

# Registered pharmacy inspection report

**Pharmacy Name:** Dickson Chemist, 35 Mitchell Arcade, Rutherglen,  
GLASGOW, Lanarkshire, G73 2LS

**Pharmacy reference:** 1091065

**Type of pharmacy:** Community

**Date of inspection:** 31/01/2024

## Pharmacy context

This is a busy community pharmacy in the town of Rutherglen in Glasgow. It provides a range of NHS and private services. This includes dispensing NHS prescriptions and providing some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. The pharmacy provides the NHS Pharmacy First service and supervises the administration of medicines for some people. It has a private prescribing service which includes prescribing low dose naltrexone (LDN). The pharmacy also dispenses medication for several specialist private clinics. And it uses automated technology to support its dispensing services.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy identifies and manages risks associated with its services, including for the private services it is associated with. And it reviews these services regularly to ensure they remain safe. It has written procedures to help team members work safely. Team members record and discuss errors so they can learn from them to help prevent a recurrence. They generally keep suitable records as required by law. And they keep people's private information secure. They know how to respond to concerns to help support vulnerable adults and children.

### Inspector's evidence

The pharmacy had a set of current standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. These included controlled drug (CD) management SOPs, responsible pharmacist (RP) SOPs, and SOPs for checks that were completed by the accuracy checking pharmacy technician (ACPT) and the accuracy checking dispensing assistant (ACDA). There were some SOPs with no review dates annotated and the RP was not aware when a formal review of the SOPs by the superintendent (SI) pharmacist was due. Team members had signed to say they had read and understood the SOPs. The pharmacy team had recently begun re-reading the SOPs to refresh their knowledge of them. This included re-reading the SOP for handing out prescriptions in response to a handout error. Team members were observed working within the scope of their roles. The managing director had completed audits of the pharmacy's compliance with its procedures and details from a recent audit were seen. This showed that the pharmacy was overall compliant with minor improvements required for recording fridge temperatures daily and completing the cleaning rota.

The pharmacy dispensed prescriptions for around twenty private clinics that offered specialist services including allergy clinics. The SI met with the clinicians from the private clinics to understand their model of care and scope of practice. And the SI met more regularly with clinics that provided higher-risk services, such as prescribing for children, or those working with a sole prescriber. This ensured the pharmacy was informed of any changes in practice. The pharmacy carried out regular checks on the registration status of the prescribers from the private clinics to ensure the prescriptions were valid. And it asked for copies of prescribing policies and indemnity insurance details. But this was not received from every clinic. The pharmacy only worked with private clinics that were registered with the appropriate regulator, for example, Healthcare Improvement Scotland (HIS). Private clinics had secure access to the pharmacy's web-based consultation platform to allow them to submit prescriptions electronically to the pharmacy. The pharmacy's prescribing platform restricted the products available for each clinic to prescribe which was based on the scope of practice and prescribing policies provided to the pharmacy. If a prescriber wished to prescribe a product not on their list, it required authorisation and review by the SI. This meant the SI ensured only appropriate products relating to the clinic were prescribed. The SI carried out a periodic review of prescribing information of private clinics to help identify inappropriate prescribing such as high volumes of prescribing. Any unusual prescribing would be initially discussed directly with the clinic.

The pharmacy dispensed private prescriptions for low-dose naltrexone (LDN) to treat medical conditions on an agreed list, such as rheumatic disorders and chronic fatigue syndrome. The use of LDN to treat these conditions was outside the manufacturer's license. Prescriptions were received from external private clinics as well as from two pharmacist independent prescribers (PIPs) employed by the

pharmacy. People requesting treatment for low dose naltrexone (LDN) were commonly referred by clinicians with a specialist interest, or through the LDN Research Trust. And they were required to have a medical diagnosis confirmed in writing by a letter from a doctor or hospital clinic. People with medical conditions not on an agreed list were referred to more experienced prescribers. The PIPs had completed specific training to prescribe LDN for these conditions and they had experience from previous roles. The pharmacy required people to provide evidence such as a letter from their consultant of an existing diagnosis and any other prescribed medication before a consultation for LDN was carried out. And evidence of this process being followed was seen. The information was added to the electronic patient medication record (PMR) by a team member and then reviewed by a prescriber. People verified their identity by submitting a photograph of themselves holding photographic identification. There was a risk assessment (RA) and prescribing policy for this service as well as for other prescribing services offered by the pharmacy. This included for treatments such as menopausal symptoms. This helped to ensure consistency in prescribing. And there was a process for review by both the SI and the PIPs as part of a quarterly clinical meeting. PIPs acknowledged they had read and reviewed these policies and electronic records were maintained by the SI. A sample of prescribing records were reviewed. Consultation entries were clear and contained information for prescribers to refer to in future consultations. Following the previous inspection, the pharmacy no longer prescribed for new people accessing the service from outside the UK.

