General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Richardson Pharmacy, 181 - 183 Blackness Road, DUNDEE, Angus, DD1 5PH

Pharmacy reference: 1041718

Type of pharmacy: Community

Date of inspection: 05/12/2019

Pharmacy context

This is a community pharmacy beside other shops on a main road closed to a city centre and GP practices. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it supplies medicines to care homes. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and the smoking cessation service. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. The pharmacy provides access to a private remote GP using Skype consultations. One of the pharmacist owners works two days per week in the pharmacy, and the other is on the premises weekly undertaking management and administration activities.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	The pharmacy team does not follow standard operating procedures for all activities.
		1.2	Standard not met	The pharmacy does not monitor or review dispensing accuracy. And it does not make any changes when it identifies areas for improvement.
		1.6	Standard not met	The pharmacy does not maintain records in line with good practice and legislation. This includes controlled drug and patient returned controlled drug registers. And private prescription and responsible pharmacist records.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not provide training to all team members in line with GPhC requirements. And it does not provide ongoing training and development.
		2.4	Standard not met	The pharmacy does not have a culture of learning. It has not acted on areas of improvement from a previous inspection. e.g. out-of-date controlled drugs, confidentiality training, training and development and near-miss recording.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy may not supply medicines safely as shelves and cupboards are very untidy. And it has out-of-date medicines which are not identified and segregated. And some medicines not properly labelled.
5. Equipment and facilities	Standards not all met	5.3	Standard not met	The pharmacy stores confidential information in an area where there is a risk of members of the public seeing it.

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

Summary findings

Pharmacy team members do not always follow clear processes so there is a risk of mistakes. They do not record all their mistakes and they do not review these. So, the team cannot identify learning points and is missing opportunities to make improvements. The pharmacy does not accurately keep all the required records.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs). But they did not include date of preparation or 'author'. And they were not all followed. Most team members had not signed the SOPs, e.g. most dispensers and the full-time medicines counter assistant had not signed the 'Request for OTC medicines' SOP. The only people who had signed most SOPs were the superintendent pharmacist and a pharmacist who no longer worked in the pharmacy. This included the 'accuracy check by an accuracy checking technician (ACT)'. It stated that a pharmacist would mark prescriptions CC and initial in the bottom left hand corner to enable the ACT to undertake the final accuracy check. No evidence of this was seen during the inspection, and team members could not describe this. The ACT was not working at the time. There was a SOP index sheet with facility to reflect roles and responsibilities. But the team had not completed this. And an old (2011) near miss SOP was included in the near miss book, potentially causing confusion. The current near miss recording SOP stated that all near misses were recorded and discussed at the time. Then they were reviewed and discussed at monthly meetings. This did not happen. Team members said they did not have meetings, and there was no evidence of reviews of incidents. The controlled drug (CD) audit SOP only had two pharmacists' signatures on it and it was out of date and not prescriptive enough. It did not state how often running balance audits were carried out and referred to an NHS authorised witness who had left several months or longer ago.

The pharmacy had a near miss log book to record dispensing errors that were identified in the pharmacy. But there were few incidents recorded. Some months there were only three entries. One contributory factor recorded was untidy shelves. But this had not been addressed and shelves were observed to be very untidy. Team members had made records of five errors reaching people over a two-and-a-half-year period. There was no evidence of review or improvements made.

The pharmacy did not have a complaints procedure but printed forms from the internet if people wished to make a complaint. The manager explained that two had been issued over the past year but had not been returned to the pharmacy. So, the pharmacy had not had an opportunity to improve services following complaints. A team member described a response to feedback about the prescription delivery service – the pharmacy had updated a person's records to ensure deliveries were not made when he was not at home. And the pharmacy prioritised the dispensing of a person's medicines who had high expectations.

