well they care for people and the advice they give. The pharmacy team members know how to raise a concern if they have one.

Inspector's evidence

Staff numbers during the inspection were: One full-time pharmacist manager, and one day per week double pharmacist cover; one full-time trainee pharmacy technician; two full-time qualified dispensers; two part-time qualified dispensers, one undertaking an accuracy checking qualification; two part-time qualified medicines' counter assistants, one working mornings, and the other afternoons; two pharmacy students, working full-time over the summer, one usually worked Saturdays and the other two days per week; one new trainee medicines counter assistant who had started the previous day; one delivery driver shared with other branches. Typically, there were six team members working in the dispensary and one or two on the medicines counter. Team members followed rotas for some tasks to ensure they were undertaken, and that everyone maintained skills in the various processes. The pharmacy used students and part-time team members to cover absence.

The pharmacy provided some protected learning time for the trainee pharmacy technician, although she undertook most of her learning at home in her own time. It also provided time for the trainee dispensing accuracy check to undertake checking. She had checked 1,000 items, checking up to 50 per day, and kept records of these. Recently the pharmacy had been busy, so she had been dispensing. The pharmacy did not currently have structured training and development in place and there was no routine protected learning time for team members. But time was allocated to read documents such as standard operating procedures. One dispenser described having a development meeting around a year previously, with actions relating to improving computer skills. The inspector observed training records from around five years before.

The pharmacist shared information with all team members when there were changes to processes e.g. computer updates and the recent introduction of scanning medicines in relation to the requirements of the Falsified Medicines Directive (FMD). She also spent time coaching team members 'on the job'.

Team members went about tasks in a methodical manner and dealt very professionally with all patient groups. There were involved in the delivery of time-consuming services such as needle exchange and the supply of naloxone.

All team members shared information and discussed incidents with colleagues. They understood the importance of reporting mistakes and they were comfortable owning up to their own mistakes, although these were not always recorded. The organisation shared information, with the superintendent pharmacist or another senior pharmacist coming to the pharmacy to explain new processes. Team members described how they would raise concerns, and they knew how to contact the superintendent pharmacist. They also knew how to contact the NHS controlled drug accountable officer to raise any concerns about controlled drugs. The pharmacy did not set targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean, and suitable for its services. The pharmacy team members use a private room for some conversations with people. People cannot overhear these conversations. The pharmacy usually protects people's information, but some conversations can be overheard in the advice area. People may know what medicines other people are receiving. The pharmacy is secure when closed. But some maintenance is required.

Inspector's evidence

These were reasonably sized premises on a corner site. There were three public facing external doors, one used for public access, one for delivery of substance misuse services and the other not used. It was a glass door that had a crack on one of the panes, which was noted at the previous inspection over three years ago. One door was inadequately bolted. The dispensary was not a regular shape, making work flow disjointed. And areas were cramped.

There was a room behind the dispensary where high risk activities such as the assembly of multicompartment medicine packs were undertaken. People were not able to see activities being undertaken in the dispensary. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers.

There was a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. There was a separate area for specialist services such as substance misuse supervision. During the day the external door to this area was unlocked, so people could access it freely. This meant that sometimes there were several people in the room. There was a bench available for people who were waiting to sit, and the shape of the room provided some privacy for people taking their medicine. Fingerprint recognition was used for identification. There was a sink and a bucket in this room. There was a door into the dispensary, but this was kept locked and could only be unlocked from the dispensary side. Supervision was undertaken through a hatch between this room and the dispensary.

There was an upstairs area accommodating some storage and staff facilities. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. The premises were observed to be clean.

The pharmacy was alarmed, had CCTV, and panic alarms. Shutters protected the front door and windows when the pharmacy was closed. Windows to the rear of the premises were protected by bars. Temperature and lighting were comfortable.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides most services safely. But there is risk associated with some instalment dispensing. Team members give people information to help them use their medicines. The pharmacy gets medicines from reliable sources and mostly stores them properly.

Inspector's evidence

There was good physical access by means of a ramp and an automatic door. The pharmacy displayed a list of services provided and had leaflets on a range of topics.

The pharmacy provided services relevent to the local community such as needle exchage, smoking cessation and naloxone supply.
Team members spoke relevant languages in addition to English – there were people from Russia and European countries living and working locally. Team members wrote notes to communicate with deaf people, and they could provide large print labels for people with impaired vision. They signposted to other services e.g. sexual services. All staff members wore badges showing their name and role.

Dispensing work flow was methodical although the unusual shape of the dispensary made this slightly challenging. One team member labelled while others dispensed, unless there was an unusually large volume of prescriptions, in which case two dispensers labelled and others dispensed. This process was interrupted at a suitable point to manage walk-in prescriptions. Team members signed dispensing labels to provide an audit trail of who had dispensed and checked medicines. They usually assembled owings later the same day or the following day.