The pharmacy electronically recorded errors identified during the dispensing process known as near misses. The team member who made the error was responsible for recording the details of the error so they could learn from it. Records of errors included the learning points to help prevent a recurrence of the error. The pharmacist manager completed a review of the data produced. They had informal weekly discussions with team members regarding the errors. The pharmacy electronically recorded errors identified after a person had received their medicines known as dispensing incidents. Details of the incident were shared with the SI. Following a recent dispensing incident team members were reminded of the importance of asking people to verbalise their address rather than them confirming what the team member had said was correct. The pharmacy had a procedure for dealing with complaints from people using the pharmacy's services. Team members aimed to resolve concerns or complaints informally. If they were unable to, they supplied contact details for the SI or one of the directors. Team members received positive feedback from people accessing the pharmacies services. They had recently implemented a new procedure which involved taking contact details for people who were unable to be supplied the full prescribed amount of their medication. This meant that team members could keep people informed of when their medicines were available and team members reported people had been appreciative of the change.

The pharmacy had current professional indemnity insurance. The RP notice was displayed prominently in the retail area and reflected the details of the RP on duty. Team members knew which tasks could and could not be completed in the absence of the RP. They had a procedure to follow if the RP was not present when the pharmacy opened, which included informing the SI and the managing director. The RP record was compliant. The pharmacy had electronic CD registers and a sample showed they were mostly compliant, although some entries did not record the address of the wholesaler supplying the CDs. But there were two current registers for some CDs, as medicines supplied in multi-compartment compliance packs were entered into a separate register. The RP discussed the legal requirements with the SI during the inspection to agree how to rectify this. Regular balance checks of the stock held against the running balance in the registers took place. The pharmacy kept its records of private prescription supplies electronically and associated prescriptions were kept.

Team members had received training about information governance (IG) and general data protection regulations (GDPR) by reading the SOPs. And they knew how to keep people's private information secure. A privacy policy notice was displayed in the retail area for people accessing services. Patient

identifiable information was kept separately and shredded on site. Team members had received training for safeguarding vulnerable adults and children. They knew to refer any concerns to the pharmacist who contacted the appropriate local authorities. The RP was registered with the protecting vulnerable groups (PVG) scheme.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has an experienced team with a wide range of skills and knowledge. Team members work effectively together and support each other with the day-to-day work. They receive ongoing development opportunities and support to obtain additional qualifications. Pharmacist prescribers have access to peer support to help them keep their knowledge up to date.

### Inspector's evidence

The pharmacy had a full-time pharmacist manager who was the RP at the time of the inspection. And they were completing their independent prescribing (IP) qualification. The pharmacy team further consisted of a trainee pharmacist, an ACPT, an ACDA, six dispensers, two of whom were trainee ACDAs and two delivery drivers. Team members had either completed, or were completing, accredited training for their roles. Most team members worked full-time, and all were on duty at the time of the inspection. The pharmacy employed two part-time PIPs who provided private prescribing services. And the managing director was a dispenser and supported the team when required. Annual leave was planned so that there was contingency for absences. Team members were trained to deliver all aspects of the dispensing services so there was continuity during periods of absence. And the pharmacy team had assessed when their busiest periods were and used relief dispensers to support additional workload if required.

