

Registered pharmacy inspection report

Pharmacy Name: Walter Davidson & Sons Ltd, 44 Main Street,
Drymen, GLASGOW, G63 0BG

Pharmacy reference: 1123367

Type of pharmacy: Community

Date of inspection: 28/09/2022

Pharmacy context

This is a community pharmacy in Drymen. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs).

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	1.1	Good practice	Team members proactively assess and manage areas of risk. They share learning from mistakes and use information from other pharmacies to make their services safer for people.
		1.2	Good practice	The pharmacy is good at recording and learning from errors. It regularly reviews these errors and makes good records of the learning and actions it takes to make services safer.
2. Staff	Good practice	2.1	Good practice	The pharmacy appropriately reviews its staffing levels and skill mix to provide assurance that they remain appropriate for the workload and services it provides.
		2.2	Good practice	The pharmacy encourages its team members to develop their skills and take further qualification training. They complete regular ongoing training, relevant to their roles, and they have time to do this while they are at work.
		2.4	Good practice	The pharmacy team demonstrates the effectiveness of its risk management strategies to provide safe delivery of its services. This includes a review of its multi-compartment compliance pack dispensing service to provide safe and effective care.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy team can demonstrate the effectiveness of risk management strategies they have adopted.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

Pharmacy team members follow good working practices. And they manage dispensing risks well to keep services safe. The pharmacy documents the mistakes team members make. And shares the learnings with the pharmacy team and the wider organisation. The pharmacy seeks to learn from other teams. And it introduces new practices to keep services safe and effective. The pharmacy keeps the records it needs to by law, and it suitably protects people's confidential information.

Inspector's evidence

The company had introduced processes to manage the risks and help prevent the spread of coronavirus. This included the use of a plastic screen at the medicines counter. And hand sanitizer at the pharmacy entrance for people to use. The company made good use of its electronic operating system to support its governance arrangements. And team members accessed the company's online policies and procedures and management tools via the pharmacy computer system. This included a range of relevant working instructions (SOPs), such as the 'responsible pharmacist' (RP) regulations and 'controlled drug' (CD) procedures. And team members recorded their signatures on paper records to show they had read and followed them. The superintendent pharmacist kept the SOPs under review and mostly updated them every two years. This ensured they reflected the good working practices in the pharmacy. Pharmacy team members signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacy had an audit trail for dispensing. It also helped the pharmacist to identify dispensers to help them learn from their dispensing mistakes. Team members recorded their own near miss errors on the pharmacy computer system. And they interacted with the system to produce an analysis and an info graphic to identify risks and show patterns and trends. Team members provided examples of changes they had made following the analysis. This included separating refrigerated eye drops to manage the risk of selection errors. The pharmacy submitted their near miss reports to the superintendent's office. And team members there carried out a further analysis to identify risks across the other 50 branches in the company. The learnings were documented in a weekly newsletter that they issued to each of the branches. The pharmacist produced evidence to show they applied some of the learnings where appropriate. For example, adding a 'red flag' alert on the pharmacy's PMR system to highlight people with similar names. The company encouraged people to provide feedback about the services they received. And blank feedback forms were available at the medicines counter. Head office provided feedback to teams and the pharmacy had been recognised as receiving the most positive feedback out of all the branches. Team members knew to record dispensing incidents on an electronic template. And the template included a section to record information about the root cause and the mitigations to improve safety arrangements. The pharmacist knew to send reports directly to the superintendent pharmacist who contacted the pharmacy to provide advice and support if necessary.

The pharmacy maintained the records it needed to by law. And it had public liability and professional indemnity insurances in place which were valid until 30 April 2023. The pharmacist displayed a 'responsible pharmacist' (RP) notice, and it was visible from the waiting area. The RP record showed the time the pharmacist took charge of the pharmacy. And it showed the time they finished at the end of the day. Team members maintained the electronic 'controlled drug' (CD) registers and kept them up to date. And they mostly checked and verified the balances on a weekly basis. People returned controlled

drugs they no longer needed for safe disposal. And an electronic destructions register showed the pharmacist had signed to confirm that destructions had taken place. Team members filed prescriptions so they could be easily retrieved if needed. And they kept records of supplies against private prescriptions up to date. The superintendent's office securely archived the pharmacy's legal records and securely disposed of them when they reached their expiry date. Team members packed and clearly labelled the boxes for the delivery driver to securely transport them to head office. The company trained team members to protect confidential information and to keep it safe and secure. And they disposed of confidential waste in designated containers that the company collected and disposed of at head office. The company trained team members to effectively manage safeguarding concerns. And they provided a few examples of scenarios when they would refer concerns to the most appropriate agency, such as the relevant GP practice.

Principle 2 - Staffing ✓ Good practice

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And they complete regular and relevant training, in work time, to improve their knowledge and their range of skills. The pharmacy reviews its staffing levels in line with changing workload. And it has reliable plans in place to cover team members absence.

