General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dalrymple Pharmacy, 6 Main Street, Dalrymple, AYR, Ayrshire, KA6 6DF

Pharmacy reference: 1097904

Type of pharmacy: Community

Date of inspection: 29/03/2023

Pharmacy context

This is a pharmacy in the small village of Dalrymple in Ayrshire. Its main activities are dispensing NHS prescriptions and providing medicines for people in multi-compartment compliance packs to help them take their medicines correctly. The pharmacy benefits from pharmacist prescribers who provide the NHS Pharmacy First Plus service, where people can seek advice and treatment for a range of illnesses. This includes for urinary tract infections and ear, nose, and throat conditions. The pharmacy has private vaccination clinics, for travel and influenza. And it provides a prescription collection and delivery service.

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	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 processes in place to help identify and manage risks with its services. And it has suitable written procedures for most of its services. Team members appropriately record and reflect on any errors. And they share learnings to help prevent it happening again. They mostly keep the records they are required to. Team members know when to act to protect vulnerable people in their community. And they keep people's private information secure.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which helped guide team members to work safely and effectively. And team members had signed to confirm their understanding and compliance with them. But there were no SOPs governing the delivery service. The SOPs had been implemented two years previously by the superintendent pharmacist (SI) when the pharmacy had changed ownership. They were not dated to indicate when a review would take place, but the SI confirmed this was planned for April. The pharmacy provided both NHS and private services. The governance of the NHS services was underpinned by documentation such as patient group directions (PGDs) and local pharmacy specifications. The pharmacist had designed an assessment form for a private vaccination service which assessed and mitigated some of the risks in providing the service by capturing past vaccination history, and if a person had any allergies or was pregnant. This documentation was up to date meaning the pharmacist was working with the most recent information.

The pharmacy team members recorded errors made and identified in the dispensing process known as near misses. Each team member was responsible for recording their near miss and learnings to help prevent a recurrence. They discussed errors and shared learnings informally as a team. For example, a near miss identified that different pack sizes of amoxicillin looked very similar and so it was suggested and implemented that these be separated on the shelf. Team members explained when they identified medicines that look-alike or sound-alike (LASAs), they highlighted these to each other to help mitigate the risk of incorrect selection. The pharmacist reviewed the data each month to identify any trends. But sometimes trends could not easily be identified due to the number of near misses recorded. The pharmacy team members recorded errors identified after a person had received their medicines known as dispensing incidents. A recent dispensing incident involved a patient receiving an incorrect medication. Team members discussed the reasons the error may have happened and identified that it involved two LASA medications. They implemented separating the medicines and highlighted where they were stored with warning stickers to alert them to be careful when selecting the medicine in the future.

Team members had clear job roles and responsibilities. They explained they knew what to do in the absence of a responsible pharmacist (RP) and they could refer to a SOP if needed. The RP notice was prominently displayed in the retail area of the pharmacy and reflected the correct details of the pharmacist on duty. The pharmacy had current professional indemnity insurance.

The pharmacy had a SOP that detailed the procedure for responding to complaints. But there was no formal complaints policy on display in the pharmacy for people using pharmacy services to read. Team members explained complaints were dealt with by the pharmacist on duty, and this was usually the SI pharmacist. They explained they had good relationships with people and complaints were rarely

received. And they explained how they acted on feedback about when medicines were not ready when people presented to collect them. And so, the pharmacy had implemented a text messaging service to prevent unnecessary journeys. Following feedback, the team had implemented a change in processes for prescription collection, including picking up prescrpitions from further afield for people living in the local community.

The pharmacy kept both paper and electronic records. The RP records were mostly completed correctly, but the pharmacist had already signed out of the RP log, ahead of time. This meant that if there were any unexpected absences the record may not be contemporaneous. The pharmacy dispensed private prescriptions to people and for animals. Records seen captured the required information and corresponding prescriptions were retained by month in a folder for easy referencing. The pharmacy supplied unlicensed medicines known as “specials”. Records for these supplies were mostly completely accurately, but some were missing the details of the prescriber. The pharmacy kept electronic controlled drug (CD) records. And the sample seen complied with regulations. The pharmacist explained balance checks of the stock held against the register running balance were completed after each supply. A random balance check confirmed that the quantity in the register reflected the quantity held in the pharmacy. And the stock volume of liquid CDs used to provide a substance misuse service was checked weekly. The pharmacy kept a paper record of CDs returned by people. These were recorded on receipt and kept separately to avoid becoming mixed with stock.

The pharmacy did not have a written information governance policy in place and team members had not been given formal training. But they had discussed how to safeguard people's private information with the pharmacist and were aware of their responsibilities for keeping this information secure. For example, they knew to ask people for consent before being signed up to the text messaging service, and they knew to communicate any confidential information to people through a secure email system. The delivery driver also knew to keep people’s private information secure. They kept confidential information separately which was uplifted by a third-party company for secure destruction.

