

Registered pharmacy inspection report

Pharmacy Name: Clarkes Chemist, 7C Merkins Avenue,
DUMBARTON, Dunbartonshire, G82 3EB

Pharmacy reference: 1090707

Type of pharmacy: Community

Date of inspection: 02/05/2019

Pharmacy context

The pharmacy is in a residential area of Dumbarton on a parade of shops. It provides a prescription collection and delivery service. And supplies medicines in multi-compartment medicine devices to help support people. It offers a range of additional services. And a consultation room and separate booth are available.

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 has procedures for the key tasks that it carries out. And the pharmacy team must follow them. But, the procedures are past their review date and expired. This means the pharmacy is unable to show that the pharmacy team are up to date with safe and effective practices. The team members understand the roles and responsibilities expected of them. And they work in a safe way and look after the people that use the pharmacy. The pharmacy keeps some records of mistakes when they happen. And senior pharmacy members carry out checks to make sure the pharmacy is running safely. The pharmacy team members use safety measures when they identify weaknesses in their procedures. And this ensures that services stay safe. The pharmacy keeps the records it needs to by law. It understands its role in protecting vulnerable people. And the pharmacy team are trained to keep confidential information safe. People using the pharmacy can raise concerns. And staff know to follow the company's complaints handling procedure. This means that staff listen to people and put things right when they can.

Inspector's evidence

The pharmacist had worked at the pharmacy for around two and a half years. The pharmacy displayed the responsible pharmacist notice. And people could identify who was in charge.

The pharmacy team signed to confirm they followed standard operating procedures. But, the procedures were out of date. And the responsible pharmacist could not tell when they had been last reviewed

The pharmacy team signed most of the dispensing labels to show they had completed a dispensing task. This included, assembly and accuracy checking prescriptions. But, dispensing labels on multi-compartment medicine devices were not always signed.

The pharmacist checked prescriptions. And gave feedback to dispensers when they failed to identify their own errors. The pharmacist recorded the near-misses. But did not always identify the contributing factors. This meant that improvement action was not always identified and discussed.

The pharmacist reviewed the near-miss records on an ongoing basis. But, a formal near-miss review was not carried out or documented. This prevented remedial action being taken to manage the dispensing risks at the pharmacy. The pharmacy team provided a few examples of change due to similar sounding names and similar looking packaging. Such as, amitriptyline/amlodipine, co-codamol strengths and gabapentin/pregabalin.

The pharmacist managed the incident reporting process. The pharmacy team knew when incidents had happened and what the cause had been. For example, spironolactone and sumatriptan had been separated when there had been a mix-up.

A complaints policy ensured that staff handled complaints in a consistent manner. A leaflet informed

people about the complaints process and provided them with contact details.

The pharmacy maintained the legal pharmacy records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date.

The pharmacy team kept the controlled drug registers up to date. And checked and verified the balance of controlled drugs on a regular basis. The pharmacist had reported a recent discrepancy to the controlled drugs accountable officer at the Health Board. And this was due to a missing Equasym XL 30mg tablet that could not be found. The pharmacy recorded controlled drugs that people returned for destruction. The staff destroyed the controlled drugs on a regular basis. And recorded their names once completed. A sample of private prescriptions were up to date and met legal requirements. A sample of specials records were up to date. And the pharmacy team recorded the name of the person who had received the medication.

The pharmacist used patient group directions to improve access to medicines and advice. A sample varenicline patient group direction was valid until March 2020.

The pharmacy trained new pharmacy team members to safeguard confidential information during their induction period. And the pharmacy team knew how to comply with data protection requirements.

The pharmacy team shredded confidential information. And archived spent records for the standard retention period.

The pharmacy stored prescriptions for collection out of view of the waiting area. And computer screens were not visible. The pharmacy team used individual passwords to restrict access to patient medication records. And took calls in private using a portable phone when necessary.

The protecting vulnerable group scheme helped to protect children and vulnerable adults. And the pharmacist had registered due to carrying out registrable activities after work. The pharmacy team were aware of vulnerable groups. And key contact details were available should a referral be necessary. The pharmacy team provided an example when a female fell over outside the pharmacy. And one of the dispensers accompanied her home. The pharmacist called later to make sure she did not need medical attention.

Public liability and professional indemnity insurance were in place. And expired on 30 June 2019.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy monitors its staffing levels. And ensures it has the right number of pharmacy team members throughout the week. The pharmacy team members support each other in their day-to-day work. They can speak up when there are problems. And suggest service improvements when needed. The pharmacist updates team members when there are service changes. But there is limited access to ongoing training. And this may prevent pharmacy team members from improving in their roles.

Inspector's evidence

The pharmacy work-load had increased over the past year. The pharmacy had appointed two new pharmacy team members to replace two people that had left. And an extra day had been added to their hours to meet the demands of the increased work-load. The pharmacist was in discussion with the superintendent pharmacist to recruit a pharmacy student to work on a Saturday. And this would provide further support.

The pharmacy kept staff qualifications on-site so that evidence of accreditation was available. And the following team members were in post: one full-time responsible pharmacist; four part-time dispensers; and one delivery driver.

The pharmacy used a holiday planner to manage annual leave. And allowed only one member of staff to take leave at the one time unless there were exceptional circumstances. The pharmacy team covered for each other. And increased their hours when necessary.

