General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Davidsons Chemist, The Pharmacy, Bridge Street, DUNKELD, Perthshire, PH8 0AH

Pharmacy reference: 1042820

Type of pharmacy: Community

Date of inspection: 21/11/2022

Pharmacy context

The pharmacy is an independent, traditional community pharmacy in the historic village of Dunkeld. It provides a range of services including dispensing prescriptions and selling over-the-counter medicines. It provides a selection of other services including a prescription collection service and a medicines' delivery service. It also provides emergency hormonal contraception. And it supplies medicines on the NHS Pharmacy First and Pharmacy First Plus services.

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

The pharmacy identifies and manages the risks associated with its services well. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future. The pharmacy has written procedures in place to help ensure that its team members work safely. And the team follows them. The pharmacy has insurance to cover its services. And it generally completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's private information appropriately.

Inspector's evidence

The responsible pharmacist (RP) highlighted and discussed mistakes as they happened. She did this to enable team members to reflect and learn. The pharmacy team recorded its mistakes in a 'near miss' log. And the technician, who was also the pharmacy's drug safety officer, reviewed them regularly. The pharmacy records showed what the team member had learned and what they would do differently in future to prevent a similar mistake. They showed that team members re-read relevant standard operating procedures (SOPs) after a near miss, to ensure that they followed a robust procedure. The RP clearly recognised that records should provide enough detail to monitor mistakes, learn as much as possible from them and promote continued improvement. The pharmacy had put measures in place to help reduce the transfer of infections. It had put screens up at its medicines' counter. And it had hand sanitiser at different locations in the pharmacy for people and the team to use. The team had a cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly

The pharmacy had a set of SOPs to follow. SOPs were up to date and staff had read them. The pharmacy received SOP updates by email. Changes to updated SOPs were highlighted in red to make it easier for staff to identify and implement them. Team members appeared to understand their roles and responsibilities and were seen consulting the RP or the technician when they needed their advice and expertise. The medicines counter assistant (MCA), who was also qualified as a dispensing assistant (DA), knew how to check for any items missing from prescriptions. She was seen to do this and then to alert the RP. The RP had placed her RP notice on display showing her name and registration number as required by law. People could give feedback on the quality of the pharmacy's services. Team members described the pharmacy as having a low number of complaints. And they generally dealt with any concerns as they arose. They also provided people with a number for head office if they were asked. But in general, the team sought feedback from conversations with people including staff at the care homes it supplied medicines to. And it was clear that the pharmacy team had a good relationship with people using its services. It had received thank you cards from people who were grateful for the team's help and support with providing their medicines. The pharmacy team could provide details of the local NHS complaints procedure for the local health board which were available online. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers. It had professional indemnity and public liability insurance in place until 30 April 2023.

The pharmacy generally kept its records in the way it was meant to, including its unlicensed specials records, emergency supply records and controlled drugs (CD) registers. It maintained and audited its CD running balances. And during the inspection a check of a product in stock matched the running balance in the pharmacy's CD register. The pharmacy kept a CD destruction register for patient returned CD

medicines. This was up to date as team members completed the record as soon as they received any. The pharmacy also had the appropriate records for supplies made under the NHS Pharmacy First service, the NHS pharmacy First Plus and 'Medicines Care Review' (MCR) serial prescriptions. But some of the pharmacy's records were not complete. The RP record had some entries missing where the RP had not signed out at the end of their shift. And a selection of private prescription records did not show the prescriber's details. The team agreed that it was important to ensure that all the pharmacy's essential records were complete and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed online training. Confidential paper waste was discarded into separate waste containers. And shredded daily. People's personal information, including their prescription details, were kept out of people's view. The RP had completed appropriate safeguarding training. Other team members had completed online training for this too. They had a good understanding of their safeguarding responsibilities and knew to report any concerns to social services, the police or a person's GP as appropriate. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy manages its workload safely and effectively. And its team members support one another. They are comfortable providing feedback to one another, so that they can improve the quality of the pharmacy's services. The pharmacy team has an appropriate range of skills and experience to support its services. And team members receive sufficient feedback and coaching to help them develop their knowledge and skills satisfactorily.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours and found a relief manager on dut as the RP. The RP had worked at the pharmacy before. On the day of the inspection the rest of the team consisted of a technician, a DA, the DA, whose role was also of an MCA, a final year pharmacy student and a delivery driver. Most of the pharmacy's team members had worked at the pharmacy for several years and were known to people in the local community. They worked regularly together. And they formed a close-knit team.

Team members had a clear understanding of what their tasks were. And when they should do them. And they were seen supporting one another to complete them. The working atmosphere was efficient and organised. Staff were up to date with the daily workload of prescriptions. And they attended to people coming into the pharmacy promptly. Team members had regular reviews about their work performance. And they had occasional one-to-ones with the regular RP. The regular RP also kept the team up to date with any changes affecting their work or any new work priorities.

The pharmacy had a 12-week induction programme for new starters, with a review every four weeks. And regular one-to-ones in between.