The pharmacy had an indemnity insurance certificate, expiring 31 July 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log but several days' entries were missing (legal requirement); private prescription records including records of emergency supplies and veterinary prescriptions, but prescribers' addresses were often not recorded (legal requirement); unlicensed specials records; and controlled drugs (CD) registers. The CD registers were untidy, making it difficult to locate particular registers. A folder was labelled MST sachets, but the

registers for MST sachets were not in this folder. The pharmacy did not audit running balances regularly which was standard good practice. Dates of audit observed included 16.01.19, 07.07.19, 19.08.19 and 01.06.19. The locum pharmacist audited one item on the day of inspection and found the actual quantity was very different to the recorded quantity. And date expired items were not always included in running balances e.g. 21 date expired Elvanse 40mg had been included several months previously but was no longer. Pharmacists seldom used registers, with dispensers taking week-about to record supplies and receipts. Some team members did not include the year when writing dates in the registers. And they did not always write in page headers and details on title pages. And some team members were obliterating entries and not using foot-notes to make amendments as the law required. The pharmacy kept a register for patient returned controlled drugs. But team members did not always record items – a large volume was observed not recorded. And the register showed that a pharmacist had carried out destruction without a witness and had not recorded the dates.

Pharmacy team members were aware of the need for confidentiality. But they had not read a policy or procedure. This was identified in the previous inspection report. They segregated confidential waste for shredding. No person identifiable information was visible to the public. But person identifiable records were stored in unlocked cupboards in the consultation room. These included private prescriptions and records, and 'pharmacy first' records. People were alone in this room for remote GP consultations. Team members had also not had any training on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. They described several examples of contacting the drug problem centre when they were concerned about some people's declining health, or if they had not collected their medicine for a few days.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough staff, most of whom are trained and qualified for their role. But there is one part-time team member who is untrained. The pharmacy does not provide on-going training and development for team members. So, they may not have the skills they require for delivering pharmacy services. And the pharmacy does not learn and improve from previous incidents.

Inspector's evidence

The pharmacy had the following staff: one part-time pharmacist working three days per week, an owner pharmacist working two days per week; one part-time accuracy checking technician; four full-time and four part-time dispensers; one full-time medicines counter assistant and one Saturday only assistant who had worked in the pharmacy for several years but not undertaken training. All dispensers were trained and had undertaken medicines counter training. One of the full-time dispensers was the pharmacy manager. Typically, the pharmacy had a pharmacist, the manager and four or five other team members working at any time. One or two team members were usually downstairs working on care-home or multi-compartment compliance pack dispensing. All dispensers were competent to dispense these, but two dispensers mainly managed the compliance packs. One of these dispensers only worked on this activity. The Saturday only assistant undertook general tasks including cleaning, serving on the medicines counter and putting away the dispensary stock for which formal accredited training was required. But the Saturday assistant had had no such training. for these activities. Team members were able to manage the workload. But they were not managing controlled drugs appropriately. Part-time team members had some scope to work flexibly providing contingency for absence.

The pharmacy did not provide any training or development to team members. They described reading material that was received by post. And the owner pharmacist told team members about new products. Team members did not have meetings but explained they shared information while working. (A SOP described monthly team meetings.) The pharmacy had not acted on areas for improvement identified at the previous inspection e.g. sustained reviewing of dispensing accuracy (near miss recording and review), dealing with date expired medicines, training and development, and information governance training or policy.

The various individuals were observed going about their tasks in a systematic manner. They knew what activities need to be done. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. The medicines counter assistant demonstrated awareness of repeat requests for medicines intended for short term use. And he dealt appropriately with such requests. He was not aware of any targets set by the pharmacy.

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 and another discreet area for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises incorporating a small retail area, dispensary and basement including dispensing areas, storage space and staff facilities. The pharmacy team used the basement to manage care home and multicompartment compliance packs dispensing and storage. The premises were clean, and well maintained, but cluttered and untidy in places. There were sinks in the dispensary, staff area and toilet. These had hot and cold running water, soap, and clean hand towels.

People were able to see some activities being undertaken in the dispensary. This included medicines' selection from untidy shelves. The pharmacy had a consultation room with a desk, chairs, sink and computer which was untidy and unprofessional looking. People were left alone in this room for private remote GP consultations using 'Medicspot'. The door closed providing privacy. The pharmacy also had a separate area for substance misuse supervision. It was a discreet area with a hatch to the dispensary. Temperature and lighting were comfortable.

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

Summary findings

The pharmacy helps people to ensure they can all use its services. It mostly provides safe services, but team members do not always follow written procedures. Team members give some people extra information to help them use their medicines correctly. The pharmacy gets medicines from reliable sources but does not always store them in a tidy and orderly manner. And some are out-of-date.

