General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Davidsons Chemist, 31 Percy Street, STANLEY, Perthshire, PH1 4LU

Pharmacy reference: 1085029

Type of pharmacy: Community

Date of inspection: 10/10/2019

Pharmacy context

This is a community pharmacy beside other shops in a village. It dispenses NHS prescriptions including medicines in multi-compartmental compliance packs. The pharmacy offers a repeat prescription collection service. And a medicines' delivery service to post offices in other villages. 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 a smoking cessation service 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 identifies and manages high risk activities such as remote collection and space constraints.
		1.4	Good practice	The pharmacy uses feedback from people to improve its services.
2. Staff	Standards met	2.3	Good practice	The pharmacy empowers team members to use their professional judgement to help people, making interventions with positive outcomes.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.3	Good practice	The pharmacy has several processes in place to obtain medicines that are difficult to source. It also records when medicines are supplied to 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 change the way they work to reduce risks. They use the limited space in the pharmacy well. And have good systems in place to enable people to collect their medicines safely in other villages. Team members record mistakes to learn from them. And they make changes to avoid the same mistakes happening again. The pharmacy asks people for feedback. And team members use this feedback to improve services. The pharmacy keeps all the records that it needs to by law. And it keeps people's information safe. 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 superintendent pharmacist kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. The pharmacy also displayed a 'roles and responsibilities' sheet on the dispensary wall. It also had a 'duties checklist'. These ensured all tasks were undertaken in a timely manner by an appropriate person. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. 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 pharmacist sometimes used a computer in the consultation room to label and access records due to limited space. This relieved pressure in the dispensary. Team members sometimes felt that risk was increased if they were all working in the small dispensary at the same time. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

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 same error happening again. There were not a lot of errors recorded. The pharmacist explained that dispensing was generally very accurate. They had separated some items involved in errors.

The pharmacy had a complaints procedure and welcomed feedback. People could complete surveys which were available at the medicines counter. The pharmacy sent these to head office in sealed envelopes. Team members described responding to feedback in different ways. The pharmacy had opened accounts with more suppliers to try and meet demand for medicines in short supply e.g. hormone replacement therapy. The pharmacist had shown all team members how to use the EMC website to help locate medicines. People's eye drops were labelled in different ways to suit their requirements. Sometimes the traditional labels were too big, and people found it difficult to handle bottles. Some people had asked that seals were not broken on outer packaging, so labels were fixed to this rather than inner tubes. The pharmacy documented these requests on patient medication records (PMR) to ensure consistency. A team member described people telling her she spoke too fast, so she was consciously trying to speak slower.

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; private

prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records well filed alpha sections; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. 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 read a SOP and undertaken general data protection regulation (GDPR) training. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members had also read a SOP and undertaken training on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacy had a chaperone policy in place and displayed a notice telling people. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. The pharmacy makes changes during absence. This ensures it always has skilled and qualified staff available to provide services. Team members have access to training material and the pharmacy gives them time at work to complete this. 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. Team members discuss incidents and learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager; one full-time pharmacy technician; two part-time dispensers, one who was undertaking training; one trainee Saturday only medicines counter assistant and a part-time delivery driver. The pharmacy displayed their certificates of qualification. Typically, there were two team members and a pharmacist working at most times. Team members were able to manage the workload. But they described some challenges during absence. Part-time team members had some scope to work flexibly providing contingency for absence. At the time of inspection, the Saturday only team member was working to cover annual leave. The pharmacist, pharmacy technician and a dispenser had worked in the pharmacy for several years.

The pharmacy provided protected learning time for all team members to undertake regular training and development. It provided team members undertaking accredited courses with additional time to complete coursework, trying to provide a morning per week. But team members sometimes got interrupted, especially during absence. So, they did some work at home in their own time. The pharmacy provided time at work for all team members to complete Numark training modules. These were available on a variety of topics, with some mandatory such as confidentiality and safeguarding. Head office dictated topics to be undertaken each month, and team members could access others as they identified needs. They kept records of training undertaken. The pharmacy displayed the topics to be done each month in the dispensary as a reminder. Team members could monitor their own progress and that of colleagues. They found this useful when there were several modules to be completed in the same timescale. The pharmacist supervised trainees, who described feeling able to ask for help and advice.

The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. Team members were very comprehensive when counselling and advising people. They used appropriate questioning, took advice from the pharmacist and referred as required. When a young child handed in a prescription the team member asked the child to bring an adult to collect the medicine. Team members described examples of other healthcare professionals advising people to purchase inappropriate medicines over-the-counter e.g. ibuprofen when it was contra-indicated. They were confident to provide advice, and in collaboration with the pharmacist provide a more appropriate medicine. A team member described identifying a medicine had been missed from a prescription. She discussed this with the GP practice receptionist, then the practice pharmacist. She agreed that an item had been missed, so provided a prescription. The medicine was supplied as expected to the person who was unaware of any problem.

Another team member had a situation with a person who became agitated when she was told that a prescription re-order form was not a prescription. The team member explained the situation well to the person and liaised with the GP practice to obtain a prescription in a timely manner. The pharmacy team member explained that she was concerned that the person was confused. The GP was aware of this but noted the pharmacy's concern on the patient's records.