Inspector's evidence

The pharmacy's workload had increased over the past 12 months. And the company had arranged for one of the dispensers to increase their hours to help manage the increased demand. A regular pharmacist manager had worked in the pharmacy for around two years. And two full-time experienced dispensers had been working there for several years. One of the dispensers had enrolled onto the 'accuracy checking dispenser' qualification. And on completion this would enable them to check prescriptions that had been authorised by a pharmacist. The company provided protected learning time during the working day. And this helped to support trainees undertaking qualifications or team members undergoing development. The company was supporting the pharmacist who was undergoing 'Pharmacist Independent Prescriber' (PIP) training. This involved providing pharmacist cover to enable them to attend off-site training during the working day. The company was supporting other pharmacists across its branches. And the trainee PIPs supported each other which the pharmacist found beneficial. The company was in the process of reviewing its training for delivery drivers. This was to ensure that the training met the required national standard. The pharmacy the NHS Flu vaccination and NHS Covid vaccination service planned for the season. And the pharmacist was up to date with the relevant 'patient group directions' (PGDs), 'service level agreements' (SLAs) and anaphylaxis training. The dispensers had also completed anaphylaxis training as part of the company's monthly training regime. The company monitored completion of the training it provided. And head office staff prompted team members when they were nearing training deadlines. The pharmacist delivered the smoking cessation service. And they were about to arrange training for one of the dispensers, so they too were eligible to provide the service.

The pharmacy had arrangements in place to cover leave. This included calling on dispensers from two nearby branches and head office for relief staff when needed. The pharmacy held a formal meeting every six to seven weeks. And team members recorded the minutes of the meetings. This included any actions that had been agreed. The company encouraged pharmacy teams across its branches to adopt new initiatives to improve their practices. And team members learned about notable practices from other branches which they recorded on the company's electronic 'tell me' log. The pharmacist provided examples of new practices they had adopted. This included the introduction of a 'do not deliver' slip that they attached to multi-compartment compliance pack storage boxes when people were admitted to hospital. This helped to manage the risk of ongoing deliveries whilst people were not at home. It also helped to avoid waste. The company provided teams with data to show how they were performing against the company's performance standards. And this helped them to identify areas for improvement. For example, it had helped team members to promote services such as the pharmacy's texting service which they used to tell people when their medication was ready for collection.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises adequately support the safe delivery of services. And the pharmacy suitably manages the space for the storage of its medicines. It has appropriate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean and well maintained, and it was tidy and well organised. The dispensary provided adequate space for dispensing and the storage of medicines. Team members used designated areas for dispensing and a separate bench to carry out accuracy checks. The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary. A sound-proofed consultation room was available for use. And it provided a confidential environment for private consultations. It also provided a sink with hot and cold running water. Team members used the dispensary sink for hand washing and the preparation of medicines. And they cleaned and sanitised the pharmacy on a regular basis to reduce the risk of spreading infection. This included frequent touch points such as keyboards, phones, and door handles. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages and reviews its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. It has arrangements in place to identify and remove medicines that are no longer fit for purpose. This ensures that medicines are suitable to supply.

Inspector's evidence

The pharmacy advertised its services and opening hours in the window. And it had a ramped entrance that provided unrestricted access for people with mobility difficulties. The pharmacy provided a range of services. And the company had introduced a pro-forma which team members used to gather information from people for the pharmacist. This helped them to refer people for advice when appropriate. Team members were issuing warning cards with supplies of opioid medication such as codeine containing products. The cards cautioned people about the risks of dependence and addiction. The pharmacy had planned a seasonal NHS Flu vaccination and NHS Covid vaccination service. And the health board had provided the relevant 'patient group directions' (PGDs) and service level agreements (SLAs) which the pharmacist had read and implemented. Team members kept stock neat and tidy on a series of shelves. And they kept the controlled drug cabinet well organised with sufficient space to keep items safely segregated. The pharmacy purchased medicines and medical devices from recognised suppliers. And the pharmacy used a tracker to show its date checking activities. Sampling showed that items were within their expiry date. Team members kept a list of short-dated stock. And they returned items to head office for onward distribution to other branches when appropriate to avoid waste. The pharmacy used a fridge to keep medicines at the manufacturers recommended temperature. And team members monitored and recorded the temperatures every day. This provided assurance that the fridges were operating within the accepted range of 2 and 8 degrees Celsius. Team members knew about valproate medication and the Pregnancy Prevention Programme. The pharmacist knew to speak to people in the at-risk group about the associated risks. And team members knew to supply patient information leaflets and to provide warning information cards with every supply.

The pharmacy supplied medicines in multi-compartment compliance packs to support people. And the pharmacist had recently carried out a review to confirm that people were benefitting from the arrangements. The company had defined the assembly and dispensing process in a documented procedure for team members to refer to. And they used supplementary records which provided a list of each person's current medication and dose times which they kept up to date. Team members used labelled storage boxes to safely store packs until they were needed. And they used a separate shelf to store packs for people that had been admitted to hospital. Team members dispensed four packs at a time. But they only supplied four packs at a time when the GP annotated people's prescriptions. They kept a week ahead of dispensing as part of the pharmacy's contingency planning arrangements. This helped to manage the workload, such as when team members were off work unexpectedly. The pharmacy had documented its contingency planning arrangements. And a hard copy was kept in a container alongside other items such as a torch and spare batteries. The pharmacy provided a prescription delivery service to help to support people. And team members kept an audit trail of the prescriptions it delivered. They recorded extra information for high-risk medications such as controlled drugs. Team members accepted unwanted medicines from people for disposal. And the pharmacy had

medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy received drug alerts and recall notifications from the superintendent's office. And team members printed, annotated, and retained the notices to show the action they had taken and what the outcome had been. For example, team members evidenced they had recently checked for Sandimmun Oral Solution.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for methadone. They kept the measures separate, so they were used exclusively for this purpose. The pharmacy kept equipment to carry out blood pressure monitoring and blood glucose testing. And the company issued new equipment on an annual basis. The blood pressure monitor was dated and was due to be replaced in September 2023. The pharmacy stored prescriptions for collection out of view of the waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. A portable phone allowed team members to carry out conversations in private if needed. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks.

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.