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: 14/01/2020

Pharmacy context

This is a community pharmacy beside other shops within a city. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it supplies medicines to a care home. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines.

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 team members follow written processes for all services to ensure that they are safe. They record mistakes to learn from them. And put strategies in place to avoid the same mistakes happening again. The pharmacy asks people for feedback to ensure that they are providing services appropriately. The pharmacy keeps all the records that it needs to and keeps people's information safe. Team members help to protect vulnerable people.

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 2 years and were signed off by the pharmacy manager. Staff roles and responsibilities were recorded on individual SOPs. There was an index page with version number and renewal date which was useful for team members who were 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 the pharmacist had recent and relevant letters regarding processes and services, at her checking bench for reference. Team members followed a duties' rota for all dispensary activities including cleaning and rest breaks. They were all competent to undertake all tasks. Medicines' counter assistants were clear about the scope of their role. A pharmacy technician had additional responsibilities such as the management of serial prescriptions and sharing information with prescribers and practice pharmacists. She also deputised for the pharmacist offering to deal with queries within her competence. An accuracy checking dispensing assistant was clear about which dispensed medicines she could check, and under what circumstances. Other team members were also clear about these additional activities.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. The accuracy checking dispensing assistant explained that she always highlighted errors to individuals who then recorded their own incident. She explained there were not many. The pharmacist reviewed these either monthly or two monthly depending on how many there had been. She reported that the team was very accurate and not many errors were identified. She made an electronic record of reviewing incidents, but did not keep records of sharing with team members. The pharmacist had only been in the pharmacy for three months, and the pharmacy had been busy with Christmas during this time. This was an area she was planning to develop. Team members had made a few errors with insulin. So, the pharmacist had spoken to them all and placed a notice on the fridge reminding them to double check device types when dispensing these. She used a safety notice board to note safety issues such as this. And she noted local initiatives e.g. NHS Grampian had been running an overdose awareness campaign. So, team members were reminded to offer naloxone to appropriate people. They were trained to supply this and could train patients if required. They also recorded errors reaching patients to learn from them. The pharmacist explained there had been none since she started, and she was not aware of any before that. She was methodically reviewing all processes in the pharmacy. She had reviewed some process already e.g. management of multi-compartment compliance packs.

The pharmacy had a complaints procedure and welcomed feedback. At the time of the inspection customer satisfaction surveys were being undertaken. The pharmacy used a template provided by Community Pharmacy Scotland (CPS). Some completed forms were in the pharmacy with positive feedback. At the end of the month a relief pharmacist planned to review these, collating responses and then provide feedback to the pharmacy.

The pharmacy had an indemnity insurance certificate, expiring 31 March 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost. A second team member double checked balances of controlled drugs that had been supplied or received each day. This was observed and was done several times a day in a methodical manner.

Pharmacy team members were aware of the need for confidentiality. They had all read and signed an agreement when they started in the pharmacy. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had access to contact details and processes to raise safeguarding concerns. They could provide details of sharing concerns with prescribers and key workers, especially if people missed regular doses of medicine. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. Team members work flexibly to ensure there are always enough members of staff to provide services. The pharmacy provides team members with time at work to undertake training. This is to ensure they have the knowledge and skills they need.Team members can share information and raise concerns to keep the pharmacy safe. The pharmacy identifies and makes changes to improve services when needed.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager with two days per week double pharmacist cover; one full-time pharmacy technician, two full-time dispensers, one part-time dispenser who was on leave, one part-time accuracy-checking dispenser; three part-time medicines counter assistants (two in mornings and one in the afternoons); two pharmacy students, one working part-time and the other working Saturdays and others days as required; and a part-time delivery driver. Typically, there were seven or eight team members in addition to pharmacists working at any time. Team members were able to manage the workload. And part-time team members and pharmacy students had scope to cover absence. The pharmacy manager had started in this branch around three months previously and was methodically reviewing all processes.

