

Registered pharmacy inspection report

Pharmacy Name: Houston Pharmacy, 1 Alpin Road, DUNDEE, Angus,
DD3 6HB

Pharmacy reference: 1041711

Type of pharmacy: Community

Date of inspection: 15/09/2020

Pharmacy context

This is a community pharmacy on a main road in a city suburb. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. 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 it supplies a range of over-the-counter medicines. The pharmacy had changed ownership within the past year and had a new superintendent pharmacist who worked full-time in the pharmacy. This pharmacy was inspected during the COVID-19 pandemic.

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	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 services to ensure they provide them safely. They review processes and change them as required making use of team members' skills to work efficiently and safely. They record mistakes to learn from them and make changes to minimise the chance of the same mistakes happening again. The pharmacy keeps all the records that it needs to by law and keeps people's private information safe. Team members know how to protect vulnerable people.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines counter and had hand sanitiser available. The pharmacy had tape on the floor to encourage people to socially distance. It allowed two people on the premises at any time. People were observed queuing outside during the inspection. They often waited until a team member invited them in. Most people coming to the pharmacy wore face coverings and team members all wore masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces several times during the day. A team member cleaned the consultation room immediately after use. The owner had carried out a personal risk assessment with each team member to identify any risk that may need to be mitigated in the pharmacy. A team member at increased risk worked in an area socially distanced from colleagues and limited her contact with members of the public.

The pharmacy had written standard operating procedures (SOPs) which team members followed. Pharmacy team members had read them, and the pharmacy kept records of this. The previous pharmacy superintendent had reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The new superintendent was planning to review the SOPs and put them into her preferred format. The last few months had been challenging. She had started in the pharmacy just before Christmas, then the COVID-19 pandemic had started early in the year. So, she now had more time and opportunity to review all processes in the pharmacy and introduce some improvements and changes. The pharmacy was installing a new and different labelling/patient medication record system in a few weeks' time. The pharmacist explained that this would be a good time to make changes to documented procedures. 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 pharmacist had already changed this process. She labelled all prescriptions and undertook a clinical check. She placed prescriptions, labels and additional notes in a basket per patient. An experienced medicines' counter assistant handed most dispensed medicines out and spoke to the pharmacist if there was additional information, as well as confirming people's identity. The pharmacist described this as an efficient process as she usually recalled what her notes meant but could easily access the person's record again if necessary. An ACT undertook accuracy checks on most prescriptions. She was very experienced but until recently had labelled many prescriptions, limiting which ones she could check. The pharmacist doublechecked schedule two and three controlled drugs. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members used near miss logs to record most dispensing errors that were identified in the pharmacy, referred to as near miss errors. They recorded their own errors to help embed the learning. They also recorded errors reaching patients to learn from them. But they did not document enough detail to undertake analysis of these errors. This was discussed and the pharmacist intended to make improvements. The pharmacist informally reviewed all near misses and errors weekly and was planning to formalise this over coming weeks. This was a great improvement from the previous inspection when errors were not recorded to learn from. The team had met recently and discussed errors and how to reduce them as part of this. Following the meeting they had re-arranged all medicines in the dispensary. They were now arranged A - Z generically which had reduced selection errors. The pharmacy had a complaints procedure and welcomed feedback. No examples were discussed.

The pharmacy displayed an indemnity insurance certificate, expiring 31 March 20. The pharmacist explained that the owner had the current valid certificate; they had discussed it this week. The pharmacy displayed the responsible pharmacist notice and accurately 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.

Pharmacy team members were aware of the need for confidentiality. They had all read and signed a SOP on the subject. They segregated confidential waste for secure shredding including labels from methadone cups. This was an improvement from the previous inspection when personal information could have been compromised. No person identifiable information was visible to the public. The pharmacy had local safeguarding information on the wall in the staff room where it was very accessible to team members should they need it. The pharmacist was PVG registered. The delivery driver was present for part of the inspection and described his COVID-19 delivery process. He described sharing any concerns with the pharmacist.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide services. They are trained and competent for their roles and the services they provide. The pharmacy gives them time for training during the working day. Team members can make decisions within their competence to provide safe services to people. They know how to make suggestions and raise concerns if they have any to keep the pharmacy safe.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist (superintendent), one full time accuracy checking technician (ACT), three full-time dispensers, one medicines counter assistant working four full days and one afternoon, one new part-time trainee medicines counter assistant and a full-time delivery driver. Team members were able to manage the workload. The pharmacist explained that she was about to register the new team member on an appropriate accredited training course. The inspector advised her to look at the GPhC website as training requirements for pharmacy support staff were changing on 1 October 20.

