

Registered pharmacy inspection report

Pharmacy Name: Gordons Chemists, 26-30 Charlotte Street,
STRANRAER, Wigtownshire, DG9 7EF

Pharmacy reference: 1091210

Type of pharmacy: Community

Date of inspection: 06/06/2019

Pharmacy context

The pharmacy is in the town centre. It receives most of its prescriptions from the local health centre. And some from outlying surgeries. It dispenses NHS and private prescriptions and sells over-the-counter medicines. And it delivers medicines to people's homes. It supplies medicines in multi-compartmental compliance packs, to help people remember to take their medicines. And it provides NHS services such as smoking cessation and a substance misuse service.

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 generally identifies and manages the risks associated with its services. The pharmacy has written procedures that the team members follow. But they have not been recently reviewed or signed by all the team. But the team members have a clear understanding of the roles and tasks. And they work in a safe way to provide services to people using the pharmacy. The pharmacy team members discuss mistakes they make during the dispensing process responsibly. But they have lapsed in the recording of these. So, they may be missing out on some learning opportunities to prevent similar mistakes from occurring. The pharmacy maintains the records it must by law. But, some records are not frequently checked to make sure they match what is in stock. So, pharmacy team members may not know if there are any errors or losses. The pharmacy has a complaints process but does not display information to people on how they can raise concerns. So, people may not feel able to make comments. The pharmacy looks after people's private information and it explains how they will use it. And the pharmacy team members know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy was in the middle of a refit with improvements made to the retrieval section within the pharmacy. There was a dedicated area, with ample shelving and bench space. This was still work in progress. The dispensary had more shelving now for stock and this was being laid out with a dedicated section for the fast-moving lines. The stock was being reviewed and the downstairs dispensary was being cleared of clutter and stock sorted in to more manageable ways. Obsolete stock and equipment were being removed from the pharmacy.

The pharmacy had standard operating procedures (SOPs) which the pharmacy team members have read. The date of review was April 2018. The pharmacy advised that these were being reviewed centrally at the moment. The team had signed previous versions except the regular relief who advised he had read them. Certain SOPs specified tasks or certain members who could carry out jobs. This included making controlled drug (CD) register entries and undertaking monthly stock checks. The SOPs had specified restrictions on entering in the registers to provide better control.

The pharmacy workflow provided different sections for dispensing activities with dedicated benches for assembly and checking, with a separate room downstairs for compliance aid preparation. The main dispensing bench had two pharmacists checking and dispensing as required.

The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used different colours of baskets for waiting, call back and delivery to distinguish patients' prescriptions by degree of urgency and this helped plan workload. And marked prescriptions for waiting, call back and delivery.

The pharmacy team members had recorded near misses found and corrected during the dispensing process. The team had recorded these on a specific template. The process had lapsed recently, and the team members could not locate the file. They advised they discussed issues with similar boxes and they had separated similar items on the shelves. The team members were able to give examples. They had used shelf alerts, but these had been removed during the changes to the stock locations on the shelves. The pharmacist advised that the pharmacy manager was on leave, but they would reinstate the

process, especially due to the change in layout and there being some newer starters. The dispenser who had recently joined the company advised of the process she previously used and was familiar with logging near misses and reviews.

The pharmacy had a process for dealing with complaints although this was not displayed in the pharmacy. The pharmacy head office shared learning from other pharmacies if it became aware of any complaints or if there were any comments which would improve services for people. One of the pharmacies had an incident when a person required a defibrillator and following this the company ensured that all the pharmacies displayed a notice where defibrillators were located. This pharmacy had a large notice in the dispensary with the location of a defibrillator in the town. There was a procedure to record and report dispensing errors.

The pharmacy had current indemnity insurance with an expiry date of 30 September 2019.

The pharmacy had the correct Responsible pharmacist (RP) notice. And the pharmacists completed the Responsible pharmacist records as required.

A sample of the CD registers looked at were complete. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy kept a record of CDs which people had returned for disposal and it had a process in place to ensure the team destroyed these promptly. And did not allow a build-up in the CD cabinet. One bag in the CD cabinet was marked as a patient returned item and this had not been entered in the register. The dispenser did this once it was drawn to her attention. But she did not know who had written 'patient return' on the bag. The records for private prescriptions were largely complete with a few emergency supplies not having reasons. The pharmacy kept special records for unlicensed products with the certificates of conformity completed.

The pharmacy displayed information on the confidential data kept and how it complied with legislation. The pharmacy displayed a notice on the door, on how it looked after information. The team had read General Data Protection Regulation (GDPR) information. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. Confidential waste was disposed of in the pharmacy, with two shredders available.

The area manager advised the team had been sent the NPA factsheet 'Clinical Governance: Safeguarding vulnerable groups' but this could not be found. He advised he would resend and ensure all staff read. The pharmacists had undergone training and advised they would use the internet for contact information. And would display for the team.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe and effective services. The pharmacy team members are competent and have the skills and qualifications they need for their role. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to some ongoing training but there is no regular training plan and records kept. The lack of formal training and records may make it difficult to tailor training and keep their skills and knowledge up to date.

