General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Davidsons Chemist, Ballater Road, ABOYNE, Aberdeenshire, AB34 5HT

Pharmacy reference: 1041650

Type of pharmacy: Community

Date of inspection: 29/08/2019

Pharmacy context

This is a community pharmacy on a main street in a village. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs and provides substance misuse services. The pharmacy supplies acute medicines to care homes. It offers travel vaccination and advice. And it offers flu vaccination during the winter season.

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	2.2	Good practice	New employees are on a structured induction programme. All team members undertake regular structured training. The pharmacy provides resources and protected time for this.
		2.3	Good practice	The pharmacy team makes interventions that have positive outcomes for people.
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

Pharmacy team members follow processes for all services to ensure that they are safe. The pharmacy updates these written processes regularly. Pharmacy team members record mistakes to learn from them. The pharmacy uses feedback from people to make pharmacy services better. The pharmacy keeps most of the records that it needs to by law. And it keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy superintendent kept records of this. New SOPs were printed, all team members read them and signed a declaration which was sent to head office. Recent ones were observed e.g. a new process for the management of instalment prescriptions. The details of the SOP for compliance pack prescriptions assembled at an offsite hub were not quite followed. This was a relatively new process and was still being established. The pharmacy superintendent reviewed SOPs every two years (or sooner) and signed them off. Staff roles and responsibilities were recorded on individual SOPs, and on a 'roles and responsibilities' chart on the wall. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The trainee medicines counter assistant described tasks she was not yet able to do, including making recommendations over the counter. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. Team members had access to a range of phone numbers for people to contact under different circumstances, including other branches, head office personnel, other healthcare professionals and suppliers.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They recoded their own incidents electronically when possible to re-enforce the learning. They also recorded errors reaching patients to learn from them. And they discussed these at the time to make improvements. These included separating similar sounding and looking products such as enalapril and escitalopram. The team members present at the time of inspection were not aware of reviewing these. The superintendent pharmacist provided evidence after the inspection that the regular pharmacist had accessed the electronic analysis and reviewed it recently. Team members were not yet aware of this. Team members described several examples of highlighting similar packaging, and changed packaging, to colleagues.

The pharmacy had a complaints procedure and welcomed feedback. The supervisor and medicines counter assistant explained that she treated people as she wanted to be treated and encouraged all team members to do the same. She acknowledged everyone as they came in. She regularly walked round the shop as a customer might and moved stock around to make it easier for people to locate. E.g. she had moved some small herbal and vitamin products onto lower shelves where they were easy to see and moved larger lightweight items to the top shelves. She ordered items into the pharmacy and for direct delivery to people's homes e.g. aids to independent living.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. The pharmacy displayed the

responsible pharmacist notice and kept the following records: responsible pharmacist (RP) 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. Team members signed any alterations to records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost. Team members used colour coding on the electronic CD registers to distinguish between different preparations to minimise the risk of entries being made in the wrong register. The pharmacy did not complete all records as expected. The RP log was not seen because team members did not know how to access it. They described how it was completed each day. The pharmacy did not always include all the detail required by law in the private prescription register e.g. prescriber name and address and veterinary species. Team members did not always audit the CD registers as per the SOP. And the previous week's entries had been made by a new untrained team member.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and recently undertaken training. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read a SOP and undertaken training on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacy had a chaperone policy in place and displayed a notice telling people. 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. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is. And then makes changes if required. This ensures skilled and qualified staff provide pharmacy services. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time during the working day to use this training. Pharmacy team members make decisions and use their professional judgement to help people. Team members can share information and raise concerns to keep the pharmacy safe. Staff members make suggestions to improve services. The pharmacy team members discuss incidents. They learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one regular locum pharmacist one day per week, one full-time pharmacy technician, one full-time trainee pharmacy technician, one part-time dispenser (11am - 4.30pm), one full-time and one part-time medicines counter assistants and two Saturday only trainee pharmacy assistants. One medicines counter assistant had recently started in the pharmacy and was working through Davidson's 12-week induction programme. One Saturday assistant was undertaking a joint medicines counter and dispensing course, and the other had recently started so was on the induction programme. The pharmacy displayed their certificates of qualification. Typically, there were 2 or 3 team members working in the dispensary and one or two on the medicines counter. Recently there had been staff absence and holidays, so there had been some challenges. All team members were now back to their usual hours, and following review, and resignations, gaps had been filled, so pressure was relieved. Team members were able to manage the workload. Part-time team members had some scope to work flexibly providing contingency for absence.

The pharmacy provided protected learning time for all team members to undertake regular training and development. The supervisor noted training to be done on a whiteboard to remind all team members. They did these modules as soon as possible. This was usually monthly with topics provided from head office. Recent topics included safeguarding, confidentiality (GDPR), dermatitis, footcare and hayfever. Each team member had a password protected record of training electronically, and paper records were also kept.

The pharmacy provided team members undertaking accredited courses with additional time to complete coursework. The trainee pharmacy technician had four hours per week. She took this as two two-hour blocks and worked in the consultation room. The regular pharmacist who was not present had recently undertaken training to enable her to provide the travel clinic. She and the pharmacy technician discussed topics suitable for continuing professional development recording. All team members coached new colleagues to help them learn systems and processes.

The various individuals were observed going about their tasks in a systematic and professional manner. 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. They asked relevant questions to establish exactly what people were requesting and provided good quality advice. This included a person asking to buy a piece of equipment that would be inexpensive to use. The pharmacist established the reason for the request and made an appointment for the person to see a specialist nurse. The person

was grateful as they had received appropriate clinical advice and not bought an unsuitable product. The pharmacist identified a serious interaction and despite the person being short of time, managed to discuss with the prescriber and obtain a prescription for a safer alternative.