The pharmacy had not previously provided structured regular ongoing training and development. The pharmacist described her plans in liaison with the other team members. During the pandemic she had not had the opportunity to implement anything but was now actively working on it. She had started selecting a drug or topic each month to discuss and share learning with all team members. The ACT often asked questions about treatments and medication, and the pharmacist used her responses to start a conversation with the whole team. It was anticipated that local training evenings would commence soon, and all team members would be encouraged to attend. The pharmacy provided training for any new processes, services or equipment. This included the recently introduced Pharmacy First service and smoking cessation. Training was planned for the new computer system as it was introduced. The new team member worked under the pharmacist's supervision. The pharmacist was hoping to start independent prescribing training soon. And she described local initiatives that had been delayed due to the pandemic that she was due to attend training for. She had recently completed refresher flu vaccination training.

Team members were observed going about their tasks in a systematic and professional manner. They were competent and they were empowered to work autonomously. The pharmacist had watched and tested the ACT's checking process to ensure it was accurate and robust before she had changed the dispensing and checking process. Team members 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. The medicines' counter assistant was very experienced and competent and was observed using the sale of medicines protocol well to inform her decision making.

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 they were comfortable highlighting errors to colleagues, including to the pharmacist. They were able to make suggestions and raise concerns to the superintendent pharmacist and owner. The owner visited the pharmacy weekly to provide support and discuss any queries or

issues. The pharmacist had recently asked her for regular protected time to undertake activities such as the preparation of new SOPs. This had been agreed in principle.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are safe and clean and suitable for its services. And they are secure when the pharmacy is closed. The team uses the design and layout of the dispensary effectively for different activities. Team members use private rooms for private conversations with people. Other people cannot overhear these conversations.

Inspector's evidence

As noted above, the pharmacy had installed a large Perspex screen to offer infection control between team members and members of the public. And it had the floor marked to encourage social distancing between people using pharmacy services. Team members cleaned dispensing benches and retail surfaces several times a day.

These were reasonably sized premises incorporating a retail area, back shop area including staff facilities, storage space in a floored attic, and a large well-designed dispensary. The design and layout helped with workflow. For example, there was a segregated area used for the management and assembly of multi-compartment compliance packs where team members were not disturbed or interrupted. The dispensed medicines' retrieval shelves, medicines dispensed by instalment and a methadone pump dispenser (Methameasure) were all in one area. This was close to the hatch to a discreet room for giving advice or supervising self-administration of medication. This meant team members did not have to walk far when supplying medicines to people and could do this discreetly. People were not able to see activities being undertaken in the dispensary.

The premises had a treatment room, consultation room and second small consultation room with a hatch to the dispensary. Team members used this for supervised self-administration of medication. The consultation room had two doors, one accessed from the medicines counter for team members to use, and the other door was from the retail area. The other small room was kept locked and used by the public when team members unlocked the door remotely for them. Team members cleaned the rooms after each use. A podiatrist used the treatment room full-time, so it was not used by the pharmacy. The inspector could not access this room as it was in use during the inspection.

The premises had a large attic used for storage, including the storage of multi-compartment compliance packs and around one month's stock of top 50 dispensing items. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water. And the sinks in the staff room and toilet had soap and clean hand towels, but not the one in the consultation room. The premises were clean, hygienic and well maintained. Temperature and lighting were comfortable.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy helps people to access its services, using different approaches during the COVID-19 pandemic. It provides safe services. Team members support people by giving them information and suitable advice to help them use their medicines. And they provide extra written information to people taking higher-risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It listed its services internally and externally. And it could provide large print labels for people with impaired vision. The pharmacy provided a delivery service. People were not asked to sign on receipt of medicines during the pandemic in the interest of infection control. A podiatrist worked from the treatment room which was not used by the pharmacy team. The previous pharmacist owner had checked her credentials to ensure she was a registered podiatrist.

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. Most of the dispensing was from 'collection service' prescriptions. The delivery driver collected these each morning from several surgeries. As described above, the pharmacist had reviewed and changed the dispensing and checking process to improve efficiency and make better use of team members' knowledge and skills.