The pharmacy team members had not received any formal training for safeguarding vulnerable adults and children. The pharmacy displayed a poster that detailed procedures for the team to follow and who to get in touch with locally to raise concerns. Team members explained in the first instance if they had any concerns, they would report these to the pharmacist who would take appropriate action if necessary. The driver explained that good relationships with people meant that he was able to identify and report back to the pharmacist any concerns he had with those he was delivering to. And he had needed to do this on a few occasions.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably trained team members who work safely and effectively to manage the workload. And team members complete regular training relevant to their roles. They feel comfortable raising concerns if necessary and making suggestions to improve working practices.

Inspector's evidence

Pharmacy team members at the time of the inspection included the SI, a full-time dispenser, a full-time accuracy checking pharmacy technician, a part-time dispenser, and a part-time delivery driver. The pharmacy also had a further part-time trainee healthcare assistant (HCA) and a regular locum pharmacist. Team members were observed working well together to manage workload. And they were able to rotate tasks so that team members could complete all tasks if there was absence or holidays. The healthcare assistant's training was overseen by the SI and the regular locum pharmacist. Team members were encouraged to further their development by completing training. This included supporting any team member who wanted to undertake additional professional qualifications and arranging for team members to attend regular training provided by the Health Board. The pharmacist explained the Health Board provided training every few weeks which covered topical issues such as smoking cessation. Team members explained their most recent session covered training for a new service being launched in Ayrshire and Arran known as the Hospital Discharge Service. The pharmacists also took the opportunity to further develop their learning, with the locum pharmacist recently having attended palliative care training.

Team members were observed asking appropriate questions when selling medicines over the counter and referring to the pharmacist where necessary. They explained they were able to identify repeated requests from people for medicines liable to misuse and referred these to the pharmacist. The pharmacist explained she had conversations with people and referred to the GP as necessary. Team members shared with each other instances where repeated requests had occurred so that they could identify and offer support to people as a team.

The pharmacist carried out annual appraisals where team members were encouraged to reflect on their performance and set any new objectives for the upcoming year. The annual review was due to be completed shortly after inspection. Team members explained they felt comfortable discussing their mistakes and sharing learnings to drive improvements in the working practices. Team members explained they felt comfortable to raise any concerns, if necessary, but they had never felt that they needed to. The pharmacist explained that the team work well together to drive performance without the need for targets to be set.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and tidy and provide a suitable space for the pharmacy's services. It has a suitably sized soundproofed room where people can have private conversations with team members and access services with the pharmacist.

Inspector's evidence

The pharmacy premises were clean, tidy, and free from clutter and trip hazards. The dispensary was small but there was room to move around comfortably. And the retail area at the front of the premises was suitably sized for people waiting to access services. There was an additional space upstairs which had an office and a room where the preparation of multi-compartment compliance packs took place. There were small bench areas within the dispensary for the dispensing of medicines, but the areas were managed well and tidy. The pharmacist had a small area for checking medicines. The room upstairs was spacious for the dispensing of multi-compartment compliance packs. Team members kept their workstations as organised as possible which reduced any risk of errors. If necessary, team members knew who to contact if repairs were needed, and these were usually completed the same day.

The pharmacy had a soundproofed room where people could have private conversations with team members. The entrance from the retail area was secured when not in use. Team members explained that screens they had installed at the medicines counter during the pandemic had been retained as they felt it gave them added privacy and security. There was a sink in the dispensary which was used for professional use and hand washing. And a bathroom next to the dispensary was clean and hygienic and provided facilities for hand washing. Team members explained they shared responsibility for cleaning tasks, and these were carried out throughout the week. The dispensary and upstairs room were bright, and the temperature was ambient throughout.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a wide range of services for people in the local community. And it manages these services safely and effectively. The pharmacy checks people accessing its services receive appropriate care. And it works well with people's regular prescriber to keep them informed. Pharmacy team members store and manage medicines as they should.

Inspector's evidence

The pharmacy had level access from the street for people with limited mobility and with pushchairs. And an internal door had been widened to allow people to gain access to the healthcare area.

The pharmacy delivered various NHS services such as Pharmacy First Plus, which included advice and treatment for urinary tract infections, skin infections and shingles. And it provided both NHS and private vaccinations for influenza, as well as a private travel vaccination service. The RP and regular locum pharmacist were independent prescribers (IPs) meaning that they could prescribe and treat people for a range of conditions. The pharmacy provided NHS consultations in a contraceptive clinic, providing contraceptive medication to people. The RP had undergone a period of shadowing and training with local NHS teams to develop her competency to deliver the service. And people were seen accessing the service during the inspection. Other services provided under the NHS were supported by patient group directions (PGDs) and local pharmacy specificiations. And these helped guide the pharmacists to provide services safely and effectively. These were reviewed and updated by the NHS and communicated to the pharmacy. But some of the copies of the PGDs available were out-of-date. These were updated during the inspection to ensure the pharmacists were working from the most recent versions. The pharmacist ensured that for both NHS and private services, any consultations and prescribing were communicated to the person's usual prescriber so that there was a record at the surgery of the supply. The pharmacist retained paper copies of notes captured during consultations and these were transferred to the patient's PMR which helped provide information for team members when dispensing, such as being able to identify how often a medication was being supplied.