Team members were observed working well together to manage the workload. There was a booklet titled "induction and refresher training." This booklet help induct new employees with a structured training plan to develop their skills and knowledge. And it provided an opportunity for team members to refresh their training. Team members assisted each other with queries and learnings. The trainee pharmacist helped answer queries about medicines from team members and knew to refer to the pharmacist if they were not sure of the answer. The trainee pharmacist received protected learning time every week. Two team members had recently completed an accuracy checking course and were awaiting confirmation that they had successfully completed the course. The pharmacist had completed training to deliver additional services as part of the NHS Pharmacy First service. And they had shared a declaration of competence with the Health Board. The pharmacy held regular team meetings with an agenda to ensure key points were shared and discussed. For example, the pharmacist manager used a recent team meeting to highlight to team members that more information was required on the near miss log.

The SI and the managing director held six-monthly performance and development reviews for team members. And supported those who wished to develop their skills and knowledge by completing additional qualifications. Team members felt comfortable to raise concerns or make suggestions for change. And there was a whistleblowing policy for team members to use if needed. Team members asked appropriate questions when selling medicines over the counter and referred to the trainee pharmacist or RP if necessary. And they knew to be vigilant to repeated requests for medicines liable to misuse such as codeine-based products. Team members referred repeated requests to the pharmacist who would have supportive conversations with people and referred them to their GP where appropriate. The pharmacy used an external company for Human Resource support and provided team members with access to a mental health support programme. The pharmacist manager had signposted team members to access this support following a recent event.

The SI met with PIPs employed by the pharmacy for a clinical meeting and peer-review session every quarter. They reviewed their current practice and discussed governance arrangements, record keeping requirements and good practice points for certain conditions. And this was an opportunity for the PIPs to receive peer support and improve their prescribing quality. For example, the group had identified a licensed medicine for the treatment of hormonal symptoms of the menopause that could be prescribed privately. The SI completed a risk assessment with the input from all the PIPs before offering this service. They considered national guidance and information from the summary of product characteristics (SPC). Through these discussions they implemented an extra requirement for people to have a blood test to check liver function before prescribing. The PIPs who prescribed low dose naltrexone (LDN) had completed training provided by the LDN Research Trust which included a Masterclass exam. PIPs employed by the pharmacy had access to a group messaging service. This allowed them access to peer-support.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy premises are clean, secure and suitable for the services it provides. It has good facilities to meet the needs of people requiring privacy when accessing its services. The pharmacy's website provides people with information about its services.

### Inspector's evidence

The pharmacy premises comprised of a main dispensary and retail area. There were additional rooms where the main automated dispensing robot was housed, a room where medicines supplied in multi-compartment compliance packs were prepared, which included a separate automated dispensing robot, and a room upstairs where private prescriptions were dispensed. In each room, different benches were used for different tasks. In the main dispensary, team members generally managed the limited space well but some baskets containing dispensed prescriptions waiting to be checked were piled on top of each other in areas where the space was limited. This could increase the risk of errors. The pharmacist's checking bench was situated so they could supervise the dispensing activities in the main dispensary. All areas were cleaned by team members according to a rota. Team members had recently experienced a ceiling leak in the main dispensary. This had been reported and fixed promptly. There was some damage to the wall and countertop and works had been scheduled to fix and replace the damaged areas.

The main dispensary had a sink which provided hot and cold water for handwashing and water for the preparation of medicines. Toilet facilities were clean and had separate facilities for hand washing. The temperature was comfortable throughout, and the lighting was bright. UV lights and an air filtering unit were installed in the room where multi-compartment compliance packs were dispensed to protect medicines removed from their original packs. And it helped protect team members from inhaling powder from medicines.

The pharmacy advertised some of its services through its website [www.dicksonchemist.co.uk](http://www.dicksonchemist.co.uk). The website provided details about the owners, its physical location and contact details. It also provided the name and the registration details of the SI. The website provided information about some of the conditions the PIPs prescribed for and the treatments available. And allowed people to book a consultation with a PIP using an online calendar. The pharmacy had two lockable consultation rooms where people could have private conversations with team members or access services from the pharmacist. The consultation rooms were well equipped to provide services with seating and a treatment couch. A waiting area adjacent to the consultation rooms provided a suitable area for people waiting for their prescriptions or receiving services. There was a separate room which provided privacy to people receiving supervised medication. The retail area had a medicines counter which restricted unauthorised access to the dispensary. The dispensary was screened in areas which provided privacy for dispensing activities and reduced the risk of distractions.



