General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Davidsons Chemist, 4 Anderson Street, Well Place, DUNBLANE, Perthshire, FK15 9AJ

Pharmacy reference: 1042822

Type of pharmacy: Community

Date of inspection: 07/10/2021

Pharmacy context

This is a community pharmacy in Dunblane. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it offers a medicines' delivery service to vulnerable people. The pharmacy team members advise on minor ailments and medicines' use. And they supply a range of over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs). The pharmacy also dispenses private prescriptions. This inspection was completed during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards 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 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 mostly follow good working practices. And they show that they are managing dispensing risks to keep services safe. The pharmacy doesn't regularly document its near miss errors. But it can show some evidence of learning from its mistakes to help improve people's safety. The pharmacy keeps the records it needs to by law, and it suitably protects people's private information. The team is equipped to adequately help safeguard vulnerable adults and children. The pharmacy has a set of written procedures to help the team correctly carry out tasks. But it has not fully implemented these. And team members do not follow all these procedures.

Inspector's evidence

The pharmacy had introduced extra control measures to manage the risks and help prevent the spread of coronavirus. Notices at the entrance reminded people visiting the pharmacy to wear a face covering and informed them that social distancing measures were in place. There was no limit to the number of people permitted into the waiting area and social distancing guidelines were seen to be followed without any instruction. Team members were wearing face masks at the time of the inspection and used hand sanitizer that was available throughout the dispensary. A protective screen at the medicine counter acted as a barrier between team members and members of the public. And hand sanitizer was available at the entrance for people to use. The pharmacy had changed ownership on 1 June 2021.

The new owner had provided access to the company's intranet and instructed the team members to read the new company's standard operating procedures within 12 weeks. Team members had looked at a few of the procedures but they hadn't read them in detail due to time constraints. They continued to follow the procedures that had been in place before the change of ownership and not the new ways of working. The new procedures were on the intranet and team members did not know how to declare that they had read and understood them. There were several examples of non-compliance with the new company requirements. For example, the pharmacist did not always annotate prescriptions for multi-compartment compliance packs to provide the 'accuracy checking technician' (ACT) with the necessary authority to check them. And the ACT carried out checks in the absence of the annotation. Dispensing of packs had been delegated to an experienced dispenser who had been deemed competent by the pharmacist. They followed safe dispensing practices and managed the risk of error. This involved checking prescriptions against pharmacy records which they followed-up. This reduced the risk of dispensing errors when carrying out the final accuracy check. Team members did not follow the 'near miss and near miss reporting' procedure. They signed medicine labels to show who had 'dispensed' and who had 'checked' each prescription. And they were responsible for documenting their own errors on an electronic near-miss record form. But they had not recorded near-misses since May 2021. There were a few examples of safety measures. Team members described a new bar-code scanning feature that verified dispensing accuracy. They believed this had reduced the number of near-miss errors. But they were unable to evidence this due to the lack of near-miss error recording. The responsible pharmacist had identified wrong quantities as the most common error. They had instructed team members to place crosses on all sides of split packs and to take greater care to avoid similar errors in the future. Team members had recently segregated edoxaban and etoricoxib to manage the risk of selection errors, but they were unable to provide further examples. The pharmacist investigated dispensing incidents to identify the root cause and to introduce extra control measures if needed. They had investigated a few incidents over the past six months and had discussed the learnings with team

members. But they had not produced an incident report as per the company procedure and could not provide further examples. Team members knew how to handle complaints, and a policy was available for team members to refer to.

People using the pharmacy were invited to provide feedback about the services they received. This helped to identify the need for improvement. Survey questionnaires were available at the medicines counter for people to complete and submit if they wished to. There had been an increase in complaints with a significant number related to increased waiting times. Team members had recently changed the way they processed prescriptions so they could respond to queries in a timely manner. They now scanned them into the system as soon as they arrived at the pharmacy and placed them in an A-to-Z box for easy retrieval.