The pharmacy provided a private travel vaccination service. The SI and regular locum pharmacist had undergone additional training to become competent in delivering the service and had to update their yellow fever training annually as per the guidance issued by Public Health Scotland. There was no formal risk assessment for the service, however, the SI had developed a SOP and a consultation form for the vaccination service which helped to mitigate some of the risks identified. Prescriptions for the service were provided privately and records of the supply were kept in the pharmacy and the GP notified.

The pharmacy delivered medicines to people in their homes. It didn't have a SOP for delivery, but the delivery driver described the process he followed. He explained that he was provided with a paper sheet detailing the people he was to deliver medication for. He explained he didn't ask people to sign for their deliveries, but he would mark them as delivered on the sheet. The pharmacy kept a copy of this delivery sheet so that any queries regarding deliveries could be resolved. The driver ensured that medicines were stored appropriately within the van, for example using a coolbox to keep fridge items cool. The driver explained any failed delivered were returned to the store and a note left for the person

to contact the pharmacy to arrange re-delivery.

The pharmacy's main activity was to dispense NHS prescriptions. And it dispensed a large amount of these into multi-compartment compliance packs to help people take their medicines correctly. Each team member was trained to deliver the service. The service was well organised, and each person had a folder which contained their prescriptions and a chart detailing each medicine and the times of day the person took them. It also contained any communications about medication changes. The accuracy checking technician ordered the prescriptions in advance so that any queries could be resolved and so there was time to dispense the packs for when the person needed them. The packs contained descriptions of the tablets so that people could more esaily identify their medicines. And patient information leaflets were supplied, so people had the correct information to take their medicines safely. Each person who received a pack had their packs stored in a seperate storage location.

The pharmacy used different tools to help deliver its services safely and effectively. Team members provided people who had a visual impairment with large print labels to help them read information on the labels. When dispensing, they kept people's prescriptions and medicines together in baskets to reduce the risk of errors. And they used stickers on prescriptions to highlight actions needed, such as interventions by the pharmacy or the inclusion of a fridge line or controlled drug. Team members signed to indicate who had dispensed and who had checked the prescription so that team members involved at each stage of the dispensing process could be identified. They provided people with a note of any medication they didn't have in stock. Upon receipt of a stock delivery, the prescriptions were completed so that people were not delayed in receiving their medication. If medicines were not available, they would liaise wih the person's GP whether an alternative medicines was appropriate to be prescribed. Team members were aware of their responsibilities when dispensing higher-risk medication such as valproate to people in the at-risk category. They knew to give people the patient card highlighting the risks and the pharmacist was aware of the counselling required. But they currently did not dispense for people who were in the at-risk category. The pharmacy received drug recalls and patient safety alerts by NHS email. Team members explained they printed them off and actioned them and retained them in a folder showing this had been completed.

The pharmacy sourced medicines from several recognised suppliers. Team members had a process to check the expiry date of medicines. But they did not record when the date checking was carried out. The pharmacist explained that the dispensary had been checked in January, and any medicines identified as going out of date in the next six months were highlighted for use first. A recent near miss that had identified an out-of-date medicine being dispensed had led to the pharmacy changing its process of date checking to quarterly. A random spot check of medicines confirmed no out of dates. However, within the CD cabinet there was one pack that had gone out of date in the previous month. And some short-dated medicines within the dispensary were not highlighted or marked to show that they were going out of date in the next six months. Team members checked the expiry dates on medicines they were dispensing. The pharmacy had one fridge which was kept neat and tidy. And team members recorded the daily fridge temperature which confirmed that medicines were stored within the required 2-8 degrees.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had up-to-date references sources including both paper and electronic copies of the British National Formulary (BNF) and BNFc (for children). It had equipment to provide its services. This included a blood pressure monitor which was annotated with the date of first use and an otoscope used to allow the pharmacist to examine people's ears. There was suitable equipment for the provision of vaccination services, including four adrenaline pens which could be used if a person had an anaphylactic reaction. However, two of these were out of date. The pharmacist immediately quarantined them and ordered replacements. There were conical measuring cylinders used to measure liquid medicines. These were crown stamped and marked to indicate which were used for water and which were used for liquid medicines.

Computers were password protected to prevent unauthorised access. And they were positioned so that only team members could see them. The pharmacy had a cordless phone so that conversations could be kept private. Medicines awaiting collection were positioned within the dispensary so that only authorised people could see them. CD destruction kits were available to destroy any patient returns or out of date CD medicines.

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.