The pharmacy supported staff that were in training. And the pharmacist had agreed protected training time each week for the new trainee dispenser. This was carried out in the consultation room.

The pharmacy did not carry out individual performance reviews to develop the pharmacy team. And provided training in response to service changes. For example, when a 'pharmacy first' initiative was introduced, and more recently when gabapentin and pregabalin had been re-classified under controlled drug legislation.

The pharmacy did not use service targets to develop the business. And the pharmacy team knew only to register people when they were suitable for services. The pharmacist had instructed the pharmacy team to monitor and reduce stock levels when they could.

The pharmacy team members raised concerns and provided suggestions for improvement. For example, the pharmacist had recently instructed the pharmacy team not to order stock for multi-compartment medicine devices in advance. The pharmacy team provided feedback that the new system would lead to delays. And the pharmacist had listened, and the ordering process had remained the same.

The pharmacist discussed queries with patients. And gave advice when handing out prescriptions.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are clean. And provide a safe, secure and professional environment for patients to receive healthcare.

Inspector's evidence

The pharmacy maintained and cleaned the premises on a regular basis. And a large well-kept waiting area presented a professional image to the public. The pharmacy provided seating in the waiting area. And a few patient information leaflets were available for self-selection.

A consultation room and separate private booth were available and were professional in appearance.

The pharmacy had allocated benches for the different dispensing tasks. The pharmacy team dispensed walk-in prescriptions near to the waiting area. And dispensed multi-compartment medicine devices on a rear bench. The pharmacist supervised the medicines counter from the checking bench. And could make interventions when needed.

A security alarm and shutters protected the pharmacy after hours. And panic buttons were available.

The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides a range of services to the surrounding area. It displays its opening times and some service information in the window. But, only provides limited access to patient information leaflets inside the pharmacy. This means that people may not always be aware of the services available to them. The pharmacy supports housebound and vulnerable people. It dispenses multi-compartment medicine devices for people who need extra help. And offers a prescription collection and delivery service. The pharmacy manages its services. But, sometimes it dispenses medicines before new prescriptions arrive from the surgery. This increases the risk of dispensing errors. And the risk that the pharmacy may not give people the right medicines at the right time. The pharmacy does not always update the pharmacy team about high-risk medicines. This means they are unable to contribute to patient safety initiatives. The pharmacy sources, stores and manages medicines to ensure they are fit for purpose. And it has the capability to follow the new falsified medicines directive.

Inspector's evidence

The pharmacy provided a ramped entrance so that people with mobility difficulties could access the pharmacy without restriction. The pharmacy displayed its opening hours at the front of the pharmacy. And a few patient information leaflets were available beside the medicines counter.

The pharmacy provided a prescription delivery and collection service to anyone who requested one. And this provided support to housebound and vulnerable people. The delivery driver collected signatures to confirm that people had received controlled drug prescriptions.

The pharmacy team used dispensing baskets. And kept prescriptions and medicines contained throughout the dispensing process. The pharmacy team attached notes to prescription bags to communicate key messages. For example, when people were prescribed high-risk medication such as methotrexate. And the pharmacist provided advice and checked to ensure blood tests were up to date.

The pharmacist was reviewing the system used to manage the chronic medication service. This was due to an increase in the number of serial prescriptions generated by the surgery. The pharmacist had considered the need to ensure that supplies were made on time. And that people who were not getting the most out of their medicines were identified and supported.

The pharmacy provided multi-compartment medicine devices for people who needed extra support. The pharmacy team did not always dispense the devices against prescriptions. And used the pharmacy patient medication record sheets instead. The pharmacist explained this was due to the high level of dispensing carried out. And to avoid people going without their medicines.

The assembled devices were placed on shelves awaiting prescriptions. And a final check was carried out by the pharmacist once they were reconciled with the patient medication record. The pharmacy team supplied patient information leaflets. But, did not always provide descriptions of medicines on the dispensing labels.

The pharmacy team kept the pharmacy shelves neat and tidy. And purchased medicines and medical devices from recognised suppliers. The pharmacy kept controlled drugs in two well-organised cabinets to avoid selection errors. For example, a separate cabinet was used to store methadone.

The pharmacy team carried out regular stock management activities. And highlighted short dated stock and part-packs. They monitored and recorded the fridge temperatures. And demonstrated that the temperature had remained between two and eight degrees.

Staff accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected.

The pharmacy team acted on drug alerts and recalls. And recorded the outcome, and the date they checked for affected stock. For example, they had checked stocks of choramphenicol in April 2019 with none found.

The pharmacist had carried out an audit in 2018 to identify people who were taking valproate medication with none found. And confirmed there had been no new prescriptions since then. The pharmacist had not briefed the pharmacy team about the use of valproate in people who may become pregnant. And they did not know about the pregnancy protection scheme or where to find safety leaflets and cards.

The pharmacy had trained staff to understand the falsified medicines directive. And although it had installed a bar-code reader and associated software, the system had not been operationalized.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services.

Inspector's evidence

The pharmacy used CE quality stamped measures for measuring liquids. And counting triangles were available.

Cleaning materials were available for hard surface and equipment cleaning. And hand washing solution was also available. The pharmacy sink was clean and suitable for dispensing purposes.

Reference sources were available. For example, the current copy of the BNF and BNF for children were in use.

A consultation room and separate booth were available. And the pharmacy protected people's privacy and dignity.

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.