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, superintendent pharmacist or other head office personnel. Team members gave appropriate responses to scenarios posed. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. Team members read this and discussed the content. The pharmacy team discussed incidents and how to reduce risks. The team had regular weekly meetings when they discussed a variety of topics including patient safety issues. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean. Although small, they are suitable for the pharmacy's services. The pharmacy team members use a private room for some conversations with people. Other people cannot hear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were small premises incorporating a retail area, dispensary and tiny back shop area including very little storage space and basic staff facilities. The team was short of storage and dispensing space. The dispensary was very congested when stock arrived. There were several deliveries during the inspection. The pharmacy now used seven wholesalers which helped to access medicines in short supply. But it increased the number of delivery boxes in the dispensary. Several people were supplied with gluten free food products on prescription. These items also took up a lot of space in the dispensary. Team members used innovative ways to create space such as hanging bags from hooks on a door. They also used a board placed over the sink to provide more dispensing space. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, 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. The team members actively promoted the use of this room. And the pharmacist used it to supervise substance misuse self-administration. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. 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 knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy was accessed by one step and an automatic door. Team members helped people if required. The pharmacy listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order and could provide large print labels. All team members wore badges showing their name and role. The pharmacy provided a delivery service to post offices in three other villages. This was a historic NHS service to 'remote collection' points. The post-master signed to acknowledge receipt of these medicines. People signed as they collected them from the post office. The post offices returned these sheets to the pharmacy when all items were collected, or after a month. They also returned uncollected medicines after a month. The pharmacy superintendent explained that operations team members visited the post offices to provide training, and discuss procedures and confidentiality. Pharmacy team members delivered to people's homes when required.

The pharmacy collected prescriptions from the GP practice twice a day, with a larger volume in the later collection. The pharmacist often labelled these, undertaking a clinical check at the same time. He used the computer in the consultation room to relieve pressure on the dispensary. Team members dispensed medicines using coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. Pharmacy team members followed a logical and methodical workflow for dispensing. They used a small dispensing bench for dispensing and checking medicines for people waiting. And they used a larger bench for dispensing and checking the collection service prescriptions. If the pharmacy technician or dispenser labelled, they marked any new items on prescriptions to help the pharmacist's clinical check. The pharmacy had a stamp for this. They also notified the pharmacist of any new patients. Team members shared information about prescriptions constantly in a natural and discreet manner. They 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. They initialled bar codes on medicines packets to confirm these had been scanned – either normal bar codes for accuracy or 2D for accuracy and FMD compliance. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. It had some dispensed medicines on retrieval shelves for several weeks. A few people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these when people requested them. The pharmacy was registering people for this service, especially if the pharmacist wanted to discuss their medicines with them, or of he needed to speak to the surgery about their medicines. He discussed pharmaceutical care issues with people including the potential for first-dose hypotension with some medicines. He always spent time with people being changed from warfarin to other anti-coagulants to ensure they knew how to take them and did not take both. The pharmacist ensured that people knew if new medicines were the same or a different class of drug. This was important for some people as they could not undertake certain activities if they were taking e.g. beta-blockers. A person had asked if he could resume blood donation after being switched to a different drug class. Despite extensive research the

pharmacist could not answer this. So, he referred the person to the blood transfusion service. He logged all interventions on the pharmaceutical care record.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Team members ordered prescriptions when the third pack was supplied, giving ample time to receive and check prescriptions before assembly. They usually assembled them about a week before the first supply was due. Some people collected all four trays together and the pharmacist had signed authorisation from prescribers to do this. Team members followed the company SOP, using a colour coded calendar to ensure all tasks were carried out in a timely manner. They stored completed packs on dedicated shelves in labelled boxes per person. They did not have tablet descriptions on packs. They supplied patient information (PILs) with the first pack of each prescription. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these in entirety for weekly supply, and weekly for daily supply. They printed all labels at the same time, so the patient medication record (PMR) didn't have accurate supply dates. But this was recorded in the instalment programme. And people signed as they received their supply, providing an audit trail. The pharmacy kept record cards for supply of all instalments including multi-compartmental compliance packs and methadone instalments.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. He 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, emergency hormonal contraception, supply of chloramphenicol ophthalmic products and flu vaccination. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence under the pharmacist's supervision. 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. This was observed to be well managed.

The pharmacy was soon to provide flu vaccination, both as a private service and for NHS staff. But there was no vaccine available yet, so the service would start over coming weeks. The pharmacist's training was up-to-date. One team member was largely responsible for delivery of the smoking cessation service. People were usually offered nicotine replacement therapy as the pharmacy had seen more success with this than varenicline. Several team members were trained and competent to measure blood pressure. They described practicing on each other periodically to keep their skill up. People did not request this service often.

The pharmacy obtained medicines from seven licensed wholesalers including Alliance and AAH. It also obtained medicines from other branches. The company provided access of stockholding to all branches. This enabled the pharmacy to identify branches that may be able to provide medicines. Several examples were described of the pharmacy obtaining medicines for people that were in general short supply. It complied with the requirements of the Falsified Medicines Directive (FMD) to the best of its ability. FMD compliant packs were scanned for accuracy and FMD verification. There were software functionality issues, and some known issues nationally with some codes. These issues were being

addressed. Dispensed medicines were scanned out at the time of supply and de-commissioning took place. 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 regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy was not part of the local palliative care network, but it stocked the medicines to avoid people having to travel for these. The pharmacist worked closely with the GP practice and they had agreed how the urgent supply of medicines could be used to help people. The pharmacist supplied medicines in this way when there was a need and sent prescriptions to the practice pharmacist to update medical records. 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 delivery of its services. It 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 annually. It also had sundries for vaccination and an anaphylaxis kit available. Team members kept crown stamped 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. It did not keep a separate counter for methotrexate tablets as they were supplied in blister packaging.

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.