

Registered pharmacy inspection report

Pharmacy Name: Davidsons Chemist, 10 Bridge Street, BALLATER, Aberdeenshire, AB35 5QP

Pharmacy reference: 1041651

Type of pharmacy: Community

Date of inspection: 22/02/2024

Pharmacy context

This is a community pharmacy in the village of Ballater, a popular tourist destination on Royal Deeside. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartment compliance packs and supplies medicines to people living in care homes. The pharmacist is a prescriber and provides the NHS Pharmacy First Plus service. The pharmacy offers some private services such as flu and travel vaccinations.

Overall inspection outcome

✓ **Standards met**

Required Action: None

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 met	1.2	Good practice	The pharmacy regularly and comprehensively reviews the errors team members make to learn from them. And it continually monitors its procedures to help improve safety and effectiveness.
2. Staff	Standards met	2.4	Good practice	Members of the pharmacy team work well together and have a good work culture of openness, honesty and learning.
		2.5	Good practice	The pharmacy team proactively engages in improving the delivery of the pharmacy's services. And it shares solutions and ideas with other pharmacies.
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 safe working practices. They record mistakes and learn from them. And they assess their ways of working and change their processes to improve the safety of services. Team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's private information and keep the records they need to by law.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs), and it maintained an electronic record to show that all team members had read and agreed to follow them. The Superintendent pharmacist (SI) reviewed these every two years. Team members described their roles within the pharmacy and the processes they were involved in and accurately explained which activities could not be undertaken in the absence of the responsible pharmacist. The pharmacy employed an Accuracy Checking Pharmacy Technician (ACPT). Team members described the process for prescriptions being clinically checked by the pharmacist prior to dispensing and how this was clearly marked on the prescriptions. This enabled the ACPT to complete the accuracy check. The pharmacy had a business continuity plan to address disruption to services or unexpected closure. Team members described the process for branch closure when there was no responsible pharmacist available.

Pharmacy team members kept records about dispensing mistakes that were identified in the pharmacy, known as near misses. And they recorded errors that had been identified after people received their medicines. Team members recorded near misses on an electronic record which could also be accessed using a quick response (QR) code from smart phone devices. They explained that an error would be highlighted to them by the pharmacist or ACPT, and it was their responsibility to enter it onto the record. This allowed them to reflect on the mistake. The pharmacy used bar-code scanning technology when dispensing which helped to manage the risk of selection errors. The pharmacy team held a monthly safety meeting led by the pharmacist manager. They used this meeting to review all near misses and errors each month and to learn from them. They introduced strategies to minimise the chances of the same error happening again. The company's patient safety officer shared a patient safety report regularly which detailed learnings from other pharmacies in the group. Team members had discussed the latest report and reflected on their own practice. They put in a new procedure to separate any new prescriptions received for people receiving multi-compartment compliance packs. The pharmacist now checked these separately against the person's current medicines and administration times before they were entered on the patient medication record (PMR). This extra step improved safety due to an extra check and avoided possible duplication of medication already dispensed.

The pharmacy had a complaints procedure and welcomed feedback. People returned paper feedback forms to a box in the retail area which were submitted to the operations manager at the company's head office. And feedback was also received via the pharmacy's company website. Examples of positive feedback was shared on the pharmacy's internal website. The pharmacy trained its team members to manage complaints. And they knew to provide the contact details for the SI's office if people wished to complain.

The pharmacy had current professional indemnity insurance. It displayed the correct responsible

pharmacist notice and had an accurate responsible pharmacist record. The pharmacy maintained accurate private prescription records including records about emergency supplies and veterinary prescriptions. It kept complete records for unlicensed medicines. The pharmacy kept digital controlled drug (CD) records with running balances. A random balance check of three CDs matched the balance recorded in the register. Stock balances were observed to be checked on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy. The pharmacy backed up the electronic PMR each night to avoid data being lost.