The pharmacy provided learning time during the working day for all team members to undertake training and development. It provided team members undertaking accredited courses with additional time to complete coursework. The pharmacy manager described staff training and development as a priority. She had recently arranged the local NHS ‘stop-smoking’ co-ordinator to come in and train all team members. They had all done this previously, but she felt refresher training would be valuable to ensure everyone was delivering the service in the same way. The pharmacy manager was developing over-the-counter (otc) fact sheets for all team members to use. She had done this in a previous role and found it useful. Team members who were mainly involved in dispensing sometimes slightly ‘de-skilled’ and lost confidence on otc medicines, so this would help them.

The various individuals were observed going about their tasks in a systematic and professional manner. They were observed to provide professional and friendly advice to people. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They explained could make suggestions and raise concerns to the manager or area manager. They gave appropriate response to scenarios posed. The pharmacy team discussed incidents and how to reduce risks. The pharmacy had responded to areas for improvement highlighted in the previous inspection report. And it had made appropriate improvements. These included: repairing a damaged window, signing all dispensing labels to provide an audit trail, improving the processes for managing some medicines supplied by instalment and recording errors identified in the pharmacy for team members to learn from them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy's services. The pharmacy team members use a private room for some discussions with people so other people cannot hear these conversations. And they use a separate area for the delivery of some services, giving people some privacy. The pharmacy is secure when closed. The pharmacy deals with maintenance issues and damage to the premises appropriately.

Inspector's evidence

These were reasonably sized premises on a corner site. There was a room behind the dispensary where high risk activities such as the assembly of multicompartment compliance packs were undertaken. The premises had an upper floor 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, hygienic and well maintained. The pharmacy had recently replaced damaged windows and locks.

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.

The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. Team members invited people into this room when they wished to discuss private matters. The pharmacy had a separate area for specialist services such as substance misuse supervision. During the day it kept the external door to this area 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. This room had a sink and a bucket for disposal of used cups. It had topical information on the wall for people accessing services and signposting to other services. There was a door into the dispensary, but the pharmacy kept this locked. Pharmacy team members supervised medicine consumption through a hatch between this room and the dispensary.Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team members know what to do if medicines are not fit for purpose.

Inspector's evidence

There was good physical access by means of a flat entrance and an automatic door. The pharmacy displayed a list of services provided and had leaflets on a range of topics. Team members spoke relevant languages in addition to English – there were people from Russia and European countries living and working locally. One Polish team member was often used to interpret. She ensured the pharmacist was aware of any relevant information shared. The local community had a large Polish population, several who did not speak fluent English. 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. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. 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 labelling marked any new items or changes on prescriptions to facilitate the pharmacist's clinical check. The pharmacist carried out clinical checks after labelling to enable the accuracy checking dispensary assistant to fulfil this role. She checked some collection service and multi-compartment compliance pack prescriptions. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. And the pharmacist initialled prescriptions following her clinical check. Some people received medicines from chronic medication service (CMS) serial prescriptions. These were appropriately managed, mainly by the pharmacy technician. She monitored compliance and liaised with the practice pharmacist when she had concerns. A recent example was a person who did not use their inhalers regularly. Following the pharmacy technician highlighting this, the practice pharmacist took the person off CMS and set up a clinical review. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. Team members checked the prescription medicine retrieval shelves every two months and removed uncollected medicines. A bag containing medicines for treating diabetes from three months previously was observed. The pharmacist explained that it was difficult to manage some people's compliance. And some people did not stay for long in the area so may receive medicines from other pharmacies.

The pharmacy managed multi-compartmental compliance packs in a room behind the dispensary with little distraction and interruption. It had adequate space for assembly and checking. Team members worked on a four-weekly cycle, at least a week in advance and assembled four packs at a time. They kept comprehensive chronological records of changes and other interventions. These included prescribers' details. The pharmacy provided some people with two packs each week if there were too

many or too large tablets to fit in one pack. It kept records of which tablets went in which tray to ensure it was always the same. The pharmacy stored patient records in folders depending on day of supply and kept a separate folder for people in hospital. This helped locate records when required. Team members hand-wrote tablet descriptions onto packaging. And they included patient name, instalment number and date of supply on the spine of packs. The pharmacy stored completed packs in individual named boxes on dedicated shelves in this room. And it kept a progress log showing packs assembled and supplied. This ensured additional packs were not supplied in error and identified any that had not been collected.