Staff could raise concerns and discuss issues with the regular RP manager, relief manager RPs or the superintendent (SP). The RP felt that she could also discuss any concerns with the regular RP, or the SP. Pharmacists could make their own professional decisions in the interest of people and were not under pressure to meet business or professional targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. Although the space is small, the pharmacy is tidy and organised. And it is sufficiently clean and secure.

Inspector's evidence

The pharmacy was on the end of the main street running through the centre of the village. It was in an old building, and it had a traditional appearance. The pharmacy had a small retail space with a medicines counter behind which it kept its pharmacy medicines. And it had a small dispensary. The dispensary was used for most of the pharmacy's dispensing activities. These included the dispensing of repeat prescriptions, medicines care review (MCR) prescriptions and instalment prescriptions. The pharmacy also had a basement which had a room for dispensing multi-compartment compliance packs, a storeroom and staff facilities. Though the main dispensary was small, the team tidied up as they worked. And they completed one prescription at a time to make sure that work surfaces did not become cluttered and untidy.

The pharmacy had a sound-proof consultation room which the team used for private conversations with people and when providing services such as emergency hormonal contraception. People could access the consultation room from the retail area. The team cleaned the pharmacy daily to ensure that contact surfaces were clean. Stock on shelves was tidy and organised. And floors and work surfaces were free from clutter. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. And makes them adequately accessible for people. The pharmacy team gets its medicines and medical devices from appropriate sources. And it stores them properly. Team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. And they support people with suitable advice and healthcare information.

Inspector's evidence

The pharmacy had steps at its entrance. It also had a ramp which it used for people who needed it, including people using wheelchairs. But the ramp was steep. And so, the pharmacy also had a bell outside, so people could catch the attention of staff if they needed extra help. The pharmacy had a small retail space. And the team kept it free of clutter and unnecessary obstacles. It had a delivery service for people who found it difficult to visit the premises. And it could also order people's repeat prescriptions for them. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. And to help avoid errors. It provided medicines in multi-compartment compliance packs for people living at home. And for people living in a supported living environment. The pharmacy's labelling directions on compliance packs gave the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines and generally with regular repeat medicines. And it had labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. The relief manager RP gave people advice on a range of matters. And she explained how she would give appropriate advice to anyone taking higher-risk medicines. The pharmacy had a small number of people taking sodium valproate medicines. But none of the people taking it were in the at-risk group. The RP described how she counselled people when supplying the medicine to ensure that they were aware of the risks associated with it. The pharmacy also supplied the appropriate patient cards and information leaflets each time.

The pharmacy offered the NHS 'Pharmacy First' service and the NHS 'Pharmacy First Plus' service. Where people could obtain medicines for a range of minor ailments and conditions. For the Pharmacy First service, several team members had been trained to supply medicines for a select range of conditions such as coughs and colds. And they followed the local health board protocol and supplied medicines from a specified list. Team members knew when to refer to the pharmacist when someone presented with a condition which they had not been trained to treat such as a urinary tract infection (UTI) or an ear infection. The regular RP was also a pharmacist independent prescriber. And under the Pharmacy First Plus service she could supply people with prescription medicines to treat several conditions as appropriate. These included antibiotics for a middle ear infection. And antibiotics for a UTI. The RP described how she had referred a patient back to her GP after suspecting that her symptoms indicated an upper UTI, which required further medical intervention. The pharmacy also had a range of patient group directions (PGDs) in place. This provided an alternative way for pharmacists to provide prescription medicines. PGDs in place included emergency hormonal contraception and antibiotics to treat UTIs. And so pharmacists could use the service most appropriate to their level of training and the circumstances at the time.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. And team members knew how to process them. The pharmacy had a system for monitoring and tracking supplies

so that the team knew when people were due to get their medicines. The system also allowed them to monitor compliance and address any issues. The RP described how she would use the pharmacy care record to identify people for review. These were often people on regular repeat prescriptions. She used the NHS medicines care review (MCR) process to identify any care issues, referring people back to their GP where further medical intervention was required. The pharmacy supplied a variety of medicines by instalment. A trained team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the labelled medicines together in individual baskets to keep the instalments together.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines, appropriately and in their original containers. And stock on the shelves was tidy and organised. The pharmacy usually date-checked the pharmacy's stocks regularly. And they kept records to help them manage the process effectively. But due to work pressures, the team recently had not been able to date check its stock as often as it used to. The inspector found a box of Xelevia 100mg tablets which had expired over three months earlier. And a bottle of Oramorph 10mg/5ml liquid which had been opened approximately six months earlier and had passed its expiry date. But the team explained that it would always conduct an expiry date check as part of its dispensing process. And so, it was unlikely that an out-of-date medicine would be dispensed. In general, short-dated stock was identified and highlighted. And the team put its out-of-date and patient returned medicines into dedicated waste containers. The team stored fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves. The pharmacy had several computer terminals which had been placed at individual workstations around the pharmacy. Computers were password protected. And prescriptions were stored in the dispensary out of people's view.

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.