Pharmacy team members were aware of the need to protect people's private information and a company privacy notice was displayed in the retail area. Team members separated confidential waste for secure destruction. No person-identifiable information was visible to the public. The pharmacy had a documented procedure to help its team members raise any concerns they may have about the safeguarding of vulnerable adults and children. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. A team member explained the process they would follow if they had concerns and would raise concerns to the responsible pharmacist (RP). They were aware of the Ask for ANI (action needed immediately) scheme to help people suffering domestic abuse access a safe place. They knew how to raise a concern locally and all team members had access to local contact details and processes. The pharmacy had a chaperone policy in place and displayed a notice telling people this.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy's team members have the necessary qualifications and skills to safely provide the pharmacy's services. They manage their workload well and support each other as they work. Team members are enthusiastic in their roles and complete regular ongoing learning to keep their knowledge up to date. The pharmacy team proactively engages in improving the delivery of the pharmacy's services. And it shares solutions and ideas with other pharmacies.

Inspector's evidence

The pharmacy employed one full-time pharmacist manager, a part-time ACPT, two part-time dispensers, and a full-time medicines counter assistant. It also employed a pharmacy undergraduate student on a Saturday. The pharmacy displayed team members certificates of qualification prominently in the retail area. Team members were seen to be managing the workload. Those spoken to during the inspection were experienced in their roles and most of them had been working at the pharmacy for several years. They demonstrated a good rapport with many people who visited the pharmacy and were seen appropriately helping them manage their healthcare needs.

The pharmacy planned learning time during the working day for all team members to undertake regular training and development. Team members were enthusiastic to share their ongoing learning. They had access to additional learning materials relevant to their roles which was provided under the direction of the SI on an electronic learning platform. Recently they had completed training relating to conjunctivitis. And team members discussed the latest training they had completed to provide the NHS naloxone emergency supply service. The pharmacist maintained training records for all team members. Team members had annual appraisals with the pharmacy manager to identify their learning needs. And the pharmacist met with the company's professional services director regularly. This provided an opportunity to identify areas for personal development as well as development of the team. There was a communication board for team members to refer to, that was displayed prominently at the rear of the dispensary. This provided notes from previous team meetings, operational updates and agenda items for the next meeting.

Team members were observed to work on their own initiative, for example to source out-of-stock medication from other pharmacies in the group to help ensure people received the medication they needed. They asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

Pharmacy team members felt able to make suggestions and raise concerns to the manager or operations manager. A team member had identified an issue where people had received multiple text messages when their medicines were ready for collection. And they had implemented a solution and received positive feedback from people about the change. The team had also reflected that when handing out prescription instalments, they could not complete an electronic confirmation of the persons details after the first instalment. The pharmacy team changed the process in order to print a separate barcode for each instalment. This reduced the risk of handing medication out incorrectly. And team members were encouraged to provide feedback to the head office support team so that ideas could be shared with other pharmacy teams and help improve safety.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides. They are clean, secure, and well maintained. And the pharmacy has a suitable, sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy premises were modern and incorporated a retail area, dispensary and back shop area including storage space and staff facilities. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. The pharmacy's overall appearance was professional. The pharmacy had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions. The medicines counter could be clearly seen from the checking area which enabled the pharmacist to intervene in a sale when necessary. There was a separate area upstairs that was used by the ACPT to check medication without distraction.

People in the retail area couldn't see activities being undertaken in the dispensary. The pharmacy had a spacious consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed which provided privacy. It provided a suitable environment for the administration of vaccinations and other services. The door was kept locked to prevent unauthorised access. Temperature and lighting were comfortable throughout the premises

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy makes its services accessible to people. And it manages its services well to help people look after their health. The pharmacy correctly sources its medicines, and it completes regular checks of them to make sure they are in date and suitable to supply. And the pharmacy team provides appropriate advice to people about their medicines.

Inspector's evidence

The pharmacy was accessed by means of a power-assisted door with a step from street level. A portable ramp was available for those who required it and the centre of the pharmacy counters were low in height for those using wheelchairs to access. The pharmacy provided large print labels for people with impaired vision. And team members demonstrated a recent example of providing these for a person who experienced difficulty reading labels following eye surgery. The pharmacy advertised some of its services and its opening hours in the main window.

Pharmacy team members followed a logical and methodical workflow for dispensing. They stored medicines in their original packaging on shelves. And they had recently re-arranged the storage of medication in the dispensary to improve workflow and reduce the risk of picking the incorrect medication. Team members used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. And they attached coloured labels to bags containing people's dispensed medicines to act as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line or a CD that needed handing out at the same time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines.

