General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Davidsons Chemist, 75 High Street, LOCKERBIE, Dumfriesshire, DG11 2JH

Pharmacy reference: 1092285

Type of pharmacy: Community

Date of inspection: 15/02/2023

Pharmacy context

This is a busy community pharmacy in Lockerbie in Dumfries and Galloway. Its main activities are dispensing NHS prescriptions and providing medicines to people in multi-compartment compliance packs to help them take their medicine correctly. It also sells medicines to people over the counter and provides services and advice under the Pharmacy First scheme.

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 suitable written procedures to guide team members to work safely and effectively. Team members record and appropriately reflect on errors. They share learnings from errors to drive improvements in working practices. They understand their role and the tasks they are responsible for. And they know how to appropriately respond to people's feedback. Team members mostly keep the records required by law and they keep confidential information secure. They respond appropriately to concerns about vulnerable people in their community.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to guide team members to complete tasks safely and effectively. Team members easily accessed these on the company's intranet. But records to confirm that team members had signed to confirm their compliance with them could not be found. They explained they had signed them previously and the company was in the process of updating the SOPs to a digital platform where electronic signatures would be captured. The responsible pharmacist (RP) SOPs were overdue for review, and a declaration from the superintendent (SI) pharmacist confirmed that the review date had been extended as there were no required changes. But there was no date to confirm when they had been extended to. Sampling of the SOP for checking the expiry date of medicines in the pharmacy confirmed that team members were following written procedures.

The pharmacy team members regularly recorded errors made and identified in the dispensing process known as near misses. They explained that each team member electronically recorded and reflected on their own near misses. Team members scanned a QR code onto a handheld device or on their phones which meant errors were recorded quickly and easily without the need to interrupt other dispensing activities to use a computer. And completed records were detailed. Team members explained that the technology allowed them to scan dispensing labels and medicine packs to help identify errors such as incorrect selections and transposed labels. And they felt this helped keep the volume of near misses low. Team members annotated the medicine label with a tick or a cross to confirm whether scanning had been completed successfully or not. This helped inform the pharmacist's check. The technology had an audio function, that informed team members when unusual strengths of medicines were identified on prescriptions. And they marked the prescription to draw attention to these items when dispensing. The pharmacy technician gathered data from near misses monthly, identified any trends and completed a patient safety review. But it was unclear as to when this was last recorded formally. Team members did however discuss errors informally and made changes to help prevent a recurrence of the error, such as separating medicines that looked alike or sounded alike and placing them in a designated "higher risk" area. They also recorded errors made in the dispensing process that were identified after the person had received their medicine, known as dispensing incidents. The pharmacist explained that a recent dispensing incident involved an incorrectly labelled medicine. A root cause analysis was carried out to establish the reasons for the error and communicated to all team members. Near misses and dispensing incidents were shared with the superintendent's team at the company's head office. Once a week a review of all near misses, dispensing incidents and learnings from other pharmacies were communicated to all pharmacies to help prevent a recurrence across all pharmacies in the group.

Team members had clear job roles and responsibilities, and there was a description of each job role

displayed in the staffing area of the pharmacy for team members to refer to if necessary. They understood what to do in the absence of the RP and were able to refer to a SOP detailing this if required. The RP notice was prominently displayed in the retail area and reflected the correct details of the pharmacist on duty.

The pharmacy had a complaints procedure which was accessed on the company's website. Team members explained that any complaints were usually resolved by the pharmacist and if they remained unresolved, they supplied people with a phone number and email to contact the company head office. Feedback was also captured via an online survey and via an instore feedback form which was either shared with the team or posted to the company's head office. The pharmacy had current professional indemnity insurance.

The pharmacy kept mainly electronic records. These were mostly accurate, and the RP record reflected the details of the pharmacist on duty. However, on occasions the RP had not annotated the record to reflect when he had ceased to be the RP. The pharmacy dispensed private prescriptions for people and animals. Occasionally, details were not annotated on the prescription, such as the date of supply or corresponding reference numbers. The pharmacy supplied unlicensed medicines known as "specials". It kept a record of who received the items but occasionally, it didn't capture details of who had prescribed them. The pharmacy kept records of controlled drugs; a sample checked complied with regulations. Team members carried out checks of the stock balance against the register running balance when stock was received or supplied and weekly. And they kept records of patient CD returned stock.

