General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Walter Davidson & Sons Ltd, 42 High Street, ELIE, Fife, KY9 1DB

Pharmacy reference: 1042080

Type of pharmacy: Community

Date of inspection: 10/12/2019

Pharmacy context

This is a community pharmacy in a rural village. 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 supplies a range of over-the-counter medicines. It offers services including smoking cessation and seasonal flu vaccination.

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	1.1	Good practice	The pharmacy shares learning internally and across the wider organisation.
		1.2	Good practice	The pharmacy regularly records and reviews errors. And team members reflect on these and introduce strategies to avoid repeat incidents. The superintendent pharmacist has oversight of these and shares relevant learning across the company.
2. Staff	Good practice	2.1	Good practice	The pharmacy reviews staffing levels and makes changes in line with the needs of the pharmacy business.
		2.2	Good practice	The pharmacy provides new employees with a structured induction programme. And it provides structured on-going training and development to all team members to ensure they have the skills they need.
		2.4	Good practice	Pharmacy team members use their professional judgement to deliver high quality services that provide good outcomes for people. They work well together to achieve common goals.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy delivers services well providing positive outcomes for people.
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 all services to ensure that they are safe. They record mistakes to learn from them. They review these and make changes to avoid the same mistake happening again. And the pharmacy shares learning across the organisation. The pharmacy uses people's feedback to make services better. The pharmacy keeps all the records that it is required to and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy superintendent kept records of this. The pharmacy superintendent reviewed them every two years or more often and signed them off. Staff roles and responsibilities were recorded on individual SOPs and on a 'roles and responsibilities' chart on the wall. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy had a chart on the wall describing what activities required a responsible pharmacist signed in, or present. Team members described activities that trainees did not yet undertake e.g. the management of multi-compartment compliance packs. 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 pharmacy had a business continuity plan to address maintenance issues or disruption to services. And it had a range of contact numbers on the dispensary wall including other pharmacies, healthcare professionals, suppliers, NHS Direct and agencies to signpost people to.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month and introduced strategies to minimise the chance of the same error happening again. They had identified that incorrect quantities were the most common type of error. The pharmacy team did not make many errors. The pharmacy scanned all dispensed items which contributed to accuracy but could not always identify the wrong quantity. The team had discussed how to improve this and acknowledged there could be a tendency for complacency due to scanning. Team members were continuing to apply their usual accuracy checking to all aspects of dispensing before passing to the pharmacist for the final check. The pharmacy had not made any dispensing errors which reached people recently. The superintendent pharmacist had oversight of incidents and errors. She shared some of these across the whole organisation for increased learning.

The pharmacy had a complaints procedure which it displayed. Team members described ordering items for people which were not normally stocked in the pharmacy. They also described reminding people that they may want to order other prescription items when they were only ordering one. This was following previous instances when people only ordered one item, then ran out of another a few days later. The pharmacy sometimes ordered items in that were being advertised locally in anticipation of customer demand e.g. Bronchostop® for children.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log, with some signing out times not recorded and a few late 'signing in' times. The pharmacist was able to correct

