General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bruce Ramsay (Dundee) Ltd., 87-89 Fintry Road, Mains of Fintry, DUNDEE, Angus, DD4 9JB

Pharmacy reference: 1041727

Type of pharmacy: Community

Date of inspection: 20/08/2024

Pharmacy context

This is a community pharmacy within a small row of neighbourhood shops in the north of Dundee. Its main activity is dispensing NHS prescriptions. The pharmacy offers a medicines delivery service and provides substance misuse services. Team members provide advice on minor ailments and medicines use. And the pharmacist is a prescriber and provides the NHS Pharmacy First Plus service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Pharmacy team members follow safe working practices. And they manage dispensing risks to keep services safe. 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. Team members make records of mistakes and review the pharmacy's processes and procedures. They learn from these mistakes and take the opportunity to improve the safety of services.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define the pharmacy's working practices. 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. SOPs covered tasks such as assembling prescriptions, dealing with controlled drugs (CDs) and the responsible pharmacist regulations. SOPs had been reviewed by the superintendent pharmacist (SI) in July 2023. Some team members had signed records to show they had read and understood the SOPs. But not all team members were up to date with this. 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.

Team members kept electronic 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. They reviewed all near misses and errors periodically to learn from them and they introduced strategies to minimise the chances of the same error happening again. Pharmacy team members demonstrated where they had clearly separated medicines that looked or sounded similar, such as zopiclone and zolpidem, and risperidone and ropinirole. The pharmacy had a complaints procedure and welcomed feedback. Team members usually resolved complaints informally, and the SI usually worked at the pharmacy to refer to if people wished to escalate the complaint.

The pharmacy had current professional indemnity insurance. It displayed the correct responsible pharmacist notice and had an accurate responsible pharmacist record. From the records seen, it had accurate private prescription records including records about emergency supplies and veterinary prescriptions. It kept complete records for unlicensed medicines. Team members maintained complete electronic controlled drug (CD) registers and they checked the physical quantity in stock matched the balance recorded in the registers weekly. A random balance check of the quantities of three CDs were correct against the balances recorded in the registers. The pharmacy had records of CDs people had returned for safe disposal.

Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste for secure shredding. No person-identifiable information was visible to the public. A privacy notice in the retail area provided assurance that the pharmacy protected people's personal information. 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 RP. And gave examples when they had referred to the RP with welfare concerns after attempting to deliver medication to a person

house. They knew how to raise a concern locally and had access to contact details and processes.

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. They feel comfortable raising concerns, giving feedback and suggesting improvements to provide a more effective service. And the pharmacy has adequate procedures in place to help its team manage the workload in the event of unplanned staff absence.

Inspector's evidence

The pharmacy employed one full-time pharmacist, two full-time pharmacy technicians, three full-time dispensers, a full-time medicine counter assistant who also provided deliveries, and a part-time medicines counter assistant. The pharmacy displayed their certificates of qualification. The SI also worked full-time in the pharmacy which meant there were two pharmacists every day, and regular locum pharmacists provided cover when required.

The SI reviewed the pharmacy’s staffing levels regularly. The pharmacy used rotas to rotate tasks between team members. This allowed all team members to manage the workload. They planned their workload in advance of planned leave and part-time team members had some scope to work flexibly providing contingency for absence.

The pharmacy provided ad-hoc learning time during the working day for all team members to undertake regular training and development. Team members did not receive formal annual appraisals. But they discussed their learning needs and development informally with the SI and were given opportunities for development and continued learning. Team members were observed to work on their own initiative, for example to phone the GP practice to ask about missing prescription items. 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. The pharmacist was an independent prescriber (PIP) and attended training and peer-review sessions with other PIPs in the area. They described attendance at recent training sessions delivered by a specialist GP.

Team members demonstrated a culture of openness and felt able to make suggestions and raise concerns to the pharmacist or SI. Following a dispensing error related to handing out mediation, the team had a staff briefing to discuss ways to learn for the incident. The briefing was documented, and team members signed to say they had read and understood it. And they suggested changes to the way medication was handed out, which resulted in an updated SOP for this. The pharmacy had a whistleblowing policy that team members were aware of. There were no targets set for team members to achieve.

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 premises was average-sized and incorporated a small retail area, large 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 pharmacy's dispensary was raised from the retail area so people were not able to see activities being undertaken in the dispensary. The pharmacy had a large consultation room which was clean and tidy with a desk, chairs, sink and computer. And the door closed which provided privacy. It provided a suitable environment for the provision of pharmacy services. Team members were seen actively encouraging use of the consultation room throughout the inspection to enable private conversations with the pharmacist. The pharmacy also had a separate private area with a door that closed for specialist services such as substance misuse supervision. 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 had good physical access by means of a level entrance and a power-assisted door. It advertised some of its services and its opening hours in the main window. There were posters in the retail area advertising local health initiatives such as vaccinations. The pharmacy provided a delivery service taking medicines to people in their homes. Team members maintained a list of deliveries which ensured that all team members were aware of the day's scheduled deliveries. This was useful if people called the pharmacy asking about their expected delivery. And the delivery driver recorded the deliveries they had completed each day.

Pharmacy team members followed a logical and methodical workflow for dispensing. They filed the day's prescriptions into ordered baskets to prioritise the workload appropriately. They used baskets to 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. When the pharmacy didn't have enough stock of someone's medicine, it provided the person with a printed slip detailing the owed item. Some people received medicines from NHS Medicines, Care and Review serial prescriptions. The pharmacy dispensed these weekly in advance of when people were due to collect them. Team members checked that people needed all the dispensed medication when they collected to avoid waste. They 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. Team members checked the shelves for uncollected medication periodically and kept records of any medication not collected. 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 always dispensed valproate in the original pack.

The pharmacy supplied medicines in multi-compartment compliance packs for people who needed extra support with their medicines. Team members managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept master sheets for each person which documented the person's current medicines and administration time. And had notes of previous changes to medication, creating an audit trail of the changes. Packs were labelled so people had written instructions about how to take their medicines. Team members did not routinely add descriptions of what the medicines looked like. But they provided people with patient information leaflets about their medicines each month. So people could refer to information about their medicines. Shelving to store the packs was kept neat and tidy.

The pharmacy had patient group directions (PGDs) for unscheduled care, urinary tract infections,

treatment of shingles and emergency hormonal contraception. The pharmacy team members were trained to carry out consultations for minor ailments under the Pharmacy First service. They were seen to work within their competence and under the pharmacist's supervision. They referred to the pharmacist as required. The RP was a prescriber 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. They kept paper copies of all the consultation notes they made, and a summary of treatment was sent to the person's regular GP.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves and in drawers. And team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy 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 two fridges 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 actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records about what it had done. Medicines affected by the most recent recall had been separated and were waiting return to the wholesaler.

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 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 an otoscope, pulse oximeter and a blood pressure meter which was calibrated as per the manufacturer’s guidance. Team members kept clean crown-stamped measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. The pharmacy used a manual pump for measuring doses on a daily basis. Team members cleaned it at the end of each day and poured test volumes daily to ensure accurate measurement. The pharmacy team kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in the dispensary inaccessible to the public. Prescriptions awaiting collection were stored in shelves behind the healthcare counter, and confidential information was not visible to people in the retail area. Computers were password protected and positioned in a way that prevented unauthorised view. And cordless telephones were in use to allow private conversations in a quieter area.

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.