Pharmacy team members completed company provided data protection and information governance training annually. They were aware of their responsibilities surrounding confidentiality and kept confidential information separately, which was transferred to the company's head office for shredding. Team members had completed training in safeguarding vulnerable adults and children and were aware of their responsibilities surrounding reporting any concerns. This included the pharmacy's delivery driver who explained he had previously highlighted concerns about an elderly person to the pharmacist who had reported these to the GP surgery. The pharmacy displayed contact details of local safeguarding teams and the pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably trained team members who work safely and effectively together to manage the workload. They complete regular training to keep their knowledge and skills up to date. And they feel comfortable to raise concerns and make suggestions for improvements.

Inspector's evidence

Pharmacy team members included the regular RP, a regular locum pharmacist, an accuracy checking pharmacy technician, a pharmacy technician, an accuracy checking assistant, four trainee dispensers, one trained dispenser, one medicines counter assistant and a delivery driver. The pharmacy was busy at the time of the inspection and team members were observed to be working safely and effectively to manage the workload. The pharmacy employed mainly part-time team members, which meant it was easier to cover holidays and sickness.

Team members were provided with monthly training and where possible this was completed in working hours. But some team members preferred to undertake their training out with working hours at home. Compliance was monitored by the company's head office team who reminded team members to complete any outstanding training. Team members confirmed they were up to date with the latest training. Pharmacy team members were observed understanding the limit of their competency when selling medicines over the counter and referred to the pharmacist for advice when required. They worked well together and supported each other to complete tasks and they felt comfortable to raise concerns if necessary. They knew who to raise them with, which included the regular pharmacist or the superintendent pharmacist. Team members had previously received performance reviews and had conversations with the pharmacist about their development, but updated reviews had not been completed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy, and it provides sufficient space for different dispensing tasks. It has a suitably sized soundproof room where people can access services and have private conversations with team members.

Inspector's evidence

The pharmacy was clean and tidy and free from clutter and trip hazards. The dispensary was well organised, and medicines were stored neatly on shelves. There was sufficient bench space for separate dispensing tasks to be completed, including a large dispensing bench in the rear of the pharmacy where dispensing of multi-compartment compliance packs took place. Access to the dispensary was restricted for unauthorised people, due to the position of the pharmacy counter, a swing barrier and a screen on the countertop.

The pharmacy had a soundproofed room where people could have private conversations with team members and access services from the pharmacist. The room had a desk and appropriate space to allow services to be carried out safely. The dispensary had a sink which was used for handwashing and preparing of medicines. And there were clean toilet facilities within the staffing area that also had a sink with hot and cold water and soap for hand washing. Lighting was bright throughout the pharmacy and the temperature was comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. And it makes its services accessible to people. Team members store and manage medicines appropriately. They make sure people taking higher-risk medicines receive the advice and information they need to take their medicines safely.

Inspector's evidence

The pharmacy retail area and medicines counter were positioned higher than street level. But a step free entrance and internal ramp from the street allowed for ease of access for people with limited mobility and with push chairs. The pharmacy team delivered various NHS pharmacy services such as the pharmacy first service, smoking cessation, and emergency hormonal contraception. The pharmacist explained that he had signed documentation to confirm his compliance with patient group directions (PGDs) which guided and supported him to provide the services safely and effectively.

The pharmacy used different tools to help deliver its dispensing services safely. Team members kept people's prescriptions and medicines in baskets to reduce the risk of their medications being mixed up. And they used stickers to highlight actions needed, such as interventions required by the pharmacist, or highlighting a prescription with a controlled drug or fridge line so that people received these medicines from the different storage locations. There was an audit trail that identified each team member involved in the stages of the dispensing process.

