General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Davidsons Chemists, 30 Main Street, CLACKMANNAN, Clackmannanshire, FK10 4JA

Pharmacy reference: 1041948

Type of pharmacy: Community

Date of inspection: 21/02/2020

Pharmacy context

This is a community pharmacy located in the centre of Clackmannan. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It offers a repeat prescription collection service and a medicines' delivery service. And it provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It also offers a smoking cessation service. The pharmacy ownership had changed on 1 November 2020.

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 work to professional standards. And they keep records about mistakes when they happen. The team members use this information to learn. And they make improvements to reduce the risk of further errors. The pharmacy keeps the records it needs to by law. And it provides training for the team to keep confidential information safe. The team members understand their role in protecting vulnerable people. People using the pharmacy can raise concerns. And the pharmacy team members know to follow the company's complaints handling procedure. They listen to people and put things right when they can. And make service changes to improve people's experience.

Inspector's evidence

The pharmacy displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. But the notice was not visible. And people in the waiting area were unable to identify the pharmacist in charge. The pharmacy ownership had changed on 1 November 2020. And the team members were being supported to implement the new company's governance arrangements. The pharmacist had been prioritising and phasing in the new company's working instructions for the team members to read. And they had signed the procedures to provide confirmation that they understood them and were applying the new practices in their daily tasks.

The pharmacy team members signed dispensing labels to show they had completed a dispensing task. And the pharmacist checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The team members recorded their errors on a new web-based system. And the quantity and quality of records had improved since the last inspection. This provided the opportunity to identify and manage any dispensing risks in the pharmacy. The pharmacist had recently introduced the system. And had planned to carry out a formal near-miss review at the beginning of March 2020. The pharmacist shared learnings with the team at the time. And they made changes to keep services safe. For example, reminding the team members to score split-packs before putting them back on the shelf to manage the risk of quantity errors. The pharmacy had recently introduced bar-code technology to the dispensing process. And the team members scanned packs to confirm the correct medication had been selected for dispensing. This had been found to improve accuracy and reduce near-misses.

The pharmacist managed the incident reporting process. And the pharmacy team members knew when incidents happened and what the cause had been. For example, they knew about a recent incident when sertraline 100mg had been supplied instead of 50mg. And the pharmacist had discussed the incident and instructed the team members to take greater care, and to always use the new bar-code scanner. The pharmacy used a complaints policy to ensure that team members handled complaints in a consistent manner. And it displayed a notice to inform people about its complaint's procedure. The pharmacy invited people to provide feedback about the services they received. And this had been mostly positive. The feedback had prompted team members to discuss prescription waiting times. And they had agreed to increase the waiting time when there was an increased demand for dispensing services. The team members had started annotating affected prescriptions with the time they received them. And this ensured they prioritised dispensing accordingly.

The pharmacy maintained the records it needed to by law. And the pharmacist in charge kept the

responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity insurance in place. And it was valid 31 May 2020. The pharmacy had implemented the company's electronic controlled drug register. And a full balance check had been carried out at the time to verify that the actual stock matched the registered stock. The team members carried out weekly balance checks. And this provided assurance that any discrepancies were identified in a timely manner. The pharmacy team recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. And a sample showed that the trimethoprim PGD was valid until October 2020.

The pharmacy displayed a notice to inform people about its data protection arrangements. And the team members had recently read the new confidentiality policy, so they followed the company's data protection arrangements. The team members knew how to safeguard personal information. And they disposed of confidential information using a shredder. And archived spent records for the standard retention period.

The pharmacy displayed a chaperone notice beside the consultation room. And it used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The pharmacy team knew to discuss their concerns with the pharmacist. For example, a team member had taken some-one that was upset into the consultation room. And they had comforted them and contacted the surgery to arrange the support they needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. The pharmacy team complete ad-hoc training. And, they learn from the pharmacist to keep their knowledge and skills up to date. The pharmacy team members support each other in their day-to-day work. And they can speak up and make suggestions to improve services. The team members speak about mistakes that happen. And they discuss the reasons for the mistakes. And this helps them to learn from each other.

Inspector's evidence

The pharmacy workload had remained stable. And dispensing was at the same level as it was at its last inspection on 9 August 219. The ownership of the pharmacy had changed on 1 November 2020. And the team members were in the process of implementing the company's new policies and procedures. The team members were learning about new ways of working. For example, they did not continue to routinely dispense up until closing time at 5.45pm. And they were carrying out new processes such as counting prescriptions and cashing up from 5.00pm onwards. An area pharmacy technician was on-site at the time of the inspection. And they were providing ongoing support whilst the team members consolidated the new ways of working. The responsible pharmacist had worked at the pharmacy for a few years. And they were being supported by the superintendent pharmacist to make the necessary changes.

The company had carried out a team review at the time they took over. And they had recruited two new team members to replace a team member that had left. And to provide extra support to deliver the pharmacy services. The company had encouraged the pharmacy technician to enrol onto the accuracy checking course (ACT). And this would enable them to carry out final accuracy checks on multi-compartment compliance packs and support the pharmacist. The company kept training qualifications at its head office. And the following team members were in post; one full-time pharmacist, one full-time pharmacy technician, one part-time pharmacy technician, one full-time dispenser, two full-time trainee dispensers and one part-time trainee dispenser.

The pharmacy managed annual leave requests. And it maintained minimum levels by authorising only one team member to be off at the one time. The team members submitted annual leave requests in advance to help arrange cover. And the team members worked extra to provide cover when necessary. The company had scheduled individual performance reviews for the following month. And a head office manager had been arranged to provide the pharmacist with on-site support to carry out the reviews.