Inspector's evidence

There were two pharmacists, one technician, four dispensers and four medicines counter assistants (MCA) who worked in the pharmacy.

There were two pharmacists present every day except Saturdays. The technician worked 22 and a half hours a week. There were three dispensers who worked full time and one who worked three days a week. One of the MCAs worked full time and, one four days a week and one three days a week. The other had a zero hours contract and worked every Saturday, and extra during the week as required. She generally worked some days in most weeks, with recent changes. The pharmacy had reviewed the staffing levels and the hours of staffing had increased. The pharmacy now had two fulltime dispensers which had replaced 1 and a half dispensers who had left.

The team advised they had their own certificates and qualifications. And the pharmacy had checked the qualifications of any starters when they commenced their role.

Team members described how they read through magazines and leaflets from suppliers and other third parties, but this was not recorded. Team members did not receive protected training time, but they read articles during their breaks. The pharmacy received up to date emails from the head office on a variety of topics to keep staff informed of requirements and actions required. The pharmacy did not keep specific records of ongoing training.

The pharmacists had done relevant training for services such as Emergency Hormonal Contraception (EHC), impetigo and trimethoprim.

The team received performance reviews which gave the chance to receive feedback and discuss development needs.

The MCA followed the sales of medicines protocol when making over the counter (OTC) recommendations and referring to the pharmacist when necessary.

The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacist or the superintendent (SI). The SI had attended the pharmacy recently, prior to the refit and had spoken individually to each team member and encouraged feedback especially in relation to the changes.

The dispensary team worked closely together, and the dispenser said they were able to provide feedback about the ongoing restructuring of the dispensary. The area manager had been present a lot

recently and they could approach him with concerns.

Some of the team advised that they had a contact at head office should they wish to raise any concerns confidentially outside the pharmacy if needed. The newer starters required to know who they could speak to.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is safe and suitable for the pharmacy services it provides. And the pharmacy team members ensure that they address safety during work being undertaken. The pharmacy has facilities for private conversations for people to have, if required.

Inspector's evidence

The pharmacy was in the middle of a refit. There were several additional staff in assisting with the refit, including fitters and the area manager. There were additional pharmacists (on the Northern Ireland register – not the GPhC) who attended to provide pharmacist input and minimise any additional disruption. They had cleared space first, to aid with the changes to shelving. The layout was improving with more space for dispensing, storing stock and medicines and devices waiting collection. The pharmacy had reviewed and considered the retrieval and collection section to provide enough space for this. The layout had been considered in light of the introduction of changes in processes from the Falsified Medicines Directive (FMD).

The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The pharmacy had a rota for the cleaning of benches, shelves and flooring. During the refit the team required to hoovering and wash the floor but as work was in progress they managed this the best they could. They continued to manage this until the pharmacy was in order. The team in the retail area kept the floor as clear as possible of boxes to reduce the risk of trip hazards. The room temperature was generally comfortable but with the doors open some of the team advised it was a bit cool. The pharmacy was and well lit.

The pharmacy had an adequately sized, signposted, sound proofed consultation room. It was not particularly clear due to the refit taking place, but people could still have a conversation in private if required. There was also a dedicated area for the substance misuse service which provided privacy for people. The team used cordless phones for private conversations.

The pharmacy was reviewing the layout of the new collection retrieval point. And the access to the dispensary. The team members were discussing the type of barrier required to ensure people would not approach the retrieval area. Or the dispensary. So, they would ensure that the pharmacy maintained, privacy and confidentiality.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are accessible to people, including people using wheelchairs. And they deliver medicines to peoples' homes. It supplies medicines in compliance packs when it will help people to take their medicines appropriately. And it makes sure people receive their packs when they need them. The pharmacy gets its medicines from reputable suppliers. It generally adheres to storage requirements during the dispensing process. It takes the right action if it receives any alerts that a medicine is no longer safe to use. And takes the correct action to return it to the supplier.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was an automatic door at the entrance and a ramp within the pharmacy which allowed easy access for all. There was some customer seating. The team members wore name badges with their role. The pharmacy had some posters in the window with services. The hours of opening were on the door. There was

A range of leaflets in a rack but this was a bit disorganised. There were plans in the refit to have a more dedicated display of health care leaflets and information for people. The pharmacy kept Pharmacy only medicines behind the medicines counter and the team members assisted people requiring these items.

The pharmacy team members advised that they provided the Chronic Medication Service (CMS) and this was currently being reviewed and refreshed by the Health Board, in the area. They were reinstating the process. The pharmacy provided serial prescriptions to around ten people.

The pharmacy had folders for the services through Patient Group Directives (PGDs). These were accessible for reference. They included trimethoprim which was popular with people being referred by their surgery, impetigo with varying levels of use and flucloxacillin which had little uptake.