The pharmacy supplied patient information leaflets (PILs) with the first pack of each prescription. It had reviewed the whole process for its management of these packs since the previous inspection. And it had introduced some changes to improve the system. These included the external marking of packs with dates and instalment numbers. And the pharmacist had recently introduced dated wallets to store prescriptions in. Team members now stored prescriptions in a wallet dated for the end of the prescription. This enabled prescriptions to be easily located if required while medicines were still being taken. And it facilitated timely submission of prescriptions to the NHS.

The pharmacy also provided pharmaceutical services to a care home. It managed this appropriately in the same area as compliance packs. It supplied medicines in original packs with medicines administration charts. The pharmacy supplied a variety of other medicines by instalments to a lot of people. A team member dispensed these in entirety on receipt. And placed the small number of tablets in a small, clear, labelled bag. If there was more than one medicine per instalment, the team member stapled the bags for that day together. A pharmacist then checked these and they were placed in labelled baskets per person on dedicated shelves close to the retrieval shelves. The team member who dispensed, completed a PC70 form with medicines listed with instalment dates. The pharmacist also checked this. The team member making the supply located the supply due that day then compared it the record on the PC70, then initialled that the supply had been made. This provided an audit trail of who had supplied what. And it provided a check at the point of supply that all expected medicines were supplied. This process had been reviewed and improved since the previous inspection. The process was safer, and all team members had been trained in it. A team member moved uncollected instalments to a separate shelf. The pharmacist reviewed these and contacted prescribers. She did not follow a set process, using her knowledge of people's usual patterns to inform her when she should share the information.

The pharmacy delivered substance misuse services to a lot of people. This included supervised consumption of methadone and buprenorphine, 'takeaway' doses of methadone, a large volume of daily and weekly instalments of a variety of medication. and around 200 needle exchange supplies each month. When methadone prescriptions were received, a team member entered the data on to the 'methameasure' computer. A pharmacist checked and confirmed it was accurate. The pharmacist initialled prescriptions to provide an audit trail. A team member poured methadone instalments for supervised doses as people presented at the pharmacy. The team member supervised consumption at the hatch. And encouraged people to drink water from the same cup before placing it in the bucket. Team members confirmed people's identity using fingerprint identification technology, photographs, and if necessary, also asked for date of birth and what dose the person expected. All dispensary team members were trained and competent to provide the needle exchange service. They were observed to be polite and professional, treating people with respect and dignity. They ensured that people were given what they needed. And they reminded people to return used equipment. They were offered disposal receptacles. The pharmacy had relevant reference material on the wall close to the supervision area. This included guidance on supervising buprenorphine and best practice for preventing harm with oral methadone.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. The pharmacist counselled people in the high-risk group appropriately. The pharmacy had also 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. Team members also discussed 'sick day rules' 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, and emergency hormonal contraception. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. The smoking cessation service was well used, with all team members trained to provide it. One team member undertook most consultations. And several people successfully quit smoking over the past few months.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It complied with the requirements of the Falsified Medicines Directive (FMD). Team members scanned medicines when they were dispensed, then again (de-commissioned) when supplied. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in two fridges with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. It used one mainly for dispensed items, and the other for most stock. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. Team members contacted people who had received 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 they cleaned daily and poured test volumes once or twice per day. The pharmacy also kept clean tablet and capsule counters in the dispensary, and separate marked ones were used for cytotoxic tablets. The pharmacy kept adequate supplies of equipment and sundries required for the needle exchange service. This included needle disposal receptacles and condoms.

The pharmacy stored paper records in the dispensary inaccessible to the public. Team members did not leave computers unattended and used passwords 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.