The pharmacy usually assembled owings later the same day or the following day using a documented owings system. Some people received medicines from 'Medicines Care Review' serial prescriptions (MCR). The pharmacy dispensed these when people requested them. Team members had no evidence of poor compliance, but this was not actively monitored. The pharmacist explained that this was a process she was going to review over coming weeks. She hoped that the new computer system being installed would have the facility to easily monitor expected supply dates.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. Team members followed a robust process. They kept record cards for each person noting the dose regime and changes including dates. This was an improvement from the previous inspection. One experienced team member had ownership of this process and re-wrote the cards frequently, especially after changes were made. Her handwriting was neat and easy to read. All team members were familiar with the process and able to undertake this during absence. The team member ensured all dispensing was up to date before planned absence. The team stored records and prescriptions for people in hospital in a separate folder. Team members assembled multi-compartment compliance packs in a designated area of the dispensary. This was separate to other dispensing with minimal interruption or distraction. They wrote the person's name and date of supply on the spine of the pack. The ACT sealed packs when she checked them. A team member added controlled drugs on the day of supply. A pharmacist checked these packs which were left unsealed until that point i.e. for up to three weeks. They were tidily stored on shelves where they were unlikely to be disturbed. The dispenser and ACT or pharmacist initialled the address label on the front of the pack to provide an audit trail. They did not include tablet descriptions on labels but provided patient information leaflets which

included tablet descriptions. The team member who had ownership of this process explained that over the next few weeks the pharmacy was changing its labelling programme and would change to backing sheets on these packs which would include tablet descriptions. The pharmacy stored completed packs on shelves in the attic. They were arranged on different shelves depending on day of delivery. Packs that people collected were stored separately. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these in their entirety on receipt of prescriptions. They stored the dispensed medicines in bags labelled with person information and date of supply. And they stored these in individual named baskets near the prescription retrieval area.

The 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 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. The medicines counter assistant was very knowledgeable and gave quality advice when selling these medicines. 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, the Pharmacy First service, smoking cessation, emergency hormonal contraception, and supply of chloramphenicol ophthalmic products. The pharmacy empowered team members to deliver the Pharmacy First service within their competence under the pharmacist's supervision. The medicines' counter assistant (MCA) described her role and was knowledgeable. She wrote details onto a form and confirmed requests with the pharmacist. They used the sale of medicines protocol and the formulary to respond to symptoms and supply treatment. The MCA explained that with the new computer system there would be a terminal at the medicines' counter which would enable her to record some consultations. This was within the service specification and helped to give greater access to the service to all members of the community.

During the pandemic the pharmacist had delivered some services remotely by phone and using the NHS NearMe video consultation tool. This had ensured service delivery while minimising footfall on the premises. Services delivered in this way included smoking cessation, urinary tract infection (UTI) treatment and supply of emergency hormonal contraception. The pharmacist carried out the consultation remotely and the team prepared medication ready of collection when the person came to the pharmacy.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not currently comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. The team used the space well in controlled drug cupboards to segregate stock, dispensed items and obsolete items. The pharmacist had put a box in place for the storage of patient returned controlled drugs. She had labelled it with the process to be followed when accepting these into the pharmacy. And the register for recording these was now kept with the box. This made it straightforward to correctly record and store these at the time of receipt. Team members poured methadone instalments using the Methameasure pump when people presented at the pharmacy. The pharmacist checked these before the supply was made. The pharmacy retained labels from supervised doses affixing it to a sheet on the wall. The pharmacist used this to confirm that instalments had been supplied and self-administration had been supervised. The she shredded the sheet. This process was a great improvement from the previous inspection. Team members checked people's identity by asking for their personal information, and what medicine/dose they were expecting to help ensure they were given the correct dose. The bottle containing methadone in the Methameasure was not always adequately labelled. The inspector

provided advice. The pharmacy stored items requiring cold storage in two fridges with minimum and maximum temperatures monitored. Team members acted if there was any deviation from accepted limits. They 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 the Medicines and Healthcare Regulatory Authority (MHRA) recalls and alerts on receipt and transferred emails to another folder which signified that they had been checked. 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 usually used with people accessing its services. But during the pandemic the pharmacy team did not use this equipment with people to minimise the risk of spreading infection. Equipment included a carbon monoxide monitor maintained by the health board and a blood pressure meter which had been replaced this year. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy had a 'Methameasure' pump available for methadone use and this was cleaned daily and test volumes poured each morning. 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 cupboards in the consultation room which were kept locked. 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 did not leave 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.