## Principle 4 - Services ✓ Standards met

### Summary findings

Overall, the pharmacy manages its NHS and private services safely and effectively. And it makes its services accessible to people, so their healthcare needs are met. It uses automated dispensing technology to support the safe delivery of its services. Team members complete checks to ensure that medicines are fit for supply. And they generally ensure people have the necessary information to take their medicines appropriately. And they know how to respond correctly to concerns that medicines might not be suitable to supply.

### Inspector's evidence

The pharmacy had level access from the shopping centre and car park which provided ease of access to those using wheelchairs and with prams. It provided NHS dispensing services, including the supervision of medicine used in the substance misuse service. Team members prepared doses of the medicine using an automated machine linked to a laptop. They asked people to confirm their name and the dose they were expecting to ensure they were supplying to the correct person. Team members checked the names and address of people who collected other medication to ensure the supply was correct.

Team members used baskets to keep people's prescriptions and medicines together to reduce the risk of errors. They signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved at each stage. Stickers were attached to prescriptions to highlight the inclusion of a CD, fridge line, or if the pharmacist wished to speak to a person when they collected their medicine. Team members had some knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. Some people received valproate in their multi-compartment compliance pack and not in the original packs and they were supplied with cards containing written warnings. The pharmacy had not completed risk assessments for this process as per recently updated guidance at the time of the inspection, but the SI subsequently confirmed they were in the process of completing this.

The pharmacy prepared some medicines in multi compartment compliance packs using an automated dispensing robot. And it provided the service for other pharmacies in the company. A dedicated team managed this process. The pharmacist manager had completed a review of the prescriptions for packs to ensure each person's medication was synchronised. Prescribers sometimes requested medicines that normally remained in the manufacturer's original pack to be supplied in a compliance pack. On these occasions the team kept a record of the date when these medicines were removed from the original packs. Packs were accuracy checked by an ACPT before the RP completed a final clinical check. Team members signed to record who had completed each of these steps. People had written instructions about how to take their medicines. These labels included descriptions of what the medicines looked like, so they could be identified in the pack. However, the manufacturer's patient information leaflets (PILs) were not always supplied.

The pharmacy kept a record of the delivery of medicines to people so that any queries could be resolved. An application embedded on a smart phone recorded the deliveries due each day so the driver could plan their route. And information such as fridge items and CDs were added to the application so they driver knew additional items were to be added to the delivery.

The regular pharmacist supplied medication for a range of conditions under patient group directions (PGDs) for the NHS Pharmacy First service, including urinary tract infections, insect bites and seasonal hay fever. They retained paper copies of the most up to date PGDs for easy referencing. The pharmacy no longer provided the NHS Pharmacy First Plus service as it didn't have a full-time PIP present in the pharmacy. People requesting the NHS Pharmacy First Plus service were referred to the company's online consultation booking on the website. PIPs working in other pharmacies in the company arranged consultations in-person at another pharmacy, or remotely using telephone call or video consultation. The regular pharmacist was aware of the medical conditions the PIPs could prescribe for and the limitations of the service. This helped prevent inappropriate referrals.

Two PIPs employed by the pharmacy specialised in prescribing LDN. Thirty-minute appointments were offered to allow the PIP time to fully complete the consultation. Consultations for LDN were mainly completed over the telephone, but also by video call or in person. Prescriptions were generated on the pharmacy's own prescribing platform and could not be amended once created. People could access their online account to see a copy of the prescription, order further prescriptions and make payments. Each prescription for LDN contained the text "To be dispensed only by Dickson Chemist unless accompanied by an ink signature." This helped prevent copies being dispensed at other pharmacies. People were advised to make their GP aware that LDN was prescribed, but the pharmacy didn't check if this was done. Prescriptions covered a three-month period and were dispensed in monthly instalments. Further supplies were made after the PIP completed a three-month review with the person. This was because the benefits from taking the medication were usually seen at three months. And PIPs completed an annual review with people to ensure ongoing treatment remained appropriate. The pharmacy team provided people with clear advice on how to use their medicines. People receiving LDN for the first time were supplied with an information pack produced by the LDN Research Trust. This contained frequently asked questions and reference sources. Every prescription for LDN was supplied with a patient information leaflet. This provided details of the unlicensed use of the medicine, how to use and store the medication, the medicine's ingredients and information on the manufacturer.