these, and amendments were attributable; 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 (weekly); 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 undertaken general data protection regulation (GDPR) training. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. The pharmacy displayed its privacy policy and a notice stating that CCTV was in operation. Team members had also undertaken training on safeguarding. They knew how to raise a concern locally and had access to contact details and processes on the intranet. The pharmacist was PVG registered. An example was described of the delivery driver raising a concern when a patient did not answer the door as expected. And curtains were closed at the property. The pharmacy tried contacting the person, and then contacted the GP practice. Appropriate action was taken to ensure the person was safe, with involvement of other agencies.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is. And then makes changes when required. This ensures skilled and qualified team members always provide pharmacy services. Team members have access to training material to ensure they have the skills they need. The pharmacy gives them time to do this training. Pharmacy team members make decisions and use their professional judgement to help people. They can share information and raise concerns to keep the pharmacy safe. The pharmacy team members discuss incidents. They learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager and relief pharmacists covering her day off; three part-time dispensers, one who worked Monday to Thursday 9am to 4pm, and two trainees who worked three days each; a part-time medicines counter assistant, a Saturday only trainee medicines counter assistant and a part-time delivery driver. A full-time dispenser had left several months previously, and the pharmacist had reviewed the staffing. Following recruitment, she replaced these hours with two part-time trainee dispensers to provide more flexibility during absence and busy periods. The trainee dispensers were undertaking a joint course to cover medicines counter and dispensary. The pharmacy provided them with time at work to do this and they also did some in their own time at home. The pharmacy displayed certificates of qualification. Typically, there were two team members working at most times. But at the time of inspection there was only the pharmacist and the experienced dispenser due to annual leave. They were able to manage the workload. The pharmacy displayed a branch duties checklist to ensure that all essential tasks were carried out daily, weekly or monthly as required. The pharmacy managed accredited training by providing more time during winter months and Saturdays which were quieter. The pharmacy was in an area popular with visitors, particularly in the summer months. The trainee dispensers and medicines counter assistant had undertaken the company’s induction program before starting on their accredited courses. The pharmacy provided learning time during the working day for all team members to undertake regular training and development using Numark modules. They had all done five modules recently including safeguarding, health and safety, confidentiality (GDPR) and during summer months they had undertaken some health and hayfever training. The pharmacist had undertaken training this year to enable her to deliver travel services including vaccination, and flu vaccination. This included emergency CPR and anaphylaxis training. The pharmacy displayed a notice in the staff area describing its training pathways and programmes. This included new employee induction, pre-registration and advanced pharmacy technician training, and continuing learning and development. Team members had access to the Numark Training platform which consisted of a range of modules on a variety of topics. Some were mandatory and team members could access others as they chose. Team members did not have annual development meetings but had continual conversations with the pharmacy manager. The dispenser explained that if she identified a training need, she could easily discuss this with the pharmacist.

The team members were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. Several examples were described of team members making decisions to provide

pharmaceutical and emergency care to people. This included first-aid being administered on several occasions and a team member giving a person a lift to his own car which was some distance away. The pharmacist had liaised with other community pharmacists and practice pharmacists to set up a group to share information and issues particularly around current medicines shortages. This was proving useful and saving people time and anxiety as issues were dealt with quickly. The group was made up of five community pharmacists and two practice pharmacists.

The pharmacy had a quality improvement board in the staff area with sections for operations updates, topics for team meetings e.g. near miss logging, scan rate update and patient safety updates. The pharmacist had noted that in October there were only three near misses, and this was attributed partly to scanning and to team members' attention to detail. The pharmacy also had a whiteboard for sharing information with all team members and this included noting multi-compartment compliance pack patients who were currently in hospital. It also displayed clinical information on different products e.g. information from secondary care regarding switching between tacrolimus products.

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. They could make suggestions and raise concerns to the manager or area manager. The pharmacy encouraged them to make suggestions on the intranet. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from. She sent a monthly safer care bulletin. A recent one included detail of the phase two NHS non-steroidal anti-inflammatory drug (NSAID) care bundle. Head office also sent regular operations update. Team members read these and signed to acknowledge this. The pharmacy held regular meetings to discuss its own incidents and issues, and those raised in company newsletters. The company had a whistleblowing policy that team members were aware of. Team members gave appropriate responses to scenarios posed. The dispenser explained that she felt comfortable raising issues with the pharmacy manager or could go to head office personnel if required. Examples were described of raising maintenance issues with head office which were addressed in a timely manner.

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 for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed. The pharmacy team members raise concerns if there is damage to the premises. The pharmacy addresses these appropriately in a timely manner.

Inspector's evidence

These were average sized premises incorporating a retail area, dispensary and back shop area including storage space and staff facilities. The premises were clean, hygienic and well maintained. A few months previously the pharmacist had highlighted to head office that a blocked roan-pipe had caused water damage. This was repaired in a timely manner. Similarly, the pharmacist raised concern that there may be mice on the premises. Head office arranged for a pest-control specialist to attend immediately. It quickly resolved the issue and provided follow-up visits to ensure it did not recur. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. And it provides services that the community requires. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets 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 low step and a wide door. Team members helped if required. It listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as NHS travel vaccines e.g. hepatitis A and typhoid if they were entitled to these. It had a hearing loop in working order and could provide large print labels. The pharmacy intranet had a link to translation services that could be accessed if required. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines. It delivered to a remote collection point, a post office in another village. The postmaster signed to acknowledge receipt of items and this was returned to the pharmacy. When people collected their medication, they signed acknowledging receipt and when all items had been collected this sheet was returned to the pharmacy. The post office called the pharmacy if any medicines had been uncollected after around two weeks. This happened very occasionally. There were only a few people accessing the service and they were all on regular repeat medication. The pharmacy did not provide the service for items requiring special storage.