Inspector's evidence

The pharmacy had good physical access by means of a low step and power assisted door. It listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order and could provide large print labels. 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. They labelled and dispensed most items at the front of the dispensary, prioritising those for people waiting. Two or three dispensers worked in this area at a time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines.

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 and kept records of supply. A dispenser had ownership of this service. She checked retrieval shelves and contacted patients if they did not collect their medicines. Most were compliant and there were reasons for non-collection e.g. working away and purchased a similar medicine. Team members attempted to synchronise people's medicines when they started on serial prescriptions. They sometimes identified pharmaceutical care issues when registering people for the service e.g. difficulties swallowing large tablets such as paracetamol, so they arranged switches to capsules or liquid.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time around a week before the first supply was made. Two team members had ownership of this. They followed a robust and thorough process and kept records of when prescriptions were ordered and received, changes and interventions. A team member checked prescriptions on receipt and queried any missing items with the GP practice. The pharmacy kept a diary to record calls. And team members recorded these on people's individual records. They stored completed packs in individual labelled box files with records and prescriptions. They supplied patient information leaflets with the first pack of each prescription. And they included tablet descriptions on the backing sheet of the first pack. But they did not attach backing sheets to the packs. So, they could be lost, and people may not know what medicines were in the packs. The ACT or pharmacist carrying out the final check sealed the packs. Dispensers left packaging to facilitate this check. The pharmacy also provided pharmaceutical services to care homes. Team members followed a robust process for this, with the homes ordering and checking their own prescriptions. But pharmacy team members also checked them and queried any missing items. The pharmacy supplied a lot of people with weekly instalments of a variety of medicines. These high-risk dispensing activities were undertaken in the basement where there was little distraction. And there was adequate space to dispense, check and store the dispensed

medicines.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. The manager explained that the regular pharmacist (owner) had undertaken a search for people in the 'at-risk' group and had counselled them appropriately. The information to be supplied was stored in a cupboard in the consultation room, but not in the dispensary close to the medicines. Team members present had not heard of the non-steroidal anti-inflammatory drug (NSAID) care bundle or 'sick-day' rules. So written and verbal information was not always given to people supplied with these medicines over-the-counter, or on prescriptions. 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 (EHC). The locum pharmacist working at the time of inspection did not supply EHC. He signposted to other pharmacies. Team members were aware of this. He thought that he had signed PGDs for this health board but was going to check. 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 ACT and manager mainly delivered the smoking cessation service. There were currently only a few people accessing this. The needle exchange service was busy. All dispensers were able to deliver it. They had been offered hepatitis B vaccination but had declined. The pharmacy offered a private GP consultation by video link and prescriptions were emailed to the pharmacy. Pharmacy team members showed people into the consultation room and set up the computer for them. The GP then described how to use the equipment that was available. Pharmacy team members cleaned the equipment after use. The GPs did not prescribe opioids. The pharmacy confirmed identity of prescribers by checking registration numbers on the GMC website.

The pharmacy obtained medicines from licensed wholesalers such as alliance and AAH. It did not comply with the requirements of the Falsified Medicines Directive (FMD). The team members had not heard of this requirement, but one had seen scanners on the premises. The pharmacy mainly stored medicines in original packaging on shelves and in cupboards. But shelves were very untidy with different medicines stacked on top of each other. A team member attributed an error to untidy shelves. Some medicines were not in packaging but there were loose strips on shelves. And some loose tablets were stored in bottles that were not properly labelled. They did not have batch numbers and expiry dates on them. Some medicines were observed out-of-date, including in a controlled drug cabinet. The cabinets were untidy and congested. Team members had not segregated some date expired medicines. And they had a large bag of date expired items including some from 2015 – these had been highlighted in the previous inspection report in 2017. And bottles of tablets in the basement where compliance packs were assembled were out-of-date. The pharmacy 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. 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 not all met**

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. But it stores confidential information where there is a risk of people seeing it.

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, and equipment used for the private remote GP consultation service, 'Medicspot'. Team members kept crown stamped measures by the sink in the dispensary. The pharmacy had a 'methameasure' pump available for methadone use and team members cleaned it at the end of each day and poured test volumes 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. People accessing the remote GP service were alone in the consultation room so could access these. 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.