A large proportion of people using the pharmacy received medicines from 'Medicines Care and Review' (MCR) serial prescriptions. The pharmacist carried out a clinical check of the prescription when they were received. Team members maintained records of when people collected their medication. This meant the pharmacist could then identify any potential issues with people not taking their medication as they should. The pharmacy notified the GP practice for a further prescription when all episodes of the prescription were collected. And they added notes of any care issues identified. This helped make sure people's medicines were reviewed by their GP appropriately. Team members checked regularly for any prescriptions that had not been collected. They then communicated with the GP practice to ensure the prescription remained appropriate. The pharmacy had recently started to send some of these prescriptions to be dispensed centrally at another of the company's pharmacies, known as the "CMS hub" pharmacy. Team members prepared prescriptions to create an electronic prescription file. This was then used by the pharmacist or ACPT to complete an accuracy check before being sent electronically to the hub and the medication was dispensed offsite. As this was a new procedure for the team, the pharmacist carried out several random spot checks on medication returned from the hub to check for accuracy. They had not identified any issues. Team members explained how they planned this workload in advance to ensure prescriptions were back with appropriate time before people were due to collect.

The pharmacy had patient group directions (PGDs) for unscheduled care, the Pharmacy First service, smoking cessation and emergency hormonal contraception (EHC). The pharmacy team members were

trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They referred to the pharmacist as required. The pharmacist was an independent prescriber (PIP) and provided the NHS Pharmacy First Plus service. They treated several common clinical conditions including those affecting the ear, nose and throat. They were trained to carry out clinical examinations and worked to a national service specification and prescribed to a local formulary. They used NHS prescriptions with a unique prescriber number so their prescribing activity could be reviewed and audited. Local GP teams were aware of the service and signposted people to the pharmacy. All consultations were documented, and a summary was sent to the person's regular GP. The pharmacist also provided this service privately to people who were not eligible for the NHS service. This was particularly useful for people visiting the area. The pharmacist recorded consultations in the same way and created signed private prescriptions on a template form.

The pharmacy supplied medicines in multi-compartment compliance packs for people who needed extra support with their medicines. Pharmacy team members managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept master backing sheets for each person and these documented the person's current medicines and administration times. There were notes of previous changes to medication, creating an audit trail of the changes. The pharmacy sent some packs to be prepared using automation at another of the company's pharmacies, known as the "MDS hub" pharmacy. Team members prepared a backing sheet which they used to record the pharmacist's clinical check. This record was then sent electronically to the hub and used to prepare the packs offsite. Packs had an accuracy check completed at the hub pharmacy and they were then sent back to the pharmacy for collection. Packs were labelled so people had written instructions about how to take their medicines. These labels included descriptions and photos of what the medicines looked like, so they could be identified in the pack. The pharmacy also provided pharmaceutical services to care homes. It dispensed medication in original packs and supplied medication administration records with these.

The pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving higher-risk medicines including methotrexate, lithium, and warfarin. The pharmacy team used alert stickers to highlight higher-risk medicine prescriptions that may require further intervention from the RP. People were supplied with written information and record books if required. Team members had knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. And they knew to dispense valproate in the original pack.

The pharmacy obtained medicines from recognised suppliers. It protected pharmacy (P) medicines from self-selection to ensure sales were supervised. And team members followed the sale of medicines protocol when selling these. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy had disposal bins for expired and patient-returned stock. The pharmacy team had discussed the process for receiving waste medicines at the last team meeting. They kept protective gloves, empty sharps bins and a tray for people to place returned medication into near the pharmacy counter. This meant they could quickly and safely deal with these items. The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records about what it had done. Team members contacted people who had received medicines subject to patient level recalls.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had access to the internet access and a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines.

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 blood pressure meter which was replaced as per the manufacturer's guidance, and an otoscope for prescribing consultations. Team members kept clean measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. The pharmacy team kept clean tablet counters in the dispensary. And it stored paper records in a locked filing cabinet in the consultation room inaccessible to the public.

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.