Team members dispensed medicines into multi-compartment compliance packs to help people take their medicines properly. They explained each person had a folder detailing the medicine they took, and these were checked against their prescriptions. And any discrepancies were queried with the GP surgery. Team members documented any changes confirmed by the GP surgery. Separate storage locations were used for each person's completed packs to minimise the risk of packs being mixed up. Pharmacy team members explained some of the packs were completed using an automated dispensing robot at another pharmacy within the company. They used this to help manage workload. And they confirmed people who had their packs dispensed in this way had given consent. Multi-compartment compliance packs were annotated with the descriptions of the medicines in the pack. But the descriptions were missing information such as colours or markings. This may make it difficult for patients to identify their medicines. Multi-compartment compliance packs supplied by the automated dispensing robot included a picture of the medicines so that people could more easily identify their medicines. Team members supplied people with patient information leaflets alongside their packs so that they had the required information about their medicines.

The pharmacy organised the dispensing of serial prescriptions to ensure that these were dispensed ahead of time. Team members had conversations with people who collected their medication later than expected to ascertain the reason why. But instances where people hadn't collected their medication at the expected time were not routinely highlighted to the person's GP which meant that opportunities to identify any non-compliance may be missed.

The pharmacy provided a delivery service, taking medicines to people's homes. Team members explained the driver had a paper record of deliveries to be made each day. And this was annotated to

include additional items such as controlled drugs or fridge lines. The driver signed a copy to confirm successful delivery to people and returned any failed deliveries to the pharmacy after leaving a note of attempted delivery. Team members explained that failed delivery prescriptions were kept separately and tracked through the computer system so that they could be easily located when a person requested re-delivery.

The pharmacy sourced medicines from a range of recognised suppliers. It had a written procedure for checking the expiry dates of medicines. And team members were observed to be following the written procedure. Team members explained that each day the head office team provided a list of medicines and other items to be counted and the expiry dates checked. This included both dispensary stock and retail stock. The information gathered was then reported back to head office. Team members identified any medicines going out of date in the next six months and used stickers to highlight their short expiry date. Random sampling of ten medicines confirmed no out-of-date medicines. Liquid medicines with a short shelf life after opening were marked with the date of opening. The pharmacy electronically recorded fridge temperatures daily, and compliance was monitored by the head office team. The head office team contacted the pharmacy to prompt them to record the temperature if required, so records were fully completed and reflected that medicines were kept within the 2-8 degrees required. Controlled drugs waiting to be supplied to people were kept separately from date expired CDs and patient returned CDs to prevent them from being mixed up. And the pharmacist destroyed the returned medicines appropriately on a regular basis.

Team members knew to obtain additional information when dispensing higher-risk medicines such as valproate, lithium, and warfarin. The medicines were kept separately from routine stock to help team members identify they were higher risk. Team members used stickers during the dispensing process to highlight that these medicines required additional counselling to ensure people took their medicines safely. They were aware of the additional counselling and patient cards to be given to people taking valproate in the at-risk group and highlighted these prescriptions to the pharmacist. The pharmacist was aware of the additional counselling and information he was required to convey when handing out prescriptions for valproate. Team members understood the procedure to manage drug alerts and medicines recalls. These were received from head office in the form of a spreadsheet which detailed the actions to be taken. Team members then signed to confirm they had been actioned and the information returned to head office.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses its equipment and facilities to maintain people's privacy.

Inspector's evidence

The pharmacy team members had electronic access to a range of reference sources including the British National Formulary (BNF) and BNFc (for children). The pharmacy had a monitor available to check people’s blood pressure and although it was not marked with the date of first use, the pharmacist confirmed it was due to be calibrated. Team members sourced equipment from recognised suppliers and measures used for liquids were crown marked to show they could be relied on for accurate measurements. Team members had marked measures so that they could easily be identified which were to be used for liquid medicines and which were to be used for water. They used triangles to count tablets, and these were observed to be clean. There was appropriate equipment for the destruction of patient returned controlled drugs. There was a cordless phone which allowed conversations to be carried out in private. Computers were password protected to prevent unauthorised access. And they were positioned so that screens could only been seen by team members. Items awaiting collection were retained in the dispensary and so were kept secure from being seen by unauthorised people.

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.