The pharmacy did not provide structured training. And the pharmacist briefed the team members so they were up-to-date in their roles. For example, they had recently briefed the team members about how to count prescriptions and cash up at the end of the day. The company had not set key performance indicators. And this was due to the pace of change as the team members adapted to new ways of working.

The new trainee dispensers were in the process of completing a structured 12-week induction programme. And the pharmacist provided support when they were able to. A pharmacy assistant had

not met the GPhC training standards at the previous inspection. And they had since been enrolled onto the NVQ pharmacy services level 2 course. But, they had yet to start the training programme.

The pharmacist had attended a meeting at the company's head office. And they had cascaded relevant information to the team members during a lunch-time meeting. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had re-arranged the main dispensing benches. And they had moved some dispensing activities to a separate area to create the necessary dispensing space for the new team members to work at.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises is clean and hygienic. It has consultation facilities to meet the needs of the services it provides. And it has an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

A well-kept waiting area presented a professional image to the public. The pharmacy provided seating. And it provided some patient information leaflets for self-selection. The pharmacy had allocated areas and benches for the different dispensing tasks. And the team members used a separate upstairs area to dispense and store multi-compartment compliance packs. The pharmacist supervised the medicines counter from the checking bench. And they could make interventions when necessary. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy provided a consultation room. And it was professional in appearance and provided a private area for people to speak to pharmacy team members.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know what services are available to them. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information.

Inspector's evidence

The pharmacy had stepped access. And the team monitored the entrance to provide support to people with mobility difficulties. The pharmacy had installed a pressure operated pad on the outside of the door. But this was in a state of dis-repair at the time of the inspection. The pharmacy displayed some leaflets in the waiting area and in the consultation room. And it displayed its opening hours in the window. The new owners had made changes to the pharmacy's opening hours. And it now remained open all day instead of closing at lunch-time. This improved access to medicines and professional advice when needed.

The pharmacist attached stickers to prescription bags. And the team members knew to alert the pharmacist when they needed to speak to people about their medication. For example, checking that people taking warfarin tablets knew to have their bloods tested regularly. The pharmacist had trained the team members to speak to people about the chronic medication service (CMS). And this enabled them to support people to take their medicines. The pharmacy team members dispensed CMS serial prescriptions for around 200 people. And they kept records to help them dispense medication that was due. The pharmacist monitored prescriptions and discussed concerns with the surgery. For example, they had raised a concern about some-one who had only collected Epilim medication on two occasions over the past year. The pharmacist was collaborating with the local surgery to improve the prescription re-ordering processes. And the pharmacist had recently been able to successfully transmit a prescription request and medication history to the GP. The pharmacy had implemented the company's web-based operating system. And the team members were being supported to use it to carry out tasks.

The pharmacy team members used dispensing baskets. And they kept prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 160 people. And the team members sent around 20% of the prescriptions to an off-site dispensing hub for dispensing. The pharmacist carried out clinical checks. And they passed prescriptions to the pharmacy technician for processing. The team members dispensed the packs. And the pharmacist carried out final accuracy checks before placing them in individual storage boxes until collection or delivery. The team members used an upstairs area that was sufficient in size and layout to safely assemble and store packs. And they used supplementary records to support the dispensing process. For example, wall-charts to show which weeks packs were due. The team members kept medication records in folders. And these were used to identify changes that they checked with the surgery. The team members isolated packs when people's prescriptions changed or in the process of changing. For example, when people went into hospital. And they updated them on receipt of new prescriptions. The team members carried out regular checks to ensure that people collected their

medication on time. And this helped them to identify potential compliance issues which they referred to the pharmacist. The team members supplied patient information leaflets. And they provided descriptions of medicines to support people to take their medicines. The pharmacy provided a delivery service. And the driver obtained signatures to confirm that people had received their medications.

The team members dispensed methadone doses once a week for around 11 people. And they obtained an accuracy check before placing the doses in the controlled drug cabinet for safe-keeping. The team members retrieved the doses and the prescriptions when people arrived at the pharmacy. And they obtained a final accuracy check at the time of supply. The pharmacy purchased medicines and medical devices from recognised suppliers. The team members carried out regular stock management activities. And they highlighted short dated stock and split-packs during regular checks. The team members monitored and recorded the fridge temperatures. And they demonstrated that the temperature had remained between two and eight degrees Celsius. The pharmacy used clear bags instead of paper prescription bags for insulin. And this allowed the pharmacist to easily carry out additional checks at the time of supply. The team members kept controlled drugs in three well-organised cabinets. And they managed the risk of selection errors, for example, they kept expired controlled drugs in bags that they kept separated.

The team members acted on drug alerts and recalls. And they recorded the date they checked for affected stock and the outcome of the checks. For example, in February 2020 they had acted on an alert concerning ranitidine with no stock found. The company had trained the team members about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards and when to issue them. The pharmacist knew to monitor prescriptions for valproate. And to speak to people that could be affected to confirm they knew about the risks. The team members knew about the Falsified Medicines Directive (FMD). And the company had implemented the software and scanners they needed to introduce the system. But it had not yet embedded the system in their day-to-day processes.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used crown-stamped measuring equipment. And the measures for methadone were highlighted, so they were used exclusively for this purpose. The pharmacy kept cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team. The pharmacy team members used a portable phone. And they took calls in private when necessary.

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.