Several examples were described and documented of ensuring people received medication and care they required. This included team members waiting in the pharmacy after closing time for a person to present with an urgent prescription; making urgent supplies of emergency medication such as adrenaline; and ordering items for people who did not have access to the Internet.

Pharmacy team members followed a logical and methodical workflow for dispensing. The pharmacy had dedicated dispensing and checking areas. It received prescriptions twice a day from the local surgery. Team members scanned prescriptions when they came in which provided confirmation that they were on the premises. They used coloured baskets to differentiate between different prescription types and separate people’s medicines and prescriptions. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. They also initialled prescriptions to provide an audit trail of personnel involved at every stage of the dispensing process including labelling and handing out. Team members scanned all medicines for accuracy when dispensing, using either the barcode or new 2-D code. They explained that this had improved accuracy. The team member labelling used a stamp to highlight new items on prescriptions. And they told the pharmacist of any other changes such as dose or unexpected date of supply. If the pharmacist was busy, the dispenser wrote a note to share this information with her. The pharmacy had computer dose codes and patient medication record (PMR) information on the wall beside the labeller e.g. instructions to set up a new surgery. It also had a notice highlighting additional accuracy checking requirements for certain items e.g. controlled drugs (CDs), insulin, injections and cytotoxic. It also noted additional items in this branch such as combination eyedrops, and team member specific items e.g. tramadol, gabapentin and pregabalin.

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 in advance. It kept records of supply and noted the next expected supply date. The pharmacist explained that she used the computer claim screen to monitor compliance, but this was not an issue. The pharmacy was actively registering people for this service. The pharmacist sometimes identified pharmaceutical care issues when discussing people's medicines with them. These were often related to items not being synchronised. She addressed these appropriately.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. It completed these around a week before the first supply was due. And sometimes earlier to accommodate planned absence. The experienced dispenser undertook most of this. And she had started to coach the trainee dispensers in this process. The pharmacy followed the company SOP which relied on a colour coded system depending on which week the prescription was managed. The dispenser placed medicines' packaging with packs for checking and these were retained for the duration of the prescription which would be beneficial in the event of a product recall. The pharmacy kept clear and thorough records of changes or other interventions. It stored completed packs in individually labelled boxes on dedicated shelves in the back-shop area. The labels had the detail of which week the pack was managed in and the day and method of supply. The pharmacy team moved packs for supply in the current week to the front shop area. This provided a visual representation of any packs uncollected. People signed to acknowledge receipt of their pack whether it was delivered, or they collected it.

A 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 put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled them appropriately. The pharmacy had also 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. 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, pharmacy first, smoking cessation, and emergency hormonal contraception. It also followed private PGDs for flu and travel vaccinations. 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 pharmacy provided a travel clinic which was proving popular. The GP practice and other pharmacies were promoting it. There was no other similar provision locally. The pharmacist had undertaken training at head office which had been provided by an external company and included anaphylaxis and vaccination techniques. She had also undertaken online training for background information on travel requirements. An experienced colleague had come to the pharmacy to witness her first vaccination. The pharmacist described being able to contact this colleague at any time for support and advice. Team sometimes referred people to the GP practice for vaccinations that they were entitled to under the NHS.

The pharmacist delivered the smoking cessation service although this was not a busy service. And she

occasionally measured people's blood pressure if they requested it or if she had a concern.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It complied with the requirements of the Falsified Medicines Directive (FMD). Medicines were scanned when they were dispensed then again when supplied using a bar code on the bag label. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Team members checked expiry dates of medicines but evidence of this was not seen. Most items inspected were found to be in date, but two date expired items were observed and removed from the shelves. 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 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 used with people accessing its services. This included a carbon monoxide monitor maintained by the health board, and a blood pressure meter which was replaced as per the manufacturer's guidance. The pharmacy had labelled it for replacement in September 2019. But the superintendent pharmacist provided information after the inspection that this was an error and the meter required replacement every two years. So, the pharmacy amended this to 20 Sept 2020. The pharmacy has the equipment and sundries required for vaccinations including emergency adrenaline, gloves, sharps boxes and alcohol gel rub. Team members kept ISO marked measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records 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 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.