The pharmacy provided a delivery service and people signed on receipt of controlled drugs.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. Team members undertook this activity daily. They supplied patient information leaflets with the first pack of each prescription. Labels had the date of labelling on them, and the packaging had the instalment number and the day of supply, but not date. The pharmacy kept a separate sheet showing when packs had been assembled and supplied. Some people received four packs at a time although prescriptions stated, 'dispense weekly’. Record-keeping and dates of supply looked confusing and may have been difficult for e.g. a locum pharmacist to understand. One person’s labels had the date '4.4.19', and a note attached saying ‘a new box was due 15.4.19 X 4 weeks’. This person received four packs at a time, and four packs were on the shelf, dated '4.4.19'. There was no prescription and a team member believed this had probably been sent for payment. The pharmacist explained prescriptions were sent for payment when the final pack had been supplied, so this was assumed to have gone on '4.4.19'. The pharmacy supplied additional packs when people were going on holiday, or if the pharmacy was closed e.g. Christmas or Easter. Team members typically wrote a note and kept this with patient information for a few weeks and then discarded it – there was no permanent or long-term record of unusual supplies or exceptions to the norm.

Team members managed the care home dispensing in the same area as multicompartment medicine packs. Some people received medicines in original packs and some were still on rack systems, although

there was a move to get all people changed onto original packs dispensing with medicines administration record (MAR) charts.

Dispensers poured methadone instalments using a 'methameasure' pump device. They poured them straight into unlabelled cups. Instalments were not checked at this point. When prescriptions were received, a dispenser entered the data onto the computer and this was checked by a pharmacist, but there was not an audit trail. Dispensers poured instalments for takeaway doses into bottles which were labelled but these were not signed. People's identity was confirmed using a fingerprint recognition device, and they were asked for their address. Pharmacy team members encouraged people to drink water after taking their medicine – there was a sink in the supervision area. They were asked to discard used cups into a bucket in this area before leaving. Team members engaged people in conversations which gave them an opportunity to check that they were well enough to receive their medicine and helped to establish a relationship. They were given information e.g. told when their prescriptions were going to run out. The pharmacy had information about supplying methadone on the wall close to the supervision area as an aide memoir for team members. The pharmacy supplied naloxone to people on request for treating opiate overdose. The pharmacist was observed to do this during the inspection and she explained that she was able to provide training for people if they required it, but most people had been trained by the substance misuse service. She made this supply in a methodical and professional manner, but it was time-consuming, taking over five minutes.

The pharmacy supplied a variety of other medicines by instalment. Team members dispensed prescriptions in their entirety and placed instalments into named boxes in a designated area of the pharmacy. They banded each medicine together. Medicines counter assistants handed these medicines out – they selected a pack from each band and compared these to prescriptions. They were not dispensary trained and did not have this checked. Labels had the date of dispensing on them, not supply. Some prescriptions had accurate records of supplies attached to them, but others did not. This made it very difficult to understand when supplies were due. One person's labels were dated '21.05.19' but these dates had been scored out. There were three instalments in the box and no record of any supply having been made. Another person's information showed that they had not collected their medicine on '31.1.19', but there was no further information recorded. Several patients' boxes had loose tablet in them, still wrapped in the blister packaging but with no batch number, expiry date or in some cases name of medicine.
The pharmacy had supplied the first instalment on '24.5.19' from an unsigned prescription for tramadol (schedule three controlled drug) dated '23.5.19', without any evidence of requesting a new prescription. This was not lawful. The pharmacy was very busy with people accessing the needle exchange service – there was a constant queue during the inspection. This was a time-consuming activity, with several minutes spent with each person. All team members were trained and competent to undertake this, and the week inspection all were having hepatitis B injections.

The pharmacist gave advice to people receiving high risk medicines including valproate, methotrexate, lithium, and warfarin were given appropriate advice and counselling. Written information and record books were provided if required. The pharmacy had the valproate pregnancy prevention programme in place. It had implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. 'Sick day rules' were also discussed with people on certain medicines, so that they could manage their medicines when they were unwell.
The pharmacy followed the service specifications for NHS services, and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, and chloramphenicol ophthalmic products.
Chronic medication service (CMS) serial prescriptions were appropriately managed. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence.

The pharmacy obtained medicines from licensed suppliers such as AAH. The pharmacy complied with the requirements of the Falsified Medicines Directive (FMD). Medicines were scanned when dispensed and handed out. Pharmacy team members checked expiry dates of medicines, and items inspected were found to be in date. They mostly stored medicines in original packaging on shelves and in cupboards. There were some tablets stored loose in bottles that were not labelled correctly. Some shelves were untidy, particularly in the room where the multi-compartment medicine packs were assembled. The pharmacy stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and took appropriate action if there was any deviation from accepted limits.

The pharmacy submitted prescriptions for pricing before all medicines had been supplied. Some owings were on retrieval shelves with no prescriptions attached.

The pharmacy protected pharmacy (P) medicines from self-selection. And team members followed the sale of medicines protocol for these.

Team members actioned MHRA recalls and alerts on receipt and kept records. They contacted people who had been supplied with medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. The pharmacy looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. And it had Internet access allowing online resources to be used. It had a carbon monoxide monitor which was maintained by the health board and used with people accessing the smoking cessation service. Team members used Crown stamped measures, including separate marked ones for methadone. And a 'methameasure' pump which was cleaned daily and test volumes were poured.

Clean tablet and capsule counters were also kept in the dispensary, and separate marked ones were used for cytotoxic tablets. Paper records were stored in the dispensary inaccessible to the public.

Team members did not leave computers unattended and were password protected. Screens were not visible to the public. They took care to ensure phone conversations could not be overheard.

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.