The pharmacist and dispenser provided the smoking cessation service and had about six people on the service. The dispenser had recently started the service after completing her training. The pharmacy provided a Minor Ailments service and the team advised that older people tended to use the service and items for throat conditions and mouthwashes were popular. The pharmacy provided the unscheduled care service and explained that it was particularly good for synchronisation of medicines for people. People liked this service as it helped them take their medicines correctly. They supplied around 36 patients with their medication through the Level C service, with original packs and a medicines administration record.

The pharmacy supplied about 100 people with multi-compartmental compliance packs to help them take their medicines. The process was undertaken downstairs and the area used, was being tidied up during the refit. There was a long bench used for dispensing the packs and there was some shelving for storage once completed. The pharmacy was looking at adding an additional row of shelving, so the dispenser could place completed trays, waiting for a check, safely on these. So, delivery drivers and others could use the bench without knocking any packs. All patients had profile records and the team recorded changes, with who had requested the change and when. The dispenser advised she undertook

a count of all items in each cell as part of her checking process. The pharmacy provided Patient information leaflets (PILs) with the first week of each cycle.

The pharmacy offered a substance misuse service for methadone and buprenorphine. It had recently installed the Methameasure system for the measuring of methadone. And developing how best to use this. It was also reviewing the layout of the controlled drugs cabinets, as one was no longer used for storing supplies of methadone.

The pharmacy provided a needle exchange service and had a section with information available to people using this service. They had forms which people completed with what they required such as needles, spoons, citric acid, water and wipes. The pharmacy displayed a notice which reminded people that they could now obtain foils as part of the service.

There was a clear audit trail of the dispensing process. The team completed the “dispensed by” and “checked by” boxes which showed who had performed these roles. And a sample of completed prescriptions looked, at found compliance with this process. There were some alerts stickers used to apply to prescriptions to raise awareness at the point of supply. These included warfarin, methotrexate and lithium which ensured patients received additional counselling.

The team used CD and fridge stickers on bags and prescriptions to alert the person handing the medication over to add these items. The CD stickers recorded the last date for supply, to make sure it was within the 28-day legal limit. This prevented supplies when the prescription was no longer valid. The local surgeries had prepared for the changes in legislation for gabapentin and pregabalin which had assisted in smooth supplies for people.

When the pharmacy could not provide the product or quantity prescribed in full, it gave patients an owing slip. And the pharmacy kept one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers if items were unobtainable at the current time for an alternative.

The pharmacy team members were aware of the Valproate Pregnancy Prevention Plan. They provided people with the warning cards to continue to raise awareness to them.

The pharmacy provided a repeat prescription collection service.

The pharmacy kept a delivery sheet as an audit trail for the delivery of medicines from the pharmacy to patients. This included a signature of receipt of the delivery. The driver used a separate delivery sheet for controlled drugs.

The pharmacy stored medicines in an organised way, generally within the original manufacturers packaging and at an appropriate temperature. The methadone bottle in the Methameasure was not labelled with the required details such as batch number, manufacturer and expiry date.

The pharmacy had two refrigerators from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team recorded temperature readings daily in the Community Pharmacy Scotland log book. And they checked these to ensure the refrigerator remained within the required temperature range.

The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. The team members marked short dated items and they took these off the shelf prior to the expiry date. The head office sent through a list of products for the pharmacy to check and if

the pharmacy was not going to use an item they could send it to another branch which would use it. The team members marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use.

The pharmacy obtained medicines from supplies such as AAH, Alliance and Ethigen. The team were aware of the Falsified Medicines Directive (FMD) and that the company were trialling this in three branches. The company were trialling with integrated systems and stand-alone scanners. The pharmacy was making room for additional terminals for the process, during the refit. The SOPs were being completed during this trial process.

The team used appropriate medicinal waste bins for patient returned medication. These were uplifted regularly. The pharmacy had appropriate denaturing kits for the destruction of CDs.

The pharmacy had a process to receive drug safety alerts and recalls from their head office. The team actioned these and the pharmacy had to notify the head office that it had completed the task.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people's privacy.

Inspector's evidence

The pharmacy had access to a range of up to date reference sources, including the British National Formulary (BNF). They used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs).

The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It had a separate range of measures for measuring methadone. It also had a range of equipment for counting loose tablets and capsules. They cleaned triangles after use. The pharmacy obtained methotrexate in blister packs when possible and the pharmacy had a separate triangle if it required to count these.

The team had access to disposable gloves and alcohol hand washing gel.

The equipment such as the carbon monoxide monitor, and blood pressure machine appeared in good working order and the team checked these as required. They checked the glucose monitor and they calibrated it regularly to make sure it was providing accurate readings. The pharmacy sent it away for checks.

The pharmacy stored medication waiting collection in the newly laid out shelving where people could not see any confidential details. The team filed the prescription in boxes in a retrieval system out of view, keeping details private. This was greatly improved from previous occasions. And was being developed to ensure it retrieval would work well for the team and people waiting to collect their medication.

The computer screens were out of view of the public.

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.