The pharmacy maintained the records it needed to by law. The pharmacist in charge displayed a responsible pharmacist (RP) notice which was visible from the waiting area. They maintained the responsible pharmacist record, but they did not always document the time they ceased their RP responsibilities. Valid public liability and professional indemnity insurance were in place until 30 April 2022. The pharmacy maintained its electronic controlled drug registers and team members kept them up to date. They checked and verified most of the controlled drug stock once a week. Team members segregated controlled drugs that had expired until they were destroyed by the accountable officer. Controlled drugs that people returned for destruction were also segregated in the cabinet. A small quantity was seen in the corner of the cabinet, but they had not been entered into the controlled drugs destructions register. The last entry had been recorded in September 2021 and signatures showed the individual who had witnessed the destructions. A notice in the waiting area informed people about the pharmacy's data protection arrangements and how it safely processed personal information. Team members understood how to protect people's privacy. And a policy was available for team members to refer to. A new assistant knew to ask people to communicate their postal address before they handed over prescriptions. This also managed the risk of hand-out errors. Confidential waste bags were used to dispose of personal information. Team members used numbered tags to secure the bags before they sent them to head office for destruction. They kept records to show what they had sent. Team members understood how to safeguard vulnerable people. A policy and contact details were available for team members to refer to. Team members knew their vulnerable patient groups and knew to refer to the pharmacist for advice on the best way to manage concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And experienced team members support those in training as much as possible. But team members experience some workload pressure partly due to changing practices and implementing new procedures. This means team members may not work in the most effective way.

Inspector's evidence

The responsible pharmacist had been working at the pharmacy for the past year. The dispensing workload had remained stable since then. But it had increased significantly since before the pandemic. The company used an algorithm to calculate the number of team members the pharmacy needed to provide its services. And the responsible pharmacist had discussed the current levels with the superintendent pharmacist and they had not changed since before the pandemic. Team members had been invited to attend meetings out with their working hours to discuss new working arrangements. But they had not attended to date.

The workflow had also changed due to the nearby medical practice sending prescriptions directly to the pharmacy. The pharmacy was also busier with an increase in referrals from the medical practice for treatments that could be supplied via PGDs. A well-established, experienced team worked at the pharmacy and team members displayed their qualifications and certificates in the dispensary and could be seen from the waiting area. Team members had been adapting to the new company's working practices since 1 June 2021 but had been unable to embed them reportedly due to time constraints. The existing team members had been providing extra support to two new team members who had no previous pharmacy experience. The new team members were providing backfill for someone who had retired and two people on long-term leave. A trainee pharmacist had been moved to another branch.

The following team members were employed at the pharmacy; one full-time responsible pharmacist, one part-time accuracy pharmacy technician (ACT), two part-time dispensers, two new pharmacy assistants (one full-time and one part-time) and two part-time medicines counter assistants. The company had recently arranged extra cover and a second pharmacist had been working at the pharmacy since the start of the week. One of the new assistants had increased their hours to full-time and a previously employed dispenser was working part-time. The new team members were working through the company's 12-week induction processes. One of them had worked at the pharmacy for around eight weeks and had only managed to read the 'labelling and assembly' procedure due to time constraints. They had been producing dispensing labels, assembling prescriptions, and working on the medicines counter. They knew to refer to the pharmacist for support. A staff rota was in place but had not been operationalized as some team members had not been trained to follow the new processes. For example, only one of the dispensers was carrying out multi-compartment compliance pack dispensing. This had caused a temporary backlog when they had taken leave and dispensing had fallen behind.

The company had recently provided on-site training to support team members with the new arrangements for the 'ordering and receipt of medicines'. One of the dispensers had been nominated to take a lead role and support colleagues to adapt to the new processes to improve the pharmacy's

performance. The pharmacist was being supported to undergo ‘pharmacist independent prescriber’ (PIP) training. Team members received individual feedback about their errors at the time they happened so they could learn. But they did not keep records of near-miss errors and so they were unable to carry out reviews of the records. This hindered them from discussing patterns and trends and agreeing on improvement action to manage the risk of dispensing errors.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, well-equipped and professional in appearance. It has a large sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy had segregated areas for the range of dispensing tasks it carried out. This provided adequate space to help keep services safe. It also allowed team members to maintain a safe distance from each other for most of the day. For example, an area at the rear of the dispensary was used for assembling and storing multi-compartment compliance packs. There was adequate shelving to organise stock and to help manage the risk of selection errors. The responsible pharmacist observed and supervised the medicines counter from the checking bench in the main dispensary. This meant they could intervene and provide advice when necessary. The pharmacy did not restrict the number of people in the waiting area. People kept a safe distance from each other or queued outside when they were unable to do so. A plastic screen at the medicines counter helped manage the risk of coronavirus infection.