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 and how they could reduce risk. The pharmacy superintendent sent a monthly safety bulletin, and all team members were given time to read these and other company documents. They signed to confirm reading and understanding, and often discussed these 'on the job'. Examples of topics covered were MHRA information, errors within the organisation for all to learn from, and a recent National Pharmaceutical Association (NPA) update. The team had occasional team meetings usually 'out of hours' as it was difficult to get together during business hours. They had a meeting two months previously. They discussed GPhC inspections, responsible pharmacist regulations, drug related deaths, date checking, drug alerts and local health centre developments. The pharmacist kept notes of meetings including who attended.

The company had a whistleblowing policy that team members were aware of. They explained that they felt comfortable making suggestions to the pharmacy manager or superintendent pharmacist and could raise concerns with them. A team member described adopting a system suggested by a relief pharmacist to improve how 'owings' were managed. The company did not set targets but provided the pharmacy with data about services. This helped remind team members to offer services to people who would benefit e.g. text service and CMS.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are safe and clean and suitable for the pharmacy services provided. The pharmacy team members use a private room for some conversations with people. People cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises incorporating a retail area, dispensary and back shop area including storage space and staff facilities. The premises were clean, hygienic and well maintained. Team members working on Saturdays cleaned on a rota basis and kept records. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. The door was kept locked to prevent unauthorised access. 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. And it supports people with other services. The pharmacy team provides safe pharmacy services. Team members give people information to help them use their medicines. And they provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had two steps at the entrance, but a portable ramp was used when needed for access. It had an automatic door. It listed its services and had leaflets available on a variety of topics. The pharmacy could provide large print labels to help people with impaired vision. All team members wore badges showing their name and role. They engaged with the local community in various ways, such as providing second hand books for sale/swap. They supported the company's chosen charity of the year by various fundraising initiatives and events. And they helped individual people in non-pharmacy ways due to the rural nature of the pharmacy.

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. And they shared information with the pharmacist by printing all warning labels that highlighted interactions and new items. Team members described discussing the importance of not ignoring alerts and warnings. The pharmacy had a notice in the dispensary reminding dispensers of items that required a double check. These included anything that didn't scan, controlled drugs, cytotoxics and injectable medication. The pharmacist used large red 'counselling cards' to ensure people needing advice were highlighted. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. They also initialled prescriptions to provide an audit trail of personnel involved at every stage of the dispensing process including labelling and handing out. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these the week before expected supply. Team members recorded date of supply and expected date of next supply. Dispensed medicines were stored on designated retrieval shelves with CMS labels to identify them. The inspector observed a few that had been dispensed several weeks ago e.g. 20 July, 5 August and 9 August. This could mean that people had been without medication for a few weeks. The pharmacy was actively registering people for this service. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. They did this in a dedicated area in the back-shop where there was little distraction. Team members followed a robust and methodical process using colour coding to identify the different weeks. They assembled packs the week before they were required. And they kept thorough records of changes and interventions. The pharmacy stored completed packs in individually labelled baskets on labelled shelves. Team members supplied patient information leaflets with the first pack of each cycle. And they put descriptions of some tablets on packaging. The pharmacy also provided acute medicines to three local care homes. A pharmacy in a village 12 miles away provided most of the pharmaceutical care to these homes. When acute prescriptions were received, a team member faxed it to the other pharmacy

for the pharmacist there to undertake a clinical check using the patient medication record (PMR). The pharmacist in the other pharmacy responded to the pharmacist in this pharmacy, confirming that there was no reason for the medicine not to be supplied, and whether a medication administration record (MAR) chart was required. Both pharmacies kept records of this. The pharmacy supplied medicines to several people by instalment. Team members dispensed these in entirety on receipt. They stored them in bags labelled with personal details and date of supply, in labelled baskets. People signed to acknowledge receipt these medicines. The pharmacy displayed a notice telling people that they would be asked to confirm their name and address even if they were well known to the pharmacy. It also had a notice telling people that certain medicines could only be supplied when the pharmacist was present.

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. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled them 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 team members had received training to enable them to provide this information.

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, supply of chloramphenicol ophthalmic products and chlamydia treatment. It also followed private PGDs for travel vaccination. The pharmacist approved all minor ailments service (eMAS) requests before dispensing. Team members wrote personal details, symptoms and their recommendation if it was within their competence, then discussed with the pharmacist. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. The regular pharmacist who was not present during the inspection provided travel vaccination and malaria prophylaxis. This was a new service and team members explained that there had been a lot of interest from people, but not many consultations yet. A medicines counter assistant delivered the smoking cessation service for people supplied with nicotine replacement therapy, and the pharmacist saw people taking Champix. The pharmacy was currently providing this service to several people and a few recent successes were described.

The pharmacy obtained medicines from licensed wholesalers such as Alliance, AAH, Phoenix and Bestway. It scanned Falsified Medicines Directive (FMD) compliant packs for dispensing accuracy and FMD verification. Team members scanned dispensed medicines again at the point of supply, at which time FMD decommissioning took place. All team members had read and signed a SOP. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. 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. It had Internet access allowing online resources to be used.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board, used with people accessing the smoking cessation service. It had an anaphylaxis kit, gloves, sharps boxes and sundries required for vaccinations in the consultation room. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in a locked cupboard in the consultation room and in the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left them unattended unless they were locked.

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.