Trained pharmacy team members prepared unlicensed LDN oral solution for prescriptions on the premises using LDN capsules supplied by a specialist manufacturing company. They recorded the batch numbers of the LDN capsules used and followed worksheets for preparing the solution. These detailed each ingredient required, the quantity to be used and the method for preparation. Records were kept of each batch prepared, including the date and initials of the team member and pharmacist who had checked the ingredients. To ensure the procedures for preparing the LDN solution were correct a batch of prepared solution had been previously sent for analysis by an external laboratory. This showed the concentration was within the expected and acceptable range. And confirmed stability for twelve months at room temperature.

A separate dispensary was used for assembling the private prescriptions issued by the pharmacy's PIPs and private clinics. Team members accessed the electronic prescribing platform to check for prescriptions received from the private clinics waiting to be dispensed. And they used the system to produce dispensing labels and shipping labels for each prescription. The RP could refer to the consultation information on the prescribing platform when required for the clinical check.

The pharmacy provided access to hyperbaric oxygen therapy. This was completed in the hyperbaric oxygen chamber situated in a clinic room adjacent to the premises. People booked a session using the pharmacy's website. A team member had completed training provided by the equipment supplier. This included how to use the equipment safely and records that were required. And they had a list of medication and medical conditions that excluded people from using the service. The team member recorded treatment in an individual therapy logbook. This detailed the pressures recorded during the session and any side effects people experienced.

The pharmacy sourced its medicines from licensed wholesalers. And it stored most of its medicines in the main automated dispensing robot. Medicines that were stored out with the automated machine were stored tidily on shelves in the dispensary. Team members checked the expiry dates of stock held out with the automated dispensing robot and kept a record of this activity. They generally marked medicines with a short expiry date to prompt them to check the medicine was still in date. However, two bottles of metoclopramide 5mg/5ml with expiry dates of 03/2024 and 07/24 were found unmarked. This was highlighted to a team member who made appropriate markings on both bottles. Team members recorded the dates of opening for medicines with altered shelf-lives after opening, so the team could assess if the medication was still safe to use. Expiry dates of medicines in the main dispensing robot were captured as they were scanned into the system. This ensured medicines with shortened expiry dates were picked first and the robot alerted team members to medicines that were due to expire. The pharmacy had two fridges for medicines that required cold storage. Team members recorded the temperatures daily and records showed the fridge was operating between the required two and eight degrees Celsius. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts were printed and actioned, and records of completion were kept. Team members followed a documented process when people reported an issue with LDN. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has a range of equipment and automation that it keeps suitably maintained to help ensure the safe supply of medicines for people. And team members use the equipment in a way that protects people's private information.

### Inspector's evidence

Team members preparing the LDN oral solution used equipment that was washed at a high temperature in an automatic dishwasher following use. The pharmacy had a separate area and a filtration cabinet for safely preparing the LDN solution. There was an ongoing service contract for the cabinet and for the automated dispensing robots which included regular cleaning and maintenance. IT support was available for the automated dispensing systems.

The pharmacy had access to up-to-date copies of reference sources including the British National Formulary (BNF) and British National Formulary for children (BNFc). And it had access to the internet so that team members could access other up-to-date information.

The pharmacy had a range of CE marked measuring cylinders to accurately measure liquid medication. The pharmacy used an automated machine to prepare doses of medicine used in the supervision service. This machine was cleaned and calibrated daily, but team members did not record the details of who had completed the calibration. Team members used triangles to count tablets and had a separately marked triangle for cytotoxic medication such as methotrexate. And it had two fridges to hold medicines requiring cold storage. The fridges had glass doors to enable stock to be viewed without prolonged opening of the door.

The pharmacy had cordless telephones so that conversations were kept private. And it stored medicines awaiting collection in the dispensary, so people's private information was protected. Confidential information was secured on computers using passwords. Computer screens were positioned within the dispensary so that only authorised people could see them.

## What do the summary findings for each principle mean?

Finding	Meaning
✓ <b>Excellent practice</b>	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.
✓ <b>Good practice</b>	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✓ <b>Standards met</b>	The pharmacy meets all the standards.
<b>Standards not all met</b>	The pharmacy has not met one or more standards.