A large sound-proofed consultation room provided the opportunity to maintain a safe distance. It was well-equipped and provided a confidential environment for private consultations. The pharmacy was clean and well maintained. A sink was available for hand washing and the preparation of medicines. Team members cleaned and sanitised the pharmacy at least once a day to reduce the risk of spreading infection. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

People can access the pharmacy's services. And these services meet people’s health needs. The pharmacy obtains its medicines from reputable sources. And it has processes for ensuring it stores its medicines safely, securely and at the correct temperature. But it cannot show it always adequately responds to drug alerts. Team members manage and deliver services safely. But they do not always follow current written procedures.

Inspector's evidence

The pharmacy promoted its services and opening hours in a window at the front of the pharmacy. It had an automatic door and a ramp provided good access for people with mobility difficulties. Leaflets and posters in the waiting area provided information about the pharmacy’s services. The pharmacy provided a prescription delivery service. This helped vulnerable people and those that were shielding to stay at home. The pharmacy provided a delivery service. Due to the pandemic the delivery driver didn’t ask people to sign for medicines.

The pharmacy used dispensing baskets to keep items contained throughout the dispensing process. This managed the risk of prescription items becoming mixed-up and the risk of dispensing errors. Dispensing benches were mostly organised, and baskets were stacked on a central island awaiting a final accuracy check. The responsible pharmacist and a second pharmacist carried out checks during the inspection. The pharmacy received serial prescriptions for a significant number of people with long-term conditions. This usually helped team members to manage the dispensing workload. But following the change of ownership in June 2021 the workload had sometimes become unmanageable and this had caused delays in supplies and an increase in complaints. A new text service was used to send messages to inform people when their prescriptions were ready for collection. This helped to reduce unnecessary visits and telephone calls from people enquiring if their prescription was ready. The pharmacy supplied medicines in multi-compartment compliance packs for people in their own homes. A central hub dispensed some of the packs to help the pharmacy manage its workload. The assembly and dispensing process was defined in a documented procedure for team members to refer to. But they had not read it to confirm they were following the correct working instructions for the company. A dispenser managed the dispensing process and ordered prescriptions to arrive on time. Dispensers checked prescriptions against patient medication record sheets before they started dispensing. They used supplementary records to help them manage dispensing. This ensured they carried out the necessary tasks in a safe and effective manner. Team members did not provide ‘patient information leaflets’ (PILs) and they did not always provide descriptions of each medication. They could not confirm if the standard operating procedure instructed them to do so. Descriptions and images of each medicine were provided on packs that were assembled at the hub.

The pharmacy purchased medicines and medical devices from recognised suppliers and team members kept the pharmacy shelves neat and tidy. They were in the process of adapting to new stock management processes. A new ‘ordering and receipt of medicines’ process was taking up a significant

amount of extra time to complete. This was impacting on the team's ability to keep up to date with other tasks. Team members had last checked expiry dates in May 2021. A random check of around 12 products showed stock to be in date. The pharmacy had medical waste bins to support the team in managing pharmaceutical waste. A large medical fridge was used to keep stock at the manufacturer's recommended temperature. It was kept neat and tidy to manage the risk of selection errors. Team members monitored the fridge temperatures and documented the checks to provide assurance that the temperature had remained stable between two and eight degrees Celsius. On the day of the inspection the temperature was within the accepted range. A procedure for dispensing valproate was available for team members to refer to. They were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. The pharmacist contacted prescribers on receipt of new prescriptions for people in the at-risk group. And they always supplied original packs which included warning cards and patient information leaflets. A standard operating procedure for how to handle drug alerts was available for team members to refer to. Drug alerts were processed and filed in an electronic folder. But the folder did not reflect recent drug alerts and team members could not provide details about any checks they had carried out.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy’s equipment is clean and well-maintained. It uses equipment appropriately to protect people's confidentiality.

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. Measures were thoroughly washed in between use. The pharmacy stored prescriptions for collection out of view of the waiting area. It arranged computer screens so they could only be seen by the pharmacy team members. The pharmacy had a cordless phone, so that team members could